Ashdown Care Limited

Culm Valley Care Centre

Inspection report

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Date of inspection visit: 5, 11 and 19 May 2015
Date of publication: 02/07/2015

Ratings

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

Overall summary

We carried out an unannounced comprehensive inspection on 5, 11 and 19 May 2015. We had decided to bring forward a planned inspection because we received three alerts from the local authority safeguarding team. These were regarding people allegedly experiencing poor care at the service and not having their manual handling needs met safely. Concerns had been expressed by health professionals regarding how quickly staff identified people's changing health needs. At the inspection people's manual handling needs were being met. We identified no evidence that people were receiving poor care and were not being referred appropriately. However these concerns were still being looked into by the local authority safeguarding team and a conclusion had not been reached.

Culm Valley Care Centre is registered to provide accommodation for 56 people who require nursing and personal care. There were 53 people using the service on the first day of our inspection. We last inspected the service in August 2014, at that inspection the service was meeting all of the regulations inspected.

There was a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. Everyone gave us positive feedback about the registered

Summary of findings

manager. They said they were happy to approach her if they had a concern and were confident that actions would be taken if required. People said the registered manager was very visible at the service and undertook an active role. Staff said they felt supported by the registered manager and the clinical lead nurses.

Staffing levels were not regularly assessed and monitored to make sure there were sufficient staff to meet people's individual needs and to keep them safe. People and staff expressed concerns about the staffing levels because they often did not have enough time to spend quality time with people. They felt there were not adequate staff to meet people's needs safely. The registered manager had taken action to address these concerns by increasing the care staff ratio in line with the occupancy at the service. However the provider did not have a robust system to continually monitor and assess the adequacy of staffing levels to meet people's changing needs.

People were not being given a choice regarding when and how frequently they required a bath or shower. People were only being given the option of one shower or bath each week. If they refused on the day allocated to them they were unable to have an alternative day and had to wait for the following week.

People received their medicines safely and were supported by staff who were trained and had the skills and knowledge to meet their needs. Care plans reflected people's needs and gave staff clear guidance about how to support them safely.

There were arrangements in place for people to have their needs regularly assessed, recorded and reviewed. People were kept informed on a day to day basis about their changing care needs. People had not always been involved in their formal reviews. This had been recognised by the registered manager and clinical lead nurses and action had been taken.

There were emergency plans and protocols in place to protect people and guide staff in the event of an emergency or untoward event.

People said they felt safe and were cared for by staff that treated them with kindness and compassion. Staff could recognise signs of abuse and knew how to raise any safeguarding concerns.

People had access to health professionals when staff had identified concerns. There had been two alerts made to the local authority safeguarding team where staff had not recognised people's changing needs and taken appropriate action. This was being addressed with the registered manager by the local commissioners and district nurse team.

People were supported to eat and drink enough to maintain a balanced diet. They were able to make choices about what they wanted to eat and drink and were positive about the food at the service.

Incidents and accidents were accurately recorded and the registered manager monitored them to identify any themes or trends in order to recognise risks and take action when required.

People knew how to raise a concern or complaint, and they felt comfortable to do so. Complaints were dealt in line with the provider's policy. The registered manager dealt with day to day concerns as they occurred to prevent them from escalating.

There was an activity program in place and people were informed by a regular newsletter. The registered manager had discussed with the local church about people in their rooms being at risk of social isolation. This had resulted in two volunteers visiting the service to spend one to one time with people, if they wished.

The provider had a robust recruitment process. New staff had a thorough induction and received training to meet people's needs. Staff were supported in their role by receiving regular supervision and annual appraisals. They were kept informed and able to contribute to the running of the service by attending staff meetings, daily handovers and completing an annual quality assurance survey.

The provider had a thorough quality assurance and monitoring system in place. This included regular audits, quality monitoring visits and annual surveys for the provider to assess the effectiveness of the service provided. People, relatives and friends were asked their views about the service and had the opportunity to attend meetings and make their views known.

Summary of findings

We found one breaches of Regulations in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The action we have asked the provider to take can be found at the back of this report.

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

Some aspects of the service were not safe.

Staffing levels were not regularly assessed and monitored to make sure there were always sufficient staff to meet people's individual needs and to keep them safe.

People said they felt safe and were kept safe by staff who could recognise signs of potential abuse and knew what to do when safeguarding concerns were raised.

The provider had robust recruitment processes in place.

People received their medicines in a safe way.

