Care Quality Commission

Priory Court Developments Limited

Broadway Care Home

Inspection report

26 Broadway
Blackpool
FY4 2HE
Tel: 01253 401809
Website: www.example.com

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Ratings

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

Overall summary

This inspection took place on 24 and 28 October 2014 and was unannounced. This meant the staff and provider did not know we would be visiting.

The Broadway care home is a detached building in a residential area of South Shore, Blackpool. It provides nursing or residential care for up to 30 older people including people living with dementia. At the time of our visit there were 23 people who lived at the home. Accommodation was arranged around the ground and first floor with office accommodation on the second floor. There was a passenger lift for ease of access and the home was wheelchair accessible.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

Some areas of the home were not clean and hygienic and were an infection control risk. Although these improved between the two days of the inspection, there were still areas of poor cleanliness. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

Risks to people were minimised because the provider had procedures in place to protect them from abuse and unsafe care. People we spoke with told us they felt safe and well cared for. However, although some areas of staff recruitment were thorough and effective others were not robust with gaps in employment not explored. This lessened the protection from unsuitable staff working in the home.

Care records were not person centred and were not always fully completed, as sometimes relevant information was missing from them. You can see what action we told the provider to take at the back of the full version of the report.

We saw sometimes the information written in the care plan was not carried out in practice. This included moving and positioning of people and the use of bumpers with bed rails. This meant staff did not respond to people's needs in an appropriate way and provide safe and effective care. You can see what action we told the provider to take at the back of the full version of the report.

Most people we spoke with were satisfied with staffing levels. We saw staffing levels were sufficient to provide nursing and personal care and keep people safe. Although this did not extend to social and leisure activities which were limited and left more dependent people unstimulated. The registered manager was also the nurse on duty for several shifts each week. This limited her opportunities to carry out managerial duties. The management team assessed and monitored the quality of the service, although not always regularly enough to be alerted to poor practice.

Although care records were limited, staff spoken with had awareness of people's needs and preferences. We saw good care and support was provided around eating and drinking. Staff were knowledgeable about people's dietary requirements including special diets.

We looked at how medicines were prepared and administered. We saw medicines were managed safely and given as prescribed.

Although staff involved and informed people, and where appropriate, their relatives, in decisions about their care, there was no formal system in place. They were kind and compassionate and treated people with respect. People and their relatives were pleased with the care and support they received. They felt there was a positive relationship with staff and felt secure sharing any information or concerns with them. They were very positive about the way staff listened to them.

Staff spoken with said they worked well as a team and were supported by the registered manager and management team. There was a low turnover of staff within the home and staff were familiar with the needs of individuals.

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?
The service was not always safe.

Infection control practices did not always ensure cleanliness or reduce the risk of cross contamination.

Some areas of staff recruitment were robust but others reduced the effectiveness and protection of people.

Staff managed medicines safely and supported people with medicines well.

Requires Improvement

Is the service effective?
The service was not always effective.

Although the home supported people living with dementia, the environment was not designed to effectively support people living with dementia or to enable people to be as independent as possible.

Procedures were in place to enable staff to assess peoples' mental capacity, should there be concerns about their ability to make decisions for themselves, or to support those who lacked capacity to manage risk.

People were offered a choice of meals and frequent drinks and staff knew their likes and dislikes so that they received a variety of nutritious foods.

Requires Improvement

Is the service caring?
The service was caring.

People were satisfied with the support and care they received and that staff respected their privacy and dignity.

Staff took into account people's individual needs. We saw staff talk with people in a patient and unhurried way, allowing them time to respond.

Good

Is the service responsive?
The service was not responsive.

Care plans were not person centred and did not provide the information needed to assist staff in providing good care.

The information recorded in the care plan was not always carried out in practice, leading to poor care.

There were limited activities available so people were often under stimulated and inactive.

Inadequate

Is the service well-led?
The service was not always well-led.

Requires Improvement

Summary of findings

There were procedures in place to monitor the quality of the service. Audits were being completed but monitoring of specific areas was infrequent and issues such as infection control were missed.

