Quantum Care Limited

Dukeminster Court

Inspection report

Dukeminster Estate
Church Street
Dunstable
Bedfordshire
LU5 4HU

Date of inspection visit:
16 June 2016
30 June 2016

Date of publication:
01 August 2016

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

Summary of findings

Overall summary

This inspection was carried out on 17 and 30 June 2016 and was unannounced.

Dukeminster Court provides care and accommodation for up to 75 people, some of whom are living with dementia. At the time of our inspection there were 68 people living at the home.

The home had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The processes in place to manage people's medicines were not always effective. Although most medicines were provided by the pharmacy in pods on a monthly cycle, where this was not the case people's medicines had run out on a number of occasions. This could have had a detrimental effect on their health and well-being.

Staff were aware of the safeguarding process. Personalised risk assessments were in place to reduce the risk of harm to people, as were risk assessments connected to the running of the home, and these were reviewed regularly. Accidents and incidents were recorded and the causes of these analysed so that preventative action could be taken to reduce the number of occurrences.

There were enough skilled, qualified staff to provide for people's needs. The necessary recruitment and selection processes were in place and the provider had taken steps to ensure that staff were suitable to work with people who lived at the home. People who lived at the home took part in the selection process for new staff. Staff received training to ensure they had the necessary skills to care for and support the people who lived at the home. They were supported to develop additional skills that would enable them to deliver a higher quality of care. Staff had regular supervisions and appraisals during which they could discuss their training and development needs.

People had been involved in determining their care needs and the way in which their care was to be delivered. Their consent was gained before any care was provided and the requirements of the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards were met.

People enjoyed the food that was available to them and had a variety of nutritious food and drink. If they did not like what they were offered at meal times they were provided with alternative food. People at risk of malnutrition or dehydration were monitored and where appropriate fortified food and drink was given to them.

Staff were kind and caring and protected people's dignity. Staff treated people with respect and supported them in a way that allowed them to be as independent as possible.

There was an effective complaints system in place. Information was available to people about how they could make a complaint should they need to about the services provided at the home. People were assisted to access other healthcare professionals and services to maintain their health and well-being.

People and staff were encouraged to attend meetings with the manager at which they could discuss aspects of the service and care delivery. People were asked for feedback about the service to enable improvements to be made. There was an effective quality assurance system in place.

During this inspection we identified that there had been a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people's medicines were not always managed appropriately. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People's medicines were not always managed appropriately. People sometimes could not have medicine that they had been prescribed as replacement stocks had not been arranged in time.

Staff were aware of the safeguarding process and appropriate referrals had been made to the local authority.

Personalised risk assessments were in place to reduce the risk of harm to people.

There were enough skilled, qualified staff to provide for people's needs

Is the service effective?

Good

The service was effective.

People had a good choice of nutritious food and drink.

Staff and managers were trained and supported by way of supervisions and appraisals.

The requirements of the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards were met.

Is the service caring?

Good

The service was caring.

Staff were kind and caring.

Staff promoted people's dignity and treated them with respect.

Is the service responsive?

Good

The service was responsive.

People were supported to follow their interests and hobbies and

a variety of activities and entertainment was provided.

There was an effective complaints policy in place and complaints were responded to quickly and effectively.

Is the service well-led?

Good

The service was well-led.

There was a registered manager in place who was supported by a deputy manager and a manager on each of the five units.

There was an effective quality assurance system in place with quality audits undertaken by the unit managers, the registered manager and the provider's quality team. .

Dukeminster Court

Detailed findings

Background to this inspection

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

This inspection took place on 17 and 30 June 2016 and was 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 using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the information available to us, such as notifications and information provided by the public or staff. A notification is information about important events which the provider is required to send us by law.

During our inspection we spoke with eleven people and five relatives of people who lived at the home. We also spoke with three care staff, the chef manager, an activities co-ordinator, the deputy manager, a unit team leader and the registered manager.

We observed the interactions between members of staff and the people who lived at the home and looked at care records and risk assessments for seven people. We also looked at how people's medicines were managed and the ways in which complaints were handled.

We looked at two staff recruitment records and reviewed information on how the quality of the service, including the handling of complaints, was monitored and managed.

Requires Improvement

Is the service safe?

Our findings

During this inspection people told us that they did not always receive their medicines when they were due. One person said, "They ran out of my evening medicine. I asked why there was only one tablet for me to take at night instead of two and they said they had run out." Another person told us, "On time yes generally well within an acceptable window, but they do run out of my medicines especially my creams for my delicate skin and that makes things difficult for me."