The premises and equipment were managed to keep people safe.

An evacuation policy, protocol and personal evacuation plans were in place to protect people in the event of emergencies or untoward events.

Is the service effective?

Good

The service was effective.

The registered manager and staff had an understanding of the principles of the Mental Capacity Act 2005 and Deprivation of Liberty safeguards.

Staff had received effective inductions, training, regular supervision and appraisals and some were undertaking higher health and social care qualifications.

People were supported to eat and drink and had adequate nutrition to meet their needs.

Is the service caring?

Good

The service was caring.

Staff were kind and compassionate towards people and maintained their privacy and dignity. Staff were friendly in their approach and spoke pleasantly to people while undertaking tasks.

People were involved in making decisions and planning their own care on a day to day basis.

Is the service responsive?

Requires improvement

Some areas of the service were not always responsive to people's needs.

People were not given the choice regarding whether they required a bath or shower, and if the time and frequency suited their personal preference.

Summary of findings

Staff made referrals to health services promptly when they recognised people's needs had changed.

Staff knew people well, understood their needs well and cared for them as individuals.

People's care plans provided a detailed account of how staff should support them. Their care needs were regularly reviewed, assessed and recorded.

The registered manager and nurses were available to deal with any concerns or complaints. People felt any concern would be dealt with effectively.

People had the opportunity to take part in group activities in the communal area. The registered manager had recognised that people stayed in their rooms were at risk of social isolation. They had been working with the local church to address this.

Is the service well-led?

Good

The service was well-led.

The registered manager understood their responsibilities, and had support

from the provider. People and staff were positive about the registered manager and said she would challenge poor practice, was fair and approachable.

The provider had good quality monitoring systems in place. People and staff were asked their views and these were taken into account in how the service was run.

There was an effective audit program to monitor the safe running of the service.

Records for the safe running of the service were promptly accessible when requested.

Culm Valley Care Centre

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection visits took place on 5, 11 and 19 May 2015. The visits were unannounced. The inspection was carried out by one inspector and an expert by experience. An expert-by-experience is a person who has personal experience of caring for someone who uses this type of care service; they had experience of services for older people.

Before our inspection, we reviewed the information we held about the home. This included previous inspection reports and notifications sent to us. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing any potential areas of concern.

We met most of the people who lived at the home and received feedback from 27 people using the service and seven visitors.

We spoke with 13 staff, which included nurses, care and support staff, the registered manager and two clinical lead nurses. We contacted the local GP practices that supported the service for their views. We also spoke with the local authority commissioners and district nurse team regarding alerts which they had received.

We looked at the care provided to nine people which included looking at their care records and speaking with them about the care they received at the service. We reviewed medicine records of six people. We looked at five staff records and the provider's training guide. We attended a staff handover meeting and looked at a range of records related to the running of the service and quality monitoring information.

Requires improvement

Is the service safe?

Our findings

People when asked said they felt safe and were happy they could raise concerns. Comments included, "I am very safe...lovely nurses...staff are marvellous." "They are gentle with me....been here for years" and "They are good girls...I feel safe".

The majority of people expressed concerns about the staffing levels. One person commented, "The carers are very good...they could do with a few more....because of my condition I need help to use the toilet ....we've got to wait a long time. There is not enough cover; they need to sort it out urgently". Comments from other people included, There are not enough staff especially at night they are rushed off their feet." "They could do with a few more, at times it is a skeleton crew and it's not good enough in this day and age" and "Staff numbers are way too low here".

Staff fed back to us their concerns about the staffing levels. They said the occupancy had increased, with more dependent people. This meant more people required two staff to provide their care, needed regular repositioning and support with their diet and fluids. However the ratio of staff had not increased to a level to meet these needs. We asked staff what they felt the impact the staffing levels had on the people living at the home. Comments included, "We cannot look after the residents properly and give personal care, we have to rush." "We struggle to give them personal care and when short staffed cannot answer the bells quickly, baths and showers sometimes don't get done". "Residents have to wait because if we are dealing with a person who needs two staff we can't leave them to answer the bell, I don't like to keep people waiting".

Staffing levels had been increased the previous week because of a higher occupancy level. This meant there were nine care staff each morning and six care staff each afternoon and four at night. Staff said they had found the additional carer each morning had enabled them to meet people's needs. Comments included, "Nine carers has made a difference" and "When nine staff are on in the morning, it is much better, before it was really hard it was a rush".