There was a range of ways for people to make their views known. People, their relatives and staff told us the management team and senior staff were approachable and willing to listen to people.

Broadway Care Home

Detailed findings

Background to this inspection

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

The inspection team consisted of a lead inspector, a specialist advisor who had experience of providing services for older people and people living with dementia 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. The expert by experience for the inspection at Broadway had experience of services that supported older people and people living with dementia.

The last inspection was carried out 11 July 2013. There were no concerns identified and we found the service was meeting all standards looked at. Before our inspection on 24 and 28 October 2014 we reviewed the information we held on the service. This included notifications we had received from the provider, about incidents that affect the health, safety and welfare of people who lived at the home. We also checked to see if any information concerning the care and welfare of people living at the home had been received.

We spoke with a range of people about the service. They included the registered manager, members of staff on duty, six people who lived at the home and nine relatives. We also observed how staff engaged with people, particularly where people were unable to speak with us because of their communication difficulties. We spoke to health care professionals, the commissioning department at the local authority and contacted Healthwatch Blackpool prior to our inspection. Healthwatch Blackpool is an independent consumer champion for health and social care. This helped us to gain a balanced overview of what people experienced accessing the service.

Before the inspection the registered manager 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. The registered manager advised that there would be improvements to the building including several new windows and the ramp at the front of the home.

During our inspection we spent time observing the care and support being delivered throughout the communal areas of the home. This included a method called Short Observational Framework for Inspection (SOFI). This involved observing staff interactions with the people in their care. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We looked at the care records of five people, the previous four weeks of staff rota's, recruitment records for two staff, the training matrix for all staff, and records relating to the management of the home.

Requires Improvement

Is the service safe?

Our findings

People who lived at the home told us they felt safe at Broadway. One person said, "It is gold standard here, I know that I am safe and well looked after." A relative told us, "Mum is safe and in a good place, as far as I can see. All the staff seem caring." However two people said that although they always felt safe, a member of staff was sometimes abrupt in their manner. One person said they had already dealt with it. We looked at this further but could not find any further concerns.

Relatives confirmed that they or their relatives never felt intimidated or were roughly handled. One relative told us, "The staff are gentle and dignified when helping, but [my family member] can get quite difficult and verbally insulting." Another relative commented, "It's very homely here, and the staff remain calm and polite to everyone even as some people may get very upset with them or with things generally."

People told us they were satisfied with the cleanliness of the home but this did not reflect our findings. We saw staff working at the service did not consistently apply infection control practices. On the first day of the inspection we looked around the home and saw infection control issues where some furnishings and equipment were unclean and unhygienic. In particular several commodes had ingrained dirt or faecal matter on the commode pan, lid and the surrounds of the commodes. Stair bannisters were dirty and sticky, as were chair arms in communal areas.

We looked around the home in the morning and where we had concerns we also visited these areas at the end of day one of the inspection. These areas were still unclean. There were also unpleasant odours in several areas of the home at various parts of the day.

On the second day of the inspection the stair bannisters had been cleaned and painted and commodes were clean. The registered manager told us, that after our feedback, she had looked around the home and seen that the environment needed improving. A deep clean was being started in communal areas. The home no longer had an unpleasant odour. However chair arms in communal areas were still dirty. This was a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw that staff wore personal protective clothing when involved in personal care or at mealtimes. We noted that staff did not wipe people's hands or face or give them the opportunity to do so before or after meals.

At the main entrance to the home there was a door mat which was full of water which was leaking from a gutter above the door. This made the entrance a slip hazard' particularly in wet weather. The registered manager told us that this would be dealt with quickly. Records were available confirming gas appliances and electrical facilities and equipment complied with statutory requirements and were safe for use.

We looked at the recruitment and selection of two members of staff. People were not always protected from unsuitable people working in the home because the home's recruitment procedure was not always followed correctly. The application forms were not always fully completed and there were gaps and discrepancies in employment histories in both files which had not been followed up. This meant the management team did not know what work the prospective member of staff had been doing in those gaps.