We checked medicines administration records (MAR) in the units. We found that there was a sheet for the staff member who administered medicines to sign when they accepted responsibility for the medicines trolley keys. There were photographs of each person on their MAR and in some cases warnings that their name was the same as or similar to someone else who lived at the home. The home used a pod system for medicines where the pharmacy placed all medicines that were to be taken at the same time in one pod for the staff to administer to people. The member of staff signed the MAR when each medicine had been taken. We saw that where people refused certain medicines included in the pod this had been recorded appropriately. People's prescribed creams and potions were stored on the medicines trolleys in the units. These were secured to the wall in the communal area in each unit when not in use. Additional supplies of creams and potions were stored in the medicines room on the first floor.

However we saw that when the medicines in the trolley had run out, the medicines room was not always checked to obtain further supplies. We noted an entry for one medicine that stated 'Not on trolley. Not given.' We also saw records that showed that the supplies available had been exhausted with stocks of one medicine prescribed to aid elimination recorded as '0' on four consecutive days and another medicine prescribed for asthma which was to be given four times daily to have been recorded as not given for four days toward the end of the cycle. We were told that the supply had been exhausted and the medicine had subsequently been prescribed on an 'as needed' (PRN) basis in the following medicines cycle. We discussed this with the registered manager and the deputy manager. The deputy manager showed us that when a person's medicine for treatment of their asthma had run out on 20 June 2016 a request for a repeat prescription had been faxed to the GP on 21 June 2016. When the prescription did not arrive a further request had been faxed to the GP on 24 June 2016. Although the service had taken steps to obtain the medicines that were needed, the person had been without this medicine for four days when the second prescription request was made. The request for a repeat prescription should have been made before the medicine ran out to enable it to be administered in accordance with the prescriber's instructions.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014.

People had mixed opinions as whether there were enough staff to support people effectively at all times. One person said, "I couldn't get anyone with the bell for ages, eventually a carer came." Another person said, "We could do with a few more [staff] but they are kind and helpful." Some relatives also thought that there were insufficient staff at times. One relative said, "[Relative] only complains about the long wait for someone to come to [them]. For example to get out of bed because [they] can't get out by [themselves] because of the

rails on [their bed. [They] feel trapped and can't get out not even to go to the toilet." We checked the record which showed how long it had taken staff to respond to call bells for the week prior to our inspection. The records we looked at showed that the longest time it had taken for staff to respond to a call bell had been eleven minutes. This had occurred when assistance had been required during a period when staff were getting people ready for bed. The registered manager accepted that this would have appeared to be a long time to the individual. During our inspection we noted that call bells were responded to promptly which indicated that there were enough staff. A relative felt that there were insufficient staff available to support their loved one to eat their meals. They told us, "There is insufficient staff for someone to sit with [relative] and encourage [them] to eat. When I am here I do it but I can't always be here at mealtimes."

The registered manager showed us the staff rota which was planned two weekly in advance. The staff were allocated to each of the five units on a regular basis so that people had continuity with the people that cared for them. People's dependency had been assessed and the registered manager told us that staff had been allocated to each unit according to the needs of the people on the unit. This had meant that during the day time period there was normally three care staff and the unit manager on four of the five units and two care staff and the unit manager on the fifth. During our inspection we observed a visible presence of care workers in each unit. At night there were six care workers and one unit manager to care for people in the home. Staff had regular shifts over the two weeks period that the rotas were planned and were therefore able to more easily plan their other commitments. Although the service used some care workers provided by agencies the use of these had been reduced with unit managers, the deputy manager and the registered manager covering some shifts when unplanned absences occurred. The registered manager told us that when agency staff were required to cover shifts on the rota this was pre-booked to ensure that, wherever possible, the agency staff were familiar with the home and the people who lived there.

People told us they felt safe living at the home. One person told us, "Yes I feel safe here, I have been in two homes before here and I would be happy to spend the rest of my days here." Another person said, "Yes I do feel safe, I have a lovely safe room." Relatives also told us that they felt that their loved ones were safe living at the home. One relative said, "[They've never been happier than here – [they] feel very safe." When asked another relative told us, "Yes [relative] is safe here I think, but I do come and see [them] every day." Another relative said, "[Name] has someone to keep an eye on them 24 hours a day." Staff also believed that people were safe living at the home. One member of staff told us, "Safe – oh yes they are. They want for nothing in here."

Entry to and exit from the building was by way of the reception area. Visitors were required to sign in and out of the building at the reception desk and the reception staff were aware of who was in the building at any time. This protected people who lived at the home from harm but the visitor's book would also be used to ensure that the building was properly evacuated in the event of an emergency. Reception staff enabled people to enter and exit freely if this was appropriate to their needs.

The provider had up to date policies on safeguarding and whistleblowing. Whistleblowing is a way in which staff can report misconduct or concerns within their workplace without fear of the consequences of doing so. Information about safeguarding people was displayed within the home. Staff told us that they had been trained in safeguarding and were able to explain the procedures on keeping people safe. One member of staff said, "The training covered who to contact if I had an issue. I would tell the manager if I saw any abuse by staff, relatives or visitors. If I had reported it and it had not been dealt with, I would call the local safeguarding team." They were aware of and understood the provider's whistleblowing policy and would not hesitate to use it.