However, staff were busy and appeared rushed and interactions with people were largely around tasks. Staff said they felt they did not have the time to spend quality time with people.

People's individual changing dependency care needs were assessed by the nurses and recorded each month. However, these assessments were not used to assess the staffing levels required to meet people's needs. The registered manager said if she felt the staffing levels were not meeting people's needs, she would speak with the provider's operations manager to get permission to increase the staffing numbers. They said the new staffing numbers had been increased because the occupancy had increased and would be reduced once the occupancy decreased. This meant the provider did not have a systematic approach to determine the number of staff and range of skills required in order to meet the individual needs of people using the service and keep them safe at all times.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulations 19 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

People received their medicines safely and on time. Comments included, "I take loads of pills....I'm not worried to know what the pills are for" and "I can't grumble they try to get it right" and "I get my medicines alright." However one person did comment, "I would like them to tell me what they are for".

We observed people being given their medicines, and talked with the nurses about people's medicines. The nurses were knowledgeable about the medicines people were prescribed. They had been assessed by the registered manager to make sure they were competent to administer people's medicines and had a good understanding of their importance. Medicines were managed, stored, given to people as prescribed and disposed of safely. The guidance regarding when it was appropriate to use 'when required' medicines' was not always clear. The clinical lead said they were a small team of nurses and knew the reason why people had prescribed, 'when required' medicines'. They said they would put in to place documented guidance, to ensure all nurses were following the same practice.

People were protected by staff that were very knowledgeable about the signs of abuse and had a good understanding of how to keep people safe. They had received training in safeguarding of adults and there were scheduled update training sessions. There had been two alerts made to the local authority safeguarding team which

Requires improvement

Is the service safe?

had highlighted on two occasions staff had not identified people's changing needs and taken appropriate action. The registered manager, the local authority commissioner and district nurse team were working together to address these concerns.

The registered manager reported safeguarding concerns promptly to the Care Quality Commission (CQC) and undertook investigations when requested.

The nurses completed risk assessments for people when they came to the service. These included manual handling risks, falls risks, choking risks, skin integrity and nutritional risks. They assessed each person using a list of needs called, the activities of daily living. These included communication, pain management, rest and sleep, social life and mobility. If the nurses identified a risk they would then generate a care plan to record how the risk would be managed.

Recruitment checks had been completed to make sure staff were only employed if they were suitable and safe to work in a care environment. Recruitment records showed all the checks and information required by law had been obtained before new staff were employed.

Accidents and incidents were reported in accordance with the organisation's policies and procedures. Staff had recorded accidents promptly and the actions they had taken at the time.

The environment was safe and secure for people who used the service, visitors and staff. There were arrangements in place to manage the premises and equipment. A maintenance person undertook regular checks, which included, checking water temperatures, window restrictors, emergency lighting and wheelchairs. Staff were able to record repairs and faulty equipment in a maintenance log and these were dealt with and signed off by the maintenance person. Fire checks and drills were carried out weekly in accordance with fire regulations and regular testing of electrical equipment was carried out. The fire system underwent a scheduled service on the second day of our visit. There was evidence of regular servicing and testing of moving and handling equipment.

There were plans for responding to emergencies or untoward events. These included an evacuation policy and protocol which gave staff information about the location of fuse boxes and important telephone contact details. There were individual personal protection evacuation plans (PEEP's) which took account of people's mobility and communication needs. This meant, in the event of a fire, staff and emergency services staff would be aware of the safest way to move people quickly and evacuate people safely.

Communal areas and people's rooms were clean with no unpleasant odours. One person commented, "My room is kept clean, It's a very good home this". Staff had access to appropriate cleaning materials and equipment and completed a daily cleaning schedule. Staff had access to personal protective equipment (PPE's) such as gloves and aprons. Staff said they had access to the cleaning products they needed to do their job effectively. A Control of Substances Hazardous to Health (COSHH) register was available to safely guide staff regarding the chemicals they were using.

Good

Is the service effective?

Our findings

People were supported by care staff who undertook training which developed and maintained their skills and knowledge. All staff training was recorded on a training guide and staff were reminded when any refresher training was due. Staff confirmed their training enabled them to feel confident in meeting people's needs and in recognising changes in people's health. Comments included, "The training is good" and "I find it really good, always doing them."