The staff files we looked at showed us that a Disclosure and Barring Service (DBS) Adult First Check had been received before new staff were allowed to work in the home. This is the initial check made by an employer to make sure that a person is permitted to start work with adults, under supervision, before a DBS certificate has been obtained. Full DBS (formerly CRB checks) had also been sought. These checks were introduced to stop people who have been barred from working with vulnerable adults being able to work in such positions.

There had been one safeguarding alert made to the local authority via the Care Quality Commission about poor care earlier in the year. This had been investigated by the local authority and the concerns were not substantiated. One relative told us about their family member's deteriorating health. The registered manager had told the relative of some unexplained bruising on their family member's arms. We learnt that this had been reviewed by a health professional as well as monitored by the manager. This meant that there was an open transparent culture and willingness to investigate issues which reduced risks to people.

Requires Improvement

Is the service safe?

Risks to people were minimised because the provider had procedures in place to protect them from abuse and unsafe care. Staff we spoke with said they would have no hesitation in reporting abuse. They were able to describe the action they would take if they became aware of abuse. This showed us that they had the necessary knowledge and information to ensure people were at less risk from abuse and discrimination.

Restrictions were minimised so that people were safe but had the most freedom possible. Although there was a keypad on the front door, the key code was available for those who were safe to leave the home unaccompanied. People told us that they could come and go and were supported to safely do things they wished.

Where people displayed behaviour which challenged the service, we saw assessments, guidance to staff and risk management plans were in place. Staff spoken with were familiar with this information and aware of how to support people. This meant staff had the guidance and support they needed to provide safe care.

We looked at how the home was being staffed. We did this to make sure there were enough staff on duty to support people throughout the day and night. Some people were highly dependent and needed a lot of staff support. We saw there was sufficient staff on each shift to assist them in personal care. However the staffing levels did not provide the staff with time to engage in activities with people.

The registered manager said agency staff were rarely used but they would need to use agency staff soon after the inspection. This was because of a nurse vacancy. However the agency was sending the same members of staff, where possible so they were more aware of the needs of people.

Most people we spoke with were satisfied with staffing levels. One person living at the home said, “The staff are here straight away if I buzz them for anything.” Relatives we spoke with felt there was enough staff on duty to meet the care needs of their family member, but not always for any activities. Staff members we spoke with told us the staffing levels were enough for them to provide good personal care but they did not have the time to spend in social activities. There was a low turnover of staff within the home and staff were familiar with the needs of individuals. Staff told us that morale was high and they worked well as a team.

We looked at how medicines were stored, given and disposed of. We spoke with people about the management of their medicines. They told us they felt staff supported them with medicines well. Only the qualified nurses, who had all been trained in the management of medicines, were involved in giving people medicines. Staff told us that they worked to the National Institute for Health and Care Excellence (NICE) guidelines for managing medicines in care homes. NICE guidelines provide recommendations for good practice on the systems and processes for managing medicines in care homes.

Medicines were ordered appropriately, checked on receipt into the home, given as prescribed and stored correctly. We observed part of a medicines round and saw that medicines were given safely and recorded after each person received their medicines. The manager had audits in place to monitor medication procedures, check compliance with procedures and learn lessons if any errors were made.

Risk assessments although not personalised in how they were written, were in place. Any accidents or incidents were reported to the manager and monitored for patterns of triggers to incidents, to assist with keeping people safe.

Requires Improvement

Is the service effective?

Our findings

We spoke with people and their relatives and looked at a sample of care and medication records. From this we could see that people and relatives were involved informally with planning their care. However there were no systems in place for staff to routinely involve people in planning their health and care needs with them. One relative we spoke with said, “When we considered the home for [our family member] they fully involved us. I had a long discussion with [the registered manager] and there were continuing care discussions which I could not attend, but she told me fully about these.” Another relative told us, “The home keeps me informed about the progress of treatment and when the staff call the doctor.” The relative added, they knew and agreed with the main aspects of the care plan.

