Burlington Care

The Limes

Inspection report

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Ratings

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

Overall summary

This inspection took place on 4 December 2014 and was unannounced. We previously visited the service on 14 May 2014 and on that occasion found that the provider met the regulations we assessed.

The service is registered to provide personal care and accommodation for 85 older people and there were 83 people living at the home on the day of the inspection. The home is situated close to the town centre of Driffield, in the East Riding of Yorkshire and is located within its own grounds. The Limes has a residential unit and a dedicated dementia unit that accommodates 33 people who are living with dementia. The units are staffed separately.

The provider is required to have a registered manager in post and on the day of the inspection there was a manager registered with the Care Quality Commission (CQC); they had been registered since 1 August 2013. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us that they felt safe living at the home. Staff had completed training on safeguarding adults from abuse and were able to describe to us the action they would take if they had concerns about someone's safety. They said that they were confident all staff would recognise and report any incidents or allegations of abuse.

People who used the service, visitors and health care professionals told us that staff were effective and had the skills they needed to carry out their roles. Records evidenced that staff took part in various training opportunities that would equip them to carry out their roles effectively.

The registered manager was aware of guidance in respect of providing a dementia friendly environment and progress had been made towards achieving this. Staff had undertaken training on dementia awareness and the Mental Capacity Act 2005 (MCA). This helped them to understand the care needs of people with a dementia related condition.

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

However, staff had not always been recruited following the home's policies and procedures to ensure that only people considered suitable to work with vulnerable people had been employed. This was a breach of Regulation 21 of the Health and Social Care Act 2008. You can see what action we told the provider to take at the back of the full version of the report.

People's nutritional needs had been assessed and people told us that they were satisfied with the meals provided by the home. We found that medicines were safely managed.

We observed good interactions between people who lived at the home and staff on the day of the inspection. People told us that staff were caring and this was supported by the visitors we spoke with.

People's comments and complaints were responded to appropriately and there were systems in place to seek feedback from people and their relatives about the service provided.

People who lived at the home, visitors and staff told us that the home was well managed, although a small number of staff told us that they did not always feel supported or listened to. The registered provider had appointed a staff advocate and it was hoped that this would give staff another person who they could discuss any concerns with.

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

Care provided was not completely safe.

Staff displayed a good understanding of the different types of abuse and were able to explain the action they would take if they observed an incident of abuse or became aware of an abusive situation.

We found that there were sufficient numbers of staff employed to ensure that the needs of the people who lived at the home could be met. However, staff were not always recruited following the home's policies and procedures to ensure only people considered suitable to work with vulnerable people had been employed.

The arrangements in place for the management of medicines were satisfactory; medication was stored safely and record keeping was accurate.

Is the service effective?

Good

Staff provided effective care.

We found the provider to be meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). Staff we spoke with understood how to protect the rights of people's who had limited capacity to make decisions for themselves. We saw that progress had been made towards providing a dementia friendly environment.

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

People's nutritional needs were assessed and met, and people told us that they were happy with the meals provided by the home. We saw that staff provided appropriate support for people who needed help to eat and drink. People told us they had access to health care professionals when required.

Is the service caring?

Good

Staff at the home were caring.

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

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

People were encouraged to be as independent as possible, with support from staff. Their individual care needs were understood by staff.

Is the service responsive?

Good

Staff at the home were responsive to people's needs.

Summary of findings

People's care plans recorded information about their previous lifestyle and the people who were important to them. Their preferences and wishes for their care were recorded and these were known by staff.

People were able to take part in their chosen activities and their visitors were made welcome at the home.

There was a complaints procedure in place and people were informed about how to make a complaint if they were dissatisfied with the service provided.

Is the service well-led?

Good

The home was well led.

There was a registered manager in post at the time of the inspection.

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

The manager carried out a variety of quality audits to monitor that the systems in place at the home were being followed by staff to ensure the safety and well-being of people who lived and worked there.

The Limes

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 checked 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 4 December 2014 and was unannounced. The inspection team consisted of an Adult Social Care lead inspector and second inspector.