On the first day of the inspection, staff were undertaking training in medical emergency training. Following the training staff said they felt it had been very good and useful. Some staff had undergone train the trainer courses in manual handling and were able to teach staff manual handling techniques. They were able to oversee manual handling practice on a day to day basis and ensure staff used the correct techniques.

New staff underwent a thorough induction. Staff said they felt the induction prepared them to undertake their role. Comments included, "I felt the induction was good and taught me what I needed to know" and "I shadowed someone and for a time, we did doubles so I was with someone" and "For two weeks I worked with another carer, that was enough, along with the training to show me what to do.

Each morning a member of care staff was delegated by the nurse to take the lead on each floor and in the afternoon the most experienced care worker took the lead. Staff said they were happy with this arrangement and had confidence in the staff taking the lead and would always go to the nurse on duty with any concerns. One nurse said, "We delegate staff to different floors, to ensure the skill mix is right. It is important not to have too much experience on one floor." This meant people were protected by having competent staff on duty who had the right mix of skills to make sure practice was safe and they could respond to unforeseen events.

Staff received on-going supervision and support. This involved individual staff, meeting with the registered manager or designated nurse at regular intervals throughout the year. They discussed their work and explored any issues that may have arisen to improve their practice. The registered manager undertook the supervision of the nurses. They completed regular clinical supervisions and competence assessments and were confident in their ability. They said they were happy the clinical skills of all of their nurses was good. Where nurses were not confident they said they ensured the nurse would not work alone at the service. The registered manager confirmed that if the nurses needed support at any time, they could ring them or the clinical leads for guidance and advice. They had been working with some staff whose first language was not English to improve their confidence and understanding.

The registered manager recorded the annual appraisal program on the training guide. During appraisals, they met with staff and reviewed their performance, identified any further training needs and future professional development opportunities.

People said they had access to health professionals when required. Comments included, "doctor comes when I need him and I get very good care" and "Doctor comes on Monday...chiropodist on Wednesday but you have to pay" and "The optician visits". When staff had identified people's changing needs they had been referred promptly to health professionals. This included the GP, district nurse team. Occupational therapist (OT) and the speech and language team (SALT). The GPs who visit the service fed back to us they had no concerns regarding the care and support people received at Culm Valley Care Centre. People had regular visits from the opticians and chiropodists. The registered manager said "One GP does a Wednesday surgery, so little things are kept until that visit. However if other problems arise we will ring the surgery for a visit or contact the out of hours GP service".

People's needs were assessed and care plans provided detailed information about each person needs. For example, staff were guided for a person with diabetes, what to do in the event of the person having a high or low blood sugar. They were also guided about what the blood sugar levels should be for the person and the diet required to maintain their blood sugar levels. Another care plan guided staff to monitor a person's skin and to use moisturising and barrier cream when required. For a third person that had an infection, staff were guided regarding how to use infection control techniques when supporting this person.

Staff protected people from the risk of poor nutrition and dehydration. People were weighed monthly and, where there had been unexplained weight loss, more regularly.

Good

Is the service effective?

These people were closely monitored and their diet and fluid intake was recorded. Staff demonstrated a good knowledge about the actions they needed to take when they identified a person at risk, this included contacting the GP and monitoring diet and fluid intake.

The registered manager and nurses demonstrated an understanding of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) and how these applied to their practice. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a decision is made involving people who know the person well and other professionals, where relevant. For example, a best interest decision needed to be made regarding whether one person needed to have their medicines crushed and covertly hidden in their food. A health professional had been asked to undertake a capacity assessment and after consultation with relevant people a decision had been made. Another person had a best interest decision made after consulting relevant people regarding the use of bedrails.

On the first day of our inspection three people's care records had not had their capacity assessment documentation completed to ascertain whether they could make a particular decision about their care and support. The registered manager said an audit had identified these gaps. They said the nurses had been having difficulty completing people's care records and undertaking reviews. The provider had agreed two additional hours of nursing time each day to address this. This would enable the nurses to complete the required capacity assessments. On the third day of our inspection all necessary capacity assessments had been completed.

There was evidence of a good understanding by staff of mental capacity and promoting people's decision making. Staff were able to tell us about people making choices, regarding where they wanted to spend their day and clothes they wanted to wear. Not all staff had received training in MCA. A program of MCA training had started and MCA training workbooks had been given out to all staff to complete.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. The registered manager had made applications to deprive people of their liberty following a Supreme Court judgement on19 March 2014 which had widened and clarified the definition of deprivation of liberty. The registered manager explained that they had also needed to make an emergency DoLS application for one person because they were at a higher risk and would not be safe to leave the service.