Specialist dietary, mobility and equipment needs had been identified in care plans, where people had specific needs. The registered manager told us of the good links with continence services and dieticians to ensure the most effective care and support for people. Records seen reflected this. People told us their healthcare needs were monitored and action taken in response to the person’s needs. One person said, “I couldn’t get better care. The staff have had all sorts of people [professionals] come in to help me.”

Broadway care home was registered to support older people and people living with dementia and needing nursing care. However the environment was not designed to effectively support people living with dementia. Neither did they use any national good practice guidance for people living with dementia. The environment did not take into account the needs of people living with dementia with decoration, signage and adaptations. There were no measures to improve well-being and independence for people living with dementia, such as contrasting coloured equipment, crockery and furnishings. The doors around the home had little to distinguish one from another, so people did not know which rooms were which. This lack of dementia friendly surroundings made it difficult for people to orientate themselves around the home or to retain their independence.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. We discussed the requirements of the Mental Capacity Act (MCA) 2005 and the associated Deprivation of Liberty Safeguards (DoLS), with the registered manager. The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people’s best interests. Deprivation of Liberty Safeguards (DoLS) are part of this legislation and ensures where someone may be deprived of their liberty, the least restrictive option is taken.

The home had policies in place in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The management team told us relevant staff had been trained to understand when an application should be made. Staff demonstrated a good awareness of the code of practice and confirmed they had received training in these areas. Staff determined people’s capacity to make particular decisions. They knew what they needed to do to make sure decisions were in people’s best interests. This meant clear procedures were in place to enable staff to assess peoples' mental capacity, should there be concerns about their ability to make decisions for themselves, or to support those who lacked capacity to manage risk.

People told us they thought the staff were suitably trained and supervised. We saw that staff were provided with frequent and relevant training and support. We spoke with the staff and checked the training records for all staff employed by the home. This confirmed staff had access to an induction programme, and mandatory training. This included health and safety, moving and handling, food hygiene, safeguarding and end of life care. Many staff had also completed national training in care.Staff told us they were well supported by the registered manager and the organisation in terms of training and attending courses. They told us they had good access to training and were encouraged to develop their skills and knowledge. This meant they were able to develop their skills and knowledge in most areas. Staff had received basic dementia awareness training which provided them with some skills and knowledge to support people living with dementia. However this was limited when providing care and support to people. One person told us they were encouraged to observe moving and handling of people, with their agreement but were not allowed to be involved in moving anyone until they had received training in how to do so correctly.

Requires Improvement

Is the service effective?

Staff received regular supervision and annual appraisal. This is where individual staff and those concerned with their performance, typically line managers, discuss their performance and development and the support they need in their role. It is used to assess recent performance and focus on future development, opportunities and any resources needed. Staff told us they felt well supported through these and the regular staff meeting. We spoke with the cook and with care staff. We were shown how meals were recorded and the choices available. Staff were aware of people's preferences and dietary requirements including special diets. They told us how they provided additional calories for people who were underweight by fortifying food and drinks for them. They also told us how they assisted people to eat more healthily. There was information about each person's special needs, likes and dislikes kept in the kitchen and available to all staff. This was regularly updated. It showed how staff effectively met people's nutritional needs.

Kitchen and domestic staff were included in staff handovers with care staff so that all staff were aware of people's support needs. The registered manager told us of the good links with dieticians to ensure the most effective nutrition for people.

We observed lunch being served. Some people ate in the dining room, others chose to eat in the lounge or their bedrooms. We saw staff supporting people who required some help in a respectful and dignified way. They reminded them of the food they had chosen. Where one person no longer wanted that meal, alternatives were offered. They gave people time to finish each mouthful of food before offering them another. They also chatted to them as they assisted them. One relative said staff were patient with their family member adding, "It takes a long time to feed her but the staff never rush and say if it takes an hour then they take that long". We saw people being encouraged to have drinks on a regular basis. This included a variety of hot and cold drinks and included smoothies to encourage people to have their 'five a day'. However we saw that all people who lived at Broadway had two handled plastic cups to drink from, whereas staff and visitors had ordinary pottery cups. Although some people would need such specialist cups, others would not, yet there was no acknowledgment that people were different and had different needs in relation to eating and drinking equipment.