Before this inspection we reviewed the information we held about the service, such as notifications we had received from the registered provider, information we had received from the local authority who commissioned a service from the home and information from health and social care professionals. The provider was not asked to submit a Provider Information Return (PIR) prior to the inspection, as this was not a planned inspection. We carried out the inspection at short notice because we had received information of concern that we needed to follow up.

On the day of the inspection we spoke with six people who lived at the home, one visitor, eight members of staff, the registered manager and the registered provider. We also spoke with two health care professionals who visited the home on the day of the inspection.

We spent time observing the interaction between people who lived at the home, relatives and staff. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at all areas of the home, including bedrooms (with people's permission) and office accommodation. We also spent time looking at records, which included the care records for three people who lived at the home, staff records and records relating to the management of the home.

Requires Improvement

Is the service safe?

Our findings

We spoke with six people who lived at the home and we asked them if they felt safe; they all told us that they did. Care plans included assessments that identified a person's level of risk. These included a nutritional assessment, a moving and handling assessment, a mental health assessment and a pressure care assessment. Assessments and risk assessments included information for staff on how to identify triggers that might result in risky situations and there were management plans in place to inform staff about how to reduce the identified risks. These had been reviewed regularly.

We checked the staff rotas and saw that staffing levels were appropriate for the number of people who lived at the home. We asked staff if there were usually enough staff on duty and they said that the manager always tried to cover staff absences although sometimes when staff rang in at very short notice, this had not been possible. We noticed that some shifts had been covered by people covering part of a shift, or two people covering part of a shift, and asked the registered manager if this created any confusion due to staff missing handover meetings. They acknowledged that this was not ideal but said that, because staff worked regular shifts, they were usually aware of people's up to date care needs. They also said that they sometimes had to cover part shifts when staff went off sick at short notice, and this was preferable to the home being short staffed.

Some staff told us about occasions when the home had been short staffed and felt that people had waited too long for attention during these periods. However, other staff told us that the people who lived at the home always received appropriate and timely care. People who lived at the home told us that there were enough staff on duty, although two people mentioned that they would like to go out more and staff did not always have time to accompany them. Visitors who we spoke with told us that they had observed that there were usually sufficient numbers of staff on duty and health care professionals told us that there was always a staff member to assist them when needed.

Ancillary staff were employed in addition to care staff; this included cooks, domestic staff and maintenance staff. This meant that care staff were able to spend most of their time concentrating on support for the people who lived at the home.

The training record evidenced that 51care staff had undertaken training on safeguarding adults from abuse which meant that 23 care staff had not completed this training. Eighteen of the 23 ancillary staff had also completed this training. There were safeguarding policies and procedures in place and the registered manager submitted alerts to the local authority as required, using the new thresholds that had been introduced by the local authority. We discussed this with the registered manager and it transpired they had not realised that, when the safeguarding threshold indicated an alert did not need to be submitted to the local authority and the issue could be managed in-house, a notification still had to be submitted to the Care Quality Commission.

Following the inspection the registered manager submitted a number of notifications in retrospect. We also noted that there was no log kept with safeguarding records where this decision making could be recorded. The registered manager told us that they would introduce this immediately. We noted that the registered manager kept a log of all other notifications submitted to the Care Quality Commission, including the type of notification and the date it was submitted.

Staff who we spoke with were able to describe different types of abuse. They were able to tell us what action they would take if they observed an incident of abuse or became aware of an allegation. Staff told us they felt all staff within the team would recognise inappropriate practice and report it to a senior member of staff.

We checked the recruitment records for four members of staff. We saw there was no job description included with staff personnel records and this provided a lack of evidence that staff understood their roles and what was expected of them. Application forms had been completed that recorded the applicant's employment history, the names of two employment referees and any relevant training. Documentation to confirm a person's identity had been obtained and retained with records. We saw that a Disclosure and Barring Service (DBS) check had not been obtained for one new employee prior to them commencing work at the home. In addition to this we saw that DBS disclosures for two people contained information that needed to be explored by the registered manager. There was no evidence of any discussions with these applicants to establish their suitability for the post and the decisions made about their employment.

Requires Improvement

Is the service safe?

An audit of staff recruitment records had been carried out by the registered manager on 3 December 2014. This recorded that one member of staff had started work prior to the receipt of two written references. An audit in November 2014 identified that a new member of staff had started work with only one written reference in place. This evidenced that the recruitment policies and procedures at the home had not been adhered to and that improvements had not been made when omissions were identified.