People were supported to eat and drink enough and maintain a balanced diet. On admission a nutrition profile was completed to identify people's food likes and dislikes. The cook had a good knowledge of people's dietary needs which were recorded on the daily choice list. People who required a pureed option had their meals formed in specialist moulds to make it look more appetising.

Meals were served in the two dining rooms or people had the choice to have their meals in their rooms. People were offered a choice from a four week rotation menu with alternatives if they did not like the options. Records of a resident's and relative's meeting held 21 April 2015 recorded that people had been asked about the menu choices available. People had put forward suggestions which the registered manager said had been discussed with the cook and where possible were being incorporated on to the menu. People were mainly positive about the food they received. Comments included, "The food is very good, not quite enough, sometimes, I get a choice of two things, I try to fit in with what's on the menu" and "Meals are absolutely delicious, they come round in the evening asking what I would you like".

At breakfast in the ground floor dining room, people said they were quite happy with the choices they had for breakfast. Comments included, "I could have cereal if I wanted but I have chosen porridge. We can have cooked breakfast on Monday, Wednesday and Friday" and "I can't grumble about the food, I like anything" and "The food is not too bad". People in their rooms had mixed views about the breakfast served. Comments included, "Food is not too bad, nothing special normal for a place like this. Have to have breakfast when they are ready" and "I don't seem to wait too long for breakfast". "You seem to wait a long time for breakfast and getting up". "I can't grumble...the food is nice...no choice at breakfast but I don't mind." Staff said they did their best to get people their breakfast as quickly as possible. The registered manager said people were always offered hot drinks when they got up in the morning.

Good

Is the service effective?

The main dining room at lunchtime had tables laid with table cloths and a small flower display. People were chatting with each other happily while they enjoyed their meals. Staff supporting people with their meals did so in a discrete, sensitive unrushed manner and appropriately engaged in conversations with people sat at the same table.

Good

Is the service caring?

Our findings

People and their visitors praised the staff at Culm Valley Care Centre. Comments included, "One of the nurses is very kind...goes that little bit further". "They're lovely girls...kind caring, loving nurses.... I couldn't wish for better....I'm a very lucky woman". "They are very good.... they respect me" The carers are kind and reliable." "The girls and staff are wonderful and magnificent". One person said, "How they treat you depends a lot on which one it is, some are a bit more I won't say rough.....too quick."

Visitors gave us positive feedback about the staff. Comments included, "Always welcomed...staff are friendly, approachable and helpful". "Staff are fine" and "I can't fault it here".

Staff treated people with kindness and compassion when delivering day to day care. While people were supported to the ground floor communal area, staff were chatting to people and asking them where they wanted to sit. People were supported by the activity person or a designated staff member when using the ground floor communal area. One person said, "(the activity person) finds time to talk to us". Another person said, "The staff are very friendly, I chat to all of them, of course you get back what you put in".

Staff were knowledgeable about people's needs, likes, preferences and personal history. Staff said a lot of new people had recently come to the home which meant there were a lot of new people to get to know. They confirmed things had recently settled down and staff were happy they knew people well.

People said their privacy and dignity was respected. One person commented, "Carers, both male and female are very discreet...the door is always closed. This morning it was (staff member), he is brilliant I can converse with him; he gives me a strip wash. I feel it is good care; he makes sure the curtain is closed and I am not exposed." A second person said, "They like us to keep our privacy".

People were involved in planning and in making decisions about their own care, treatment and support on a day to day basis. Staff asked people where they wanted to spend the day and what clothes they chose to wear. One person said, "They don't say it's time to go to bed we do what we want" another said "I go to bed when I want to." People were consulted by the nurses about decisions and changes around their health needs. For example, one person had been consulted about their weight loss and given information around how this could be managed.

People were given a choice regarding whether they wanted to attend activities and were kept informed. They were given a copy of the home's newsletter which included the activity programme, fundraisers and information about people celebrating their birthdays.

Two people said they were not happy they needed to vacate the ground floor lounge after supper each day. The registered manager said it was very difficult because of the lay out of the building. This meant after supper there were not enough staff to allow a staff member to stay on the ground floor to support people that stayed in the lounge. The registered manager confirmed they had made people and their visitors aware the lounge would be closed after supper and people would be asked to move the first floor lounge, when they came to the service. They discussed the option with one person who had raised this concern and suggested they stay in the lounge with a bell to ring for assistance if they required it. The person had refused this option and said they would prefer to have a staff member present. On our third visit to the service, at 19.00 hours, there were ten people were using the first floor lounge. They appeared comfortable and said they were happy and one person had visitors.