The main meal was provided at lunchtime and consisted of soup, a cooked main meal and a sweet. There were two options offered plus additional alternatives. Evening meals were a lighter type of meal such as quiche and chips or burgers with several choices available. The cook told us that the food cupboards were never locked, as some people needed encouragement to eat and staff didn't want people to be hungry between meals. The cook showed us the foodstuff in the kitchen and stores. There was a variety of fresh foods available and these were replenished several times each week. The people we spoke with told us they enjoyed their meals. They told us they always received as much as they wanted to eat. People said that the meals were very good and they were given lots of choice. They told us they were informed daily about meals for the day and choices available to them. One person said, "The food is great, lots of fresh fruit and loads to choose from."

We had responses from external agencies including the continuing care health team, mental health team, social services contracts and commissioning team and local district nursing team. They told us they were satisfied with the care provided and had no concerns about the home. This information and from to speaking with people at the home, their family members and the staff team, helped us to gain a balanced overview of what people experienced living at Broadway care home.

We recommend that the service finds out more information, based on current best practice, in relation to the specialist needs of people living with dementia and the environment.

Good

Is the service caring?

Our findings

As part of the inspection process, we spoke with people who lived at the home and their relatives. They were pleased with the care and support they received and said they were well looked after by the care staff. One person said, "It's the nicest home I've lived in and I've been at two others before moving here. The last one was horrible. I like it much better here because they don't judge me. They just help me." Another person told us, "Staff are doing a really good job with my medication and treatments are all being provided properly." A relative told us, "It's first class here, it's caring and cosy, and [my family member] feels more like a guest than someone staying in a home. Another relative told us they felt their family member was safe with the staff at the home and that the staff were kind and caring.

All the people and their relatives we spoke with confirmed that staff were kind and compassionate. They gave examples including how staff helped people, spoke to them and took the time to allow people to walk at their own pace, even when that took a long time or go to the toilet with safety and dignity. There were quiet and private areas within the home which families could discuss any sensitive issues.

The relationships between staff and people receiving support demonstrated dignity and respect. People told us they had good relationships with staff and they were treated with kindness, respect and dignity. We saw staff knocking on doors before entering and ensuring toilet and bathroom doors were shut when people were inside. One person said "I trust all of the staff to give me the best care they can." A relative told us "Yes, it's pretty good here, the staff are quick to help and they are always polite and helpful." We spoke with staff about how to ensure people were treated in a respectful way. They told us that treating people with respect was of major importance. One member of staff said, "Would I like to be talked to rudely or washed with the door open? No I wouldn't, so you don't do it to anyone else."

Relatives told us how they were supported by the registered manager and staff as well as their family members who lived at Broadway care home. They said the needs of relatives were considered. One person told us, "I've never been happier than living here now, and it's a gold standard for us as they've really supported us both. The staff are absolutely wonderful." A relative said, "I think the staff are caring, dedicated and focussed. There are nice little touches like ensuring [my family member] can still have her favourite glass of sherry each night after her tea."

We saw staff talking with people in a patient and unhurried way, allowing them time to respond. Staff took into account people's individual needs especially their communication needs. There was good thoughtful and compassionate interaction particularly where people were ill or anxious. One person was showing irritation and anxiety. A member of staff sat with the person and distracted them by talking about people they knew. After a while the person became less irritable and began talking to people.

We observed staff sitting and chatting to one person who was unable to communicate easily. The member of staff carried on what seemed initially to be a one sided conversation. However they were observing for movement indicating the person was enjoying the company and after a short while the person responded.

Although care records were limited, staff spoken with had awareness of people's needs and preferences. We saw evidence people who lived at the home, and/or their family members had been involved in their care. One relative told us, "The manager is keeping us fully informed and involved including the changes to [my family member's] medication and care, and, they have acted upon our suggestions." Confidentiality of information was maintained as it was stored securely and staff were aware of the confidentiality procedure. There was information available to people about accessing advocacy support. The registered manager told us that where people were unable to speak for themselves, advocates had occasionally been used to help with decision making.