These shortfalls could have resulted in people considered unsuitable to work with vulnerable people being employed. This was a breach of Regulation 21 of the Health and Social Care Act 2008. You can see what action we told the provider to take at the back of the full version of the report.

We asked people who lived at the home if they received their medication at the right time and they all confirmed they received their medication when they needed it. A team leader explained the home's medication management systems to us and showed us how medication was stored and recorded.

The medication trolleys were stored in the medication room and were securely fixed to the wall. There was a dedicated medication fridge and we saw that fridge temperatures were recorded on a daily basis. In addition to this, the temperature of the room was also recorded each day. These daily checks ensured that medication was stored at the correct temperature.

The system in place to check that the medicines prescribed by the GP were the same as those supplied by the pharmacy was robust and there was a system in place to audit the management of medicines.

Medication was supplied in 'pods' that recorded the person's name and the name of the tablet. The 'pods' were colour coded to match the colours recorded on the MAR chart to identify the times that the medication needed to be taken. MAR charts included the person's photograph and a picture of the tablet or medication. This helped identify for staff the correct times of administration and helped to reduce the risk of errors occurring. There were topical charts in people's bedrooms that identified the area of the body where creams should be applied.

We checked the storage and recording of controlled drugs (CD's) and saw that this was satisfactory. We checked a random sample of CD's and the balance of medicines corresponded to the records in the CD register. We saw that two staff signed the CD book and the MAR chart to record administration of CD's.

We checked the records for medicines returned to the pharmacy, including CD's, and saw that these were satisfactory. We checked MAR charts and saw that recording was satisfactory, although we reminded the team leader that it was good practice for two staff to sign hand written records to reduce the risks of errors occurring; this had happened on some occasions but not on others.

We noted there were no protocols in place to record the administration of 'as and when required' (PRN) medication and the team leader described to us how this could be incorporated into the home's medication system.

The eight senior care staff had completed training on the administration of medication, although we saw that refresher training was overdue. One person had completed this training in 2005 and two people had completed the training in 2010. Night staff had also completed medication training so people had access to their medication during the night if needed.

We saw that suitable mobility equipment was in place to enable staff to transfer and move people safely and on the day of the inspection we saw staff using this equipment appropriately. We looked at maintenance records to check that the premises were maintained in a safe condition. Hoists and lifts were serviced regularly to ensure they were safe to use and a portable appliance test had taken place in March 2014. There was a current electrical installation certificate in place and the gas safety certificate was dated October 2014. We saw that water temperature and window restrictor tests were undertaken by the registered manager each month; the maintenance person also checked these every three months.

Fire safety checks were being carried out consistently in-house although we noted that the fire risk assessment dated 2012 recorded that a review would take place in May 2013 and there was no evidence that this had happened. The registered manager assured us that the risk assessment had been reviewed and we reminded them that the review needed to be recorded to evidence that the assessment contained up to date information. The last recorded fire drill took place in October 2013 although the

Requires Improvement

Is the service safe?

registered manager assured us that drills had taken place since then but may not have been recorded. The fire alarm system and equipment had been checked by a qualified contractor in September 2014.

Good

Is the service effective?

Our findings

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the Mental Capacity Act 2005 (MCA) legislation which is designed to ensure that the human rights of people who may lack capacity to make decisions are protected. The registered manager and all senior care workers had completed training on the MCA and DoLS on either 24 November 2014 or 1 December 2014.

The training record indicated that all but five care workers had completed training on dementia awareness and that all senior care workers had completed this training. Sixteen of the 23 ancillary staff had also completed training on dementia awareness. This meant that staff were aware of the principles of capacity, decision making and restraint. Discussion with the registered manager showed that they understood the principles of the MCA and when it would be appropriate to submit a DoLS authorisation form to the local authority.

Following the inspection, the registered manager confirmed that 43 people who lived at the home had been diagnosed with a dementia related condition. No specific dementia care model was being followed at the home but the registered provider told us that they used the Bradford University website to seek guidance about supporting people who were living with dementia. The registered manager told us that they would read a variety of information on the different dementia care models and choose one to follow that best suited the needs of the people who lived at the home. We saw that care plans were currently based on a nursing model of care and included a document called "This is me" that had been devised by the Royal College of Nursing and the Alzheimer's society, and this was being used to record people's specific care needs. This included information about the person's previous lifestyle and their hobbies and interests.