There were many thank you cards expressing families feelings about the care their loved one had received. Two cards which were sent to the registered manager and staff the month before our visit, which praised them for their support and kindness. Comments on the cards included, "Thank you for all of your kindness and gentleness shown in caring for my mum".

Visitors were welcomed and there were no time restrictions on visits. People said, "My son can come any time" and "Visitors are treated with respect." "My family come in the afternoon, they are made welcome...they know they get a cup of tea if they come at 3 o'clock." Visitors said, "We can visit anytime and are often given coffee".

Requires improvement

Is the service responsive?

Our findings

People were not being given a choice of when and how frequently they required a bath or shower because there was task allocated care. A bath list was in use to guide staff to know which days people were scheduled to have a bath or shower. However there were only 53 people's names recorded on this list and each person only had a designated slot once a week. The registered manager said that if people wanted more baths they could and the bath list was in use to ensure people were offered at least the option once a week. The registered manager highlighted a few people whose allocated bath or shower slots had been changed to meet people's preferences. Staff said they did not have the time to offer people alternative baths. Comments included, "We have two baths or showers allocated in the morning and two in the afternoon, people have set bath days. "If they refuse their bath we give them a bed bath, we used to offer them an alternate bath on another day but now we are too busy and have enough problem getting the baths we have to done." Another said, "We try to fit them in, not able to offer another bath because we are so busy. A person said, "I have a shower every Saturday afternoon ....if they are not too busy in the week. They like to keep to one a week....daily bowl of hot water." This meant people did not always receive personal care that met their needs and reflected their personal preferences.

People and their nominated families were involved in the initial assessment and planning of their care. Before a person used the service the registered manager or a clinical lead nurse undertook a pre admission assessment. They met with the person and where appropriate their relatives and gathered information about their health and care needs and how they wanted to be supported. This was so they could assess whether they could meet the persons needs at the service. The staff used the information gathered from the pre admission assessment to generate people's care plans. The majority of care plans were person centred and reflected people's needs. A social life care plan identified people's life history, interests and hobbies. These were all completed but not consistently with the same level of detail. This had been identified in the registered manager's audit and was being addressed. People and their relatives where appropriate had not always been involved in reviewing their care plans. The registered manager and staff had identified they did not have a formal system to ensure all people contributed on a regular basis to their care plans and were addressing this.

Staff were kept informed about people's changing needs. During a staff handover, staff were given up to date information about each person. Staff were made aware of people's fluid and diet intake and about anybody who was unwell or required additional monitoring. For example, one person had an area of skin which had become vulnerable and staff were told to undertake regular repositioning.

People and visitors said they would be happy to raise concerns with the registered manager or nurse on duty and were confident they would be dealt with. Their comments included, "I've only got to call the nurse and they come" and "I'm like that, if anything was wrong I would voice my views" and "If I had a concern I would be happy to raise it with (nurses), with what I have seen I think they would deal with it properly." However one person said "I would have liked my top clothes to be ironed, it's not very nice to put on things that have not been ironed....I told the manager.....no solution". Records of a residents and relatives meeting 21 April 2015 recorded this had been addressed.

The complaints folder contained one complaint regarding loss of a person's possessions which had been verbally resolved to the complainant's satisfaction and in line with the provider's complaints policy. The registered manager said they had not received any formal complaints in the last year, only concerns. They had dealt with these at the time to stop the concerns becoming more serious and developing into complaints.

People had the opportunity to partake in activities. An activities worker was employed and spent their duty based in the ground floor communal area. They said they were unable to undertake one to one visits to people who were bed bound or chose to stay in their room due to time restraints. The majority of people who were in their rooms said they chose to reside in their room. Comments included, "I like my own company". "I have enough to do on my own "and "The activities ...bingo...boring...I'm happy in room". The registered manager had recognised that not all people wanted to join in with group activities and wanted to ensure they did not become socially isolated. They said people in their rooms would be offered a choice; but a lot chose not to go to the lounges but would go to church

Requires improvement

Is the service responsive?

services or to watch entertainers. They had contacted the local church and two volunteers had started visiting people who expressed a wish on a one to one basis. This meant the registered manager had taken action to prevent people from the risk of social isolation.