We spoke with four relatives and a person who lived at Broadway about their wishes and end of life planning. They could all recall conversations with the senior staff and that this subject had been introduced sensitively. One person and their relative told us they specifically wanted to be at the home then and had made their wishes clear with their doctor. They said the home had in large part now become their family and friends and they both felt this way.

Inadequate

Is the service responsive?

Our findings

We spoke with the registered manager about how they developed care plans when people were admitted to the home. Senior staff told us care plans and risk assessments were completed soon after admission. We looked at the care records of five people we chose following our discussions and observations during the day. Each person had a care plan and risk assessments.

Care plans were not person centred and were limited in the information provided. The care plans were generic with the same broad issues already typed on a care plan template and crossed out or briefly added to as appropriate. The statements on the care plan were general and did not offer guidance to staff of how to support that person. For example, under the heading communication for all people looked at it read: Give time to express feelings, listen carefully but no specific or personal information related to that person.

Three of the five people's files we looked at, did not have all parts of the care plan forms completed. This included life histories, and specific areas of care such as information about continence, physiotherapy, and exercise plans and end of life care. This meant that staff did not have information focussed upon the person's whole life, including their goals, skills, abilities and how they prefer to manage their health.

Other forms not completed appropriately included, falls information, where one person who had frequent slips during transfers, did not have specific, detailed information and guidance. They only had basic information which did not give staff adequate guidance. Also end of life and resuscitation forms were limited and in some instances were out of date. Staff did not know who should not be resuscitated. There was no easily accessible information regarding this and one person whose file we looked at had conflicting information regarding end of life and resuscitation. This meant staff would not be able to respond quickly and appropriately if the need to resuscitate the person arose. These omissions were a breach of Regulation 20 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw sometimes the information written in the care plan was not carried out in practice. We saw two people had been assessed for bedrails and bumpers for the bedrails to reduce the risk of entrapment. However although the people were in bed the bumpers were not in place. This put people at risk of entrapment and injury. The registered manager told us that the bumpers were usually attached to the bed rails, immediate action was taken to ensure these were then positioned appropriately.

We saw in the care plans of two people they needed regular repositioning to avoid skin damage. However, the charts kept in the resident's rooms showed no recordings to confirm that the repositioning had been completed. We informed the registered manager of the error; she told us one person could move herself around the bed. However the care plan instructed repositioning every two hours. Later the records regarding repositioning had been completed retrospectively, the registered manager told us the repositioning had been done but hadn't been recorded. These care practices were a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The home had few activities available during each day in which to involve and stimulate people. Several people, particularly those with high care needs were sat in the lounge for long periods of time with little to do. We saw that one person had asked at a review to go out on short walks but there was no record that this happened. We spoke with staff who acknowledged that they were not often able to take the person out. They told us that they had not enough time to engage in social and leisure activities with people

Some people and their relatives said there was often not much going on. They mentioned occasional activities like music or films but said other activities were infrequent. We saw that some people had a previous interest in knitting and other crafts which they had given up for reasons associated with poor sight. Staff had not built on these previous hobbies or looked at ways for example such as contrasting wool/thread and needles so that they could still be encouraged to rebuild or retain such interests.

Opportunities to involve people in daily living activities were missed. The tables for meals were laid out by a staff member some time before the meal was served, rather than involving people in this activity. Setting the tables so far ahead of the meal could have confused people, as the expectation would be for a meal to be served soon after this.

Inadequate

Is the service responsive?

Some people were ill and remained in bed in their bedrooms throughout the inspection. Although they may not have wanted lively activities there was little attempt to provide relaxing music or companionship. Although members of staff were patient and committed, the approach was more task orientated than a person centred approach to people's needs. Person centred care aims to see the person as an individual. Instead of treating the person as a collection of illnesses and behaviours, person-centred care considers the whole person, taking into account each individual's unique qualities, abilities, interests, preferences and needs. The delivery of care should fit the individual rather than the individual fitting the routines of the home.