The registered manager was aware that the environment needed to be adapted to suit the needs of people with dementia and the organisation had made a start on these improvements. For example, one wall in the lounge / dining room identified the area of the room that was for eating meals. Bedroom doors were painted in bright colours with letter boxes, numbers and name plates, so that they looked like a front door and assisted people to identify their own room. However, there was a need for clearer signs to direct people to the lounge, dining room and bathroom.

Care plans recorded a person's capacity to make decisions and also whether they had a representative appointed to act on their behalf. We asked people who lived at the home if they were able to make decisions about their care and they all told us that they were happy with their involvement in decision making. Relatives told us they were involved in decision making when this was deemed to be appropriate. We discussed this with the registered manager and it was clear they were aware of the need to arrange best interest meetings when people did not have the capacity to make decisions for themselves.

The overall training record identified which training should be completed by senior staff, by care workers and by housekeeping staff. We saw that 75% of staff had attended training on safeguarding adults from abuse, infection control, moving and handling, health and safety and fire safety. In addition to this, a number of staff had achieved National Vocational Qualification (NVQ) or equivalent at Level 2 or 3, including housekeeping staff.

Staff who we spoke with were able to tell us about training they had attended and most staff told us that they felt the training they received kept them up to date with good practice guidance. However, one member of staff said that some people seemed to receive more training than others. Other staff told us that they had not received training such as moving and handling or safeguarding adults from abuse during their induction training. The organisation had recognised that new staff needed to complete some training during their induction period and before they started to work unsupervised, and they had introduced a new induction programme. New staff will have ten supernumerary days before they commence work on the staff rota; three classroom days and seven days shadowing experienced staff. The induction programmes were currently held twice a month but there were plans in place to recruit a new trainer; the organisation planned to then increase the induction programmes to weekly.

We saw that care plans included details of a person's medical conditions and any special care needs they had to maintain their general health. Information about some health care conditions was included in care plans to ensure

Good

Is the service effective?

staff were aware of the person's specific needs. People's assessments and care plans were reviewed on a regular basis to ensure that there was an up to date record of the current health care needs.

There was a record of any contact people had with health care professionals, for example, GP's, dieticians and the falls team. This included the date, the reason for the visit / contact and the outcome. We saw advice received from health care professionals had been incorporated into care plans. Details of hospital appointments and the outcome of tests / examinations were retained with people's care records. Health care professionals told us that they had a good relationship with the registered manager and staff and when they gave advice it was followed appropriately.

We asked people who lived at the home if they were able to access their GP or other health care professionals when they needed them. They were all able to tell us about occasions when staff had contacted the doctor on their behalf.

People had patient passports in place; these are documents that people can take to hospital appointments and admissions with them when they are unable to verbally communicate their needs to hospital staff. They include details of the person's physical and emotional health care needs. This meant that hospital staff would have access to information about the person's individual needs.

We saw that care plans recorded any special dietary needs and that, when nutrition had been highlighted as an area of concern, food and fluid charts were used to monitor a person's dietary intake. People were also weighed on a regular basis as part of nutritional screening. When concerns had been identified about people losing or gaining too much weight, advice had been sought from a dietician and this had been incorporated into care plans.

People's specific dietary requirements and preferences were known to staff, including the cook. The cook told us that eight people required a soft or pureed diet and that other people had diabetes and required a low sugar diet. Staff who we spoke with were able to describe people's special dietary requirements, such as the use of thickeners to assist people with swallowing. Staff told us that there was a list in the office and another list in the kitchen that recorded people's specific needs.

The mealtime was promoted as a pleasant experience. There was a menu on display that the cook updated each lunchtime. There were choices available for main course and dessert and people were asked at mealtimes what they would like to eat. The tables were set with Christmas tablecloths and napkins and there were condiments on the table. We observed that some people had been provided with equipment to assist them to eat independently and that staff assisted other people to eat and drink; we noted that this was unhurried and carried out with a caring approach.