There were personalised risk assessments for each person who lived at the home. Each assessment

identified the people at risk, the steps in place, the equipment available to minimise the risk, such as which hoist and sling to use when transferring people and the action staff should take should an incident occur. Examples of risk assessments carried out included the risks associated with leaving the building, with the use of inhalers for medicines administration and smoking. The risk assessment in one care record for smoking advised staff to escort the person to the patio area and stay with them until they had finished their cigarette and extinguished it. Staff were to ensure that the cigarette had been properly extinguished before escorting the person back inside.

The registered manager had appointed a Falls Champion to identify causes of falls and to take steps to reduce these where possible. The service had also introduced a falls flow chart which staff were to follow in the event of a person experiencing a fall. We saw that where people had been assessed as at risk of falling, a falls diary was kept and the cause of any fall was recorded. The falls were also recorded in the incident and accident log. Analysis of these records enabled the staff to take steps to reduce the risk of a person suffering a fall. One step recommended for an individual was to ensure that they were well hydrated as this would reduce the risk of them falling. Analysis of the falls record showed that there had been a reduction in the number of falls in recent months.

Risk assessments were reviewed regularly to ensure that the level of risk to people was still appropriate for them. Staff told us that they were made aware of the identified risks to each person and how these should be managed by a variety of means. These included looking at people's care plans, their daily records and by talking about people's experiences, moods and behaviour at shift handovers. This gave staff up to date information and enabled them to reduce the risk of harm occurring.

The provider's health and safety manager had carried out assessments to identify and address any risks posed to people by the environment. These had included fire risk assessments, the checking of portable electrical equipment and the use of external areas, such as the garden. Each person had a personal emergency evacuation plan that was reviewed regularly to ensure that the information contained within it remained current. These enabled staff to know how to keep people safe should an emergency occur.

Accidents and incidents were reported to the manager. We saw that they kept a record of all incidents, and where required, people's care plans and risk assessments had been updated following accidents or incidents. The records were reviewed by the manager to identify any possible trends to enable appropriate action to reduce the risk of an accident or incident re-occurring. The records showed that, following an incident in January 2016, modifications had been made to the emergency door release and an additional member of staff was employed at night. This demonstrated that the provider acted promptly to reduce the risk of a similar incident occurring.

We looked at the recruitment documentation for two members of staff who had recently started work at the home. We found that the provider had robust recruitment and selection processes which had included pre-selection checks on literacy skills, qualifications and transferable skills. This was followed by an interview with the manager and a person who lived at the home. If the person did not think a candidate was suitable to work with the people who lived at the home then the candidate would not be offered a position. We saw that appropriate checks had been carried out before new members of staff started work. These included Disclosure and Barring Service Checks (DBS), written references, and evidence of their identity. This enabled the provider to confirm that staff were suitable for the role to which they were being appointed.

Good

Is the service effective?

Our findings

Most people and their relatives told us that staff had the skills that were required to care for them. One person said, "I think the staff are well trained, they are all very good." Another person told us, "Well trained to look after me? Oh yes, but we have always got new ones coming on you know." However one person said, "No I don't think they do. They don't know how to help me." However, they did not tell us in what way the staff had been unable to help them. A relative told us, "They are all very well trained."

Staff told us that they received a full induction when they started working at the home and there was a programme in place which included the training they required for their roles. One member of staff told us, "I had a week's induction when I covered the mandatory areas, such as moving and handling, health and safety, fire and dementia. I went to another home as Dukeminster Court had not opened when I started. I was able to shadow experienced staff for as long as I wanted and until I felt comfortable on my own. The dementia training was really good at explaining how it [dementia] affects people in different ways. It gave me an understanding of why they [people] act as they do." Another member of staff told us, "I started here [number] months ago. I had a full week's induction. I then shadowed for a week. I asked to come off shadowing because I knew what I was doing."

Staff told us that they had regular on-going training and were able to ask for any additional training they wanted. One member of staff said, "We can do any training we ask for – it is very good like that here." The registered manager showed us the electronic system used to manage staff training needs. They told us that the deputy manager would normally identify and book any training required. Each member of staff had a training report which detailed the actual training they had completed. They also had a training plan which detailed when they needed to refresh training in particular areas. In addition to the provider's mandatory training the registered manager was arranging additional training from external providers in areas such as pressure care. This meant that people were cared for by staff who were enabled to develop and improve their skills.

Staff also told us that they received regular supervision and felt supported in their roles. One member of staff told us, "I have had regular supervisions." Staff were able to discuss the training they had received and any that they wanted to maintain or improve their skills during their supervision meetings. This meant that they were supported to enable them to provide care to a good standard. We saw records for each line manager which showed that regular supervision with staff had taken place.