There was evidence that there were organised parties and events throughout the year. The staff team also decorated the home in 'themes'. When we inspected Halloween decorations brightened the lounge and dining room. People told us they enjoyed these. However these events were infrequent and did not make up for the lack of activities on a day to day basis.

People reported that the home was responsive in providing care to meet their changing needs. We saw that call bells were answered quickly. People said they didn't have to wait long for staff to assist them. One person said, "The staff are lovely. They come to help me quickly if I call them."

We saw that staff responded in good time to health needs. They made referrals to other health and social care professionals as needed. This included psychologist, mental health professionals, dieticians and chiropodists.

These referrals meant they were receiving the care they needed from other professions in a timely manner. One person had developed slight pressure areas. We saw specialist pressure aids were in place to assist with the care and management of this. Records showed the person's GP had been involved with the person's care.

Records showed that changes to care were made if needed. One relative said the care of their family member had been changed as a result of a fall. In practice assisting people with moving and transferring and reducing falls was being managed. People told us about any falls they or their relatives had experienced and how the service responded well to these situations. They told us how the service was trying to avoid further falls. One relative told us how well staff had involved and liaised with them to reduce the risk of further falls to their family member.

The home had a complaints procedure which was made available to people they supported and their family members. We saw there hadn't been any recent complaints. The registered manager told us the staff team worked very closely with people and their families and any comments and minor issues were dealt with before they became a concern or complaint.

People said they did not need to complain but would do so if they felt it was needed. They felt that any ideas or concerns were taken seriously and staff dealt with these satisfactorily. One person said, "Complain, there is nothing to complain about here. It is marvellous." A relative said, '"I think it's excellent. Any minor issues have always been dealt with straightaway."

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in place. The registered manager had been in place for a number of years and staff told us they found her supportive and approachable.

The registered manager was also the only nurse on duty on three or more shifts each week. This meant that as well as her managerial duties she carried out the nursing care of people and medicines and other nursing duties. This was partly because she had a maximum of two supernumerary days for management of the home each week. In addition she was covering a nurse vacancy in the team. It was positive that the manager was working closely with staff but being the only nurse on shift made fitting in her managerial tasks difficult. This meant that although the management of the home was satisfactory in some areas, there were several areas where management oversight had been missing including developing person centred care and activities and infection control issues.

There were procedures in place to monitor the quality of the service. Audits were being completed by the registered manager but there were sometimes gaps of several months between audit areas being repeated. Audits included monitoring the homes environment, care plan records, infection control, financial records, medication procedures and maintenance of the building. Although audits were carried out they were not frequent enough to alert the manager to the infection control issues and care responsiveness issues we saw.

People told us senior staff were approachable and willing to listen to people. A relative told us, “I have good regular contact with the home manager and staff, although this isn’t very formal.” People who lived at the home, relatives and staff said they felt supported by the registered manager. They felt secure sharing any information or concerns with them. They said the registered manager listened to them and would take any action where necessary. Relatives we spoke with told us they were told of any incidents or accidents in a timely manner and the registered manager worked in an open and transparent way.

People were given information about the home and the organisation in the form of leaflets and booklets. This included information about the provider and home. The information could be made available on request in large print, braille and different languages.

People regularly told us that their views were respected. They said relatives were made welcome and encouraged to be involved in the provision of the care for their family members and friends. People said it was easy to chat or ask about things or for help. There were frequent informal chats with the registered manager about people’s views of the home and with relatives but no formal residents meetings. However people and their relatives were encouraged to complete surveys about the care provided.

Staff meetings were held to involve and consult staff. Staff told us they were able to suggest ideas or give their opinions on any issues. Systems were in place to assist the management team and staff to learn from events such as accidents and incidents, complaints, concerns, whistleblowing and investigations. This reduced the risks to people and helped keep people safe.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The registered person had not taken proper steps to ensure that each person was protected against the risks of receiving unsafe or inappropriate care as they had not taken action to ensure the welfare and safety of service users.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records **People were not protected against the risks associated with poor record keeping because the registered person did not have appropriate and accurate information about the care and treatment of each person.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **The registered person did not operate effective infection control practices.**