In the dementia unit we saw that five people needed constant prompts to encourage them to eat their meal and other people needed one to one assistance. This meant that staff were 'up and down' throughout the mealtime, resulting in an atmosphere that was not as calm as in the residential unit. We noted that there were no picture menus to assist people who had difficulty making decisions in choosing a meal. However, we saw that staff assisted people by showing them both meals on offer.

Good

Is the service caring?

Our findings

We observed that staff displayed kindness and empathy towards people who lived at the home. People looked appropriately dressed, their hair was tidy, men were clean shaven (if that is what they had chosen) and they looked cared for. The staff who we spoke with were clear that they would treat people as individuals and promote their independence. They acknowledged that sometimes it took a long time for people to see to their own personal care and to mobilise, but understood that it was important for people to retain the abilities they had. They said that they were confident all staff were patient and allowed time for people to help themselves. We observed that staff were skilled in encouraging people to talk with them and to each other.

We asked people if they felt staff really cared about them and the responses included, "Yes, (the staff) are more like friends" and "Yes, we are well looked after. Staff are kind and courteous." The visitors and the health care professionals who we spoke with told us staff were kind, considerate and caring and that they were skilled enough to work with people with more complex needs. They told us that they had every confidence that staff provided effective care.

People told us that staff encouraged them to be as independent as possible and on the day of the inspection we observed staff encouraging people to walk and to undertake activities to promote their independence. Staff asked people if they needed assistance and only provided assistance when people requested it or needed it.

People who lived at the home told us that their privacy and dignity was respected and on the day of the inspection we observed that people's privacy and dignity was promoted by staff. We saw that staff knocked on bedroom doors before they entered. We observed health care professionals visit the home to carry out procedures and that people were assisted to the treatment room so they could be seen in private. We saw an audit that had been carried out by the registered manager on the topic of dignity. The registered manager had directly observed staff practices and had spoken with staff individually about any issues they had identified.

We noted that a care plan for a female who lived at the home recorded they preferred to be assisted by a female carer and a care plan for a male recorded that they had no preference. This indicated that people were asked about their preferences for care. There was a mix of male and female staff available at the home so that people's preferences could be met.

Staff told us that they had a handover meeting at the changeover from one shift to the next. They told us that this ensured information was shared between all members of the staff team. They said that communication between staff, and between the care staff and managers, was good and this ensured they were aware of people's up to date care needs. Staff told us they looked back over several days in the handover notes if they had been off work so they were brought up to date with people's current care needs.

The health care professionals we spoke with told us that, when they visited the home and spoke with staff, staff were always aware of the person's specific health care needs.

In one of the care plans we reviewed we saw that the person had a 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) form in place. The form had been signed by the person's GP and recorded that the decision had been discussed with the person's relative (who was also the next of kin) and consultant. We spoke with a health care professional who was visiting the home with a local GP on the day of our inspection. They were at the home to carry out reviews of people's care and told us that each person's DNACPR status would be discussed during these reviews.

Prior to the inspection we had received information of concern about two unexpected deaths. All of the staff we spoke with told us that people at the home received excellent care at the end of their lives and that staff ensured they were peaceful and respected. No staff had any concerns about end of life care. This was supported by the health care professionals who we spoke with.

We spoke to one health care professional who had specific responsibility for end of life care. They told us that staff at The Limes were skilled in supporting people at the end of their life. They said that staff had good communication skills and would initiate sensitive discussions with people about the best place for them to be at the end their life. They described how district nurses and care home staff would work together to ensure that people received appropriate care and said that care staff would sit with people and hold their hand. They said, "I would choose The

Good

Is the service caring?

Limes as a good place to provide end of life care." They added that staff always contacted family regularly to keep them up to date and that family members were able to stay at the home overnight if they wished to do so. They said that staff would ensure family members were provided with meals whilst they were staying at the home.

Some staff told us that they or their colleagues had completed training on end of life care, although we noted that this was not recorded on the overall training record.

We saw information in care plans that indicated people had been appointed an independent advocate when they requested or needed one. One person's care plan recorded the role of their advocate, including that they would visit the person and pass on any wishes they had to the registered manager.

Good

Is the service responsive?