People were engaged in activities during our visit. There were puzzles and reminiscence cards. People said they were happy with the activities in the main lounge. Comments included, "We're not miserable...we have bingo...we like our dominoes" and "They always try to entertain us one way or another", we do pottery, bingo, puzzles, knitting and singing." The activity person said they had a fund for activities. This was supplemented by people and staff involved with fund raising for activities. This included, knitting toys to sell and card making. One person was knitting white bunny rabbits and said happily to us they had a list of orders to complete.

Good

Is the service well-led?

Our findings

People and visitors said they would be confident speaking with the registered manager if they had any concerns about the service provided. Staff said they felt supported by the registered manager. Comments included, "I would go to the manager she would sort it out, she is really good". And "The manager is really good, I have been to her in the past and she has listened. "Quite a good manager keeps us on our toes and corrects us if she sees something wrong …treats us fairly."

There was a structured management and leadership structure at the service. The registered manager received support from two clinical lead nurses. They undertook staff support and supervisions and completed and oversaw care records. The provider's operations manager visited the service regularly to undertake quality monitoring audits. This included looking at people's care records, recruitment files and speaking with people, their visitors and staff. They completed reports and required the registered manager to complete an action plan which was reviewed at their next visit. Staff spoke positively about the operations manager and said they would be happy to approach them if they had any concerns. One staff member said, "I met with the over manager, she asked how I was getting on, she was really nice".

The registered manager had an effective annual audit program which she completed to monitor the quality of the service provided. This included infection control, medicines and a visual check of premises. On the visual check of premises in February 2015, they had recorded areas of concerns and the actions required. For example, a roof was leaking and this had been repaired and five windows were scheduled to be replaced. One nurse commented on the registered manager's medicine audit, they said "The manager is fair, if she finds a medicine problem she will look at it and deal with the problem or monitor it." The registered manager undertook a monthly care plan audit. The audit in April 2015 had identified some missing information and gaps in people's care records. The registered manager had increased the nurse's hours and completed an action plan, for the nurses to complete. They were monitoring the progress of the actions and said they would be reviewing everybody's care records as a result of the audit.

Staff were actively involved in developing the service. Staff meetings were held regularly. Only two staff had attended the last meeting held in February 2015 and staff present were asked for their views. The meeting discussed the new approach Care Quality Commission (CQC) inspection process and about communication skills. The meeting was documented, so all staff were aware of the discussions and the outcomes. The provider had sent out 37 staff surveys in October 2014 to ask staff their views. The ten that were returned had been collated and in response to staff comments, some staff had been signed up for higher level health and social care diplomas. The registered manager had discussed the outcome of the survey with staff at a staff meeting.

The provider actively sought the views of people and their families and friends to develop the service. A quality assurance questionnaire for people who use the service had recently been implemented. People were asked 18 questions about the catering, laundry, premises, management and the care and support they received. The registered manager confirmed no responses had yet been received at the time of our inspection.

Relatives and friends had been sent a survey in the summer of 2014. The responses had been mainly positive with a few comments about laundry and activities. The registered manager said they had arranged a meeting in September 2014 to discuss the outcome of the survey. No relatives had attended the meeting and people did not want the meeting and would prefer to play bingo, so there were no minutes. However a residents and relatives meeting held on 21 April 2015 discussed the laundry and how there were difficulties with lost items of clothing due to labels fading. It was agreed that the clothes would be left out for people and their relatives to sort through to identify any lost clothing. During our visit lost property clothes were placed on a table in the main lounge with a sign guiding people and their relatives to have a look.

The provider actively sought feedback from health professionals supporting people at the service. A survey had been sent to nine health professionals to ask their views about the quality of the service. The eight responses received by the provider were positive about the service provided at the home.

The registered manager monitored and acted appropriately regarding untoward incidents. They looked at trends and patterns in accidents to ensure appropriate

Good

Is the service well-led?

actions were taken to reduce risks. For example, it was identified a person had not been able to reach their call bell. This had been resolved by the call bells being swapped around and the person had an accessible call bell pendant.

The registered manager and provider were meeting their legal obligations. They notified the CQC as required, providing additional information promptly when requested and working in line with their registration.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The provider did not have a systematic approach to determine the number of staff required in order to meet the needs of people using the service and keep them safe at all times. Regulation 18 (1)**