Our findings

We saw in care plans that people's needs had been assessed when they were first admitted to the home, that care plans had been developed to record people's individual needs and that care plans were regularly reviewed and updated accordingly. We saw care plans included information about a person's previous lifestyle, their hobbies and interests and their family relationships in a document called "All about me". We overheard conversations between people who lived at the home, visitors and staff and it was clear that staff knew people well, including their likes and dislikes and their individual preferences for care. Visitors told us they were always made welcome at the home and we saw that they were made welcome on arrival.

Assessment tools had been used to identify the person's level of risk. These included those for pressure care, tissue viability, mental health and nutrition. Where risks had been identified, risk assessments had been completed that recorded how the risk could be managed or alleviated. Assessments and risk assessments had also been reviewed on a regular basis.

The health care professionals we spoke with told us that, when they visited the home and spoke with staff, staff were always aware of the person's specific health care needs. We spoke with a health care professional who was visiting the home with a local GP. They told us that they visited the home on a regular basis to carry out care home reviews. At these reviews they discussed current issues, weight monitoring, eating and drinking, pressure area care and any action that needed to be taken by the district nursing team.

Staff explained to us how they were able to recognise changes in a person's behaviour that indicated they were not well, when they were unable to express this verbally. This information was also recorded in care plans to ensure that all staff were made aware. One person's care plan recorded, "I clench my fists if I become anxious." Care plans also included advice for staff on how to manage a person's behaviour. A visitor who we spoke with told us that they were confident staff would recognise any deterioration or change in people and that they were always kept informed about important events.

Prior to the inspection we received information of concern in respect of people being assisted to get ready for bed as early as 5.00 pm for the convenience of staff. Some staff who we spoke with confirmed that people might be in their night clothes as early as this, especially if they had had a bath in the afternoon. However, staff told us that this would have been the person's choice. They added that this did not mean the person was encouraged to go to bed early. People who lived at the home who we spoke with told us that they could choose what time they went to bed. We discussed this with the registered manager who assured us that it was the home's policy for people to be assisted to bed at a time chosen by them, and that she would ensure this was adhered to by staff.

There was an activities coordinator employed at the home; they spent their time facilitating both group activities and individual activities. On the day of the inspection we saw that they were skilled in engaging people with dementia in a variety of activities that interested them. When people did not want to interact they persevered and tried different activities to see if they became interested. However, if people made it clear that they wished to be left alone, this was respected by staff. We also saw other staff spending time with people; sometimes just talking to them and sometimes engaging them in their chosen activities.

We saw the entertainment guide for December 2014.This recorded a variety of activities during the month, including a staff Christmas carol concert, a staff pantomime, a Christmas party with entertainment and a visit from a local school to sing carols. The entertainment was due to take place in the residential and the dementia units.

We carried out a Short Observational Framework for Inspection (SOFI) in the main lounge; this is a way of observing care to help us understand the experience of people who could not talk with us. The SOFI observation did not highlight any concerns about staff interaction with people who had a dementia related condition. We saw that staff communicated with people who had limited verbal communication by using appropriate touch, eye contact and gestures to help them understand and interact.

The complaints procedure was displayed but we noticed that it was not easily accessible to people who lived at the home; it was placed high on the wall and was in small print. The registered manager told us that an easy read version was available in each person's bedroom but they would ensure that the notice on display in the entrance area was

Good

Is the service responsive?

more suitable for the needs of people who lived at the home. They actioned this whilst we were at the home. There was also a leaflet available that gave people clear instructions about how to complain. This also invited people to express concerns, make suggestions or requests and leave comments.

We asked people who lived at the home if they knew how to express concerns or make a complaint. All of the people we spoke with told us that they would not hesitate to speak to staff, although one person said, "I don't think we've ever had any problems." A visitor told us that they would go to the office and they were sure that any problems would be sorted out.

We checked the complaints log and saw that any complaints received had been recorded thoroughly, including the outcome of any investigation undertaken. When appropriate, the details of complaints investigations had been discussed in staff supervision meetings and / or at staff meetings. The registered manager had also arranged additional training for staff on end of life care following a complaint received from a family member. This evidenced that the registered manager was open and transparent in discussing concerns with staff and how the service needed to improve.

In staff personnel records we saw evidence of supervision meetings. These are meetings that take place between a member of staff and a more senior member of staff or manager to give them the opportunity to talk about their training needs, any concerns they have about the people they are supporting and how they are carrying out their role. We saw the action had been taken in response to issues raised by staff in supervision meetings. For example, one person had said that policies and procedures were not easily accessible and a copy had been placed in the staff office.

Most staff said that they felt supported by the registered manager and other senior staff but one person said that the manager was more supportive in one to one meetings than in staff meetings, and one staff member said that they did not feel listened to. It was hoped that the newly appointed staff advocate would give staff the opportunity to speak to someone other than the registered manager (if this was their choice) when they had problems.

Good

Is the service well-led?

Our findings

We found the atmosphere at the home to be friendly and welcoming, and this was supported by the people who lived at the home, health care professionals and visitors who we spoke with.

We saw evidence of a satisfaction survey that had been carried out in August 2014 with people who lived at the home and relatives. A report had been produced that included an analysis of responses; we saw that responses were mainly positive. The report also included an action plan to address any areas where concerns had been identified. For example, feedback suggested that some of the activities provided did not suit the needs of people who lived at the home. The action plan recorded that people would be consulted when they first arrived at the home about their preferred activities so that future activities could be based on people's choices. The system would have been enhanced by an additional progress report to identify the outcome of any action taken.

Staff meetings were held; we saw that there were separate meetings for senior staff, night staff and day staff. There was a planner for 2014 that recorded the dates for all meetings during the year so that staff were aware in advance of when these meetings would take place. The most recent day staff meeting was in November 2014. Topics discussed included staff rotas, personal care (a reminder that people may need a change of clothes after eating a meal and to have their hands and face washed), wheelchairs, the homes code of conduct and medicines (a reminder that senior staff must not give medicines to junior staff to hand to people who use the service). The staff who we spoke with confirmed that they attended staff meetings and these were a 'two way' process; information was shared with them but they got the opportunity to ask questions, raise concerns and make suggestions for improvement. Some staff told us that they thought separate staff meetings led to some separation between staff teams. However, the registered manager told us that some of the staff meetings were for all staff.

The registered manager had carried out a variety of quality audits to check that systems in place at the home were being followed and that people were receiving appropriate care and support. These included audits of care plans (ten were audited on 3 December 2014), recruitment records, medication, accidents and incidents, domestic and laundry, infection control, dignity and daily charts such as food and fluid charts. For example, the dignity audit identified that there was no dignity champion in place and that staff 'talked over people'. There was an action plan in place to address these concerns but this did not include a timescale for completion. The infection control audit identified that staff were wearing nail varnish and jewellery when this was not allowed. This action plan did include timescales and there was a record stating that staff had been spoken with during supervision meetings.

A further audit was carried each month to monitor all occurrences at the home, including incidents, accidents, falls, deaths, safeguarding incidents and notifications to CQC. We saw that these had been completed consistently throughout 2014.

There had been a problem with the call bell system and this was acknowledged by the registered manager and provider. This was being repaired by a contractor on the day of the inspection and by the time we left the home it was fully operational. Staff told us that call bells in some rooms were sounding when they had not been activated. This created confusion for staff, as they were responding to call bells when people did not require assistance. Some staff said that people may not have received appropriate care during this period, as they may have had to wait a long time for assistance. Other staff said that people who lived at the home had not been inconvenienced and that they had carried out 30 minute checks in bedrooms to ensure that people were safe. The people who lived at the home told us that they had been able to summon help whilst the call bell system had not been working properly and they were aware that call bells had been repaired that day.

We asked staff if there were any incentives available to them and they told us that they received a slight increase in salary when they achieved National Vocational Qualification awards (or equivalent).

The registered provider told us that they had recently recruited a staff advocate. It was hoped that this person would be able to support staff with any problems they had, and that this in turn would result in a more positive working environment for staff and reduce staff turnover.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers The registered person had not operated effective recruitment procedures in order to ensure that no person employed for the purposes of carrying on a regulated activity unless that person was of good character, had the qualifications, skills and experience which were necessary for the work to be performed and was physically and mentally fit for that work. Regulation 21 (a)(i)(ii)(iii)