People's capacity to make and understand the implication of decisions about their care were assessed and documented within their care records. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests

and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We looked at the home's records around the requirements of the Mental Capacity Act 2005, and the associated Deprivation of Liberty Safeguards and saw that these had been followed in the delivery of care. Records showed that, where applicable, assessments of people's mental capacity had been carried out and decisions had been made on their behalf in their best interest. We saw that one care record we looked at contained an authorisation from the relevant supervisory body to deprive a person of their liberty in order to keep them safe. People told us that staff asked for permission before they supported them. Staff told us that they always asked for people's consent before providing any care or support and explained how they communicated with people. One member of staff said. "I gain consent by communication – saying 'Good Morning', then reading facial gestures if they are not able to speak and looking at their eyes sometimes." We noted that, where able, people had signed consent to their care plans.

People and their relatives told us that they had a good variety of nutritious food and drink. They all reported that they could ask for foods that were not on the menu if they did not like what was on offer. One person told us, "There is always a good choice. Lots of fresh fruit and vegetables. You can have a hot drink any time you want." We noted that there was a small kitchen area in the centre of the communal area where people could make drinks and help themselves to fruit or snacks, including home-made cakes. Another person told us, "I enjoy the food, I look forward to mealtimes."

We observed the lunch time experience for people who lived on two of the units at the home. The main meal was served in the evening but there was a choice of soup, sandwiches or a hot snack. The tables were nicely presented and people were asked what meal they would prefer. Staff checked with people as to whether they required assistance or wanted to eat independently. We heard a member of staff ask one person as they attempted to eat their meal, "Would you like me to help?" However, on the first day of our inspection we noticed that one person had been given soup, even though they had said that they did not want it. The soup was left in front of them until they got up, tipped the soup away and returned to their room. We had earlier spoken with their relative who was concerned about them as they had only recently been discharged from hospital. The relative told us "[Relative] is not eating or drinking. Trouble is still no-one is prompting [them] to eat or taking time to sit and feed [them] at mealtimes there just are not enough of them you see. When I sit with [them] I can encourage [them] to eat and drink." We advised the registered manager of what we had observed at lunch time and of our concerns about this person. They took immediate steps to ensure that the person was given choices of alternative foods until they agreed to eat something. Their care plan was reviewed immediately to reflect that staff were to sit with the individual and encourage them to eat. They were also given a fortified diet because of their frailty.
On the second day of our inspection we looked at the care records for this person that showed that they had gained weight following the registered manager's intervention.

In another unit a relative assisted their loved one to eat a freshly prepared cheese omelette, which looked and smelled delicious. The relative told us that they came every lunchtime to help the individual to eat their meal and the food was always freshly prepared and looked as good as the omelette.

People's care plans indicated whether they were likely to require assistance to eat their meal. Staff that supported people in eating made some attempt to talk to them by asking questions such as, "Have you finished?" or "Did you enjoy that?" Although the staff were often rushed in their interactions with the residents at lunchtime and had little time for social chatter we did note that one group of people were sat at the dining table having finished their meal and a member of staff was sat with them as they had a sing-song.

We spoke with the chef manager who told us that they were advised of any special dietary needs by the care

staff. Any special dietary requirements were then entered on a noticeboard in the kitchen. We saw that this displayed the names of people who required special diets as well as any allergies they had and their specific likes and dislikes. A relative had provided information on the dietary requirements of an individual and the chef manager ensured that these were adhered to.

People's weight was monitored and food and fluid charts were completed for people where there was an identified risk in relation to their food and fluid intake. These provided detailed information on what they had consumed. One member of staff said, "We write down all that they eat and drink throughout the day and total it. This information is put on their file for the [unit managers] to look at. I ask the resident if they would like anymore food; I would go up to the kitchen to get them something else if they did not want to eat the food on the trolley. I have one diabetic resident on the unit [who] has special diet that is provided by the kitchen." Where needed, referrals had been made to the local dietetic service and the speech and language therapists.

People were supported to maintain their health and well-being and to attend medical appointments in different ways. One person told us, "My [relative] takes me to hospital, the chiropodist comes in every six weeks but I have my own one. The optician does come from time to time." Another person said, "The district nurse I saw before I came in here comes to see me still every day because of my sores, My GP is just across the road so she asks him to come and see me sometimes. I only came in in [month]so I don't know about opticians or chiropodist yet." A relative said, "The district nurse and physiotherapist who used to see [relative] before have continued to see [them] here." However, a unit manager told us, "We find the residents always want to see the GP. We always monitor them first, if they ask this before we get a GP. Very often we don't need to when we have been monitoring them." One relative told us, "At the start of the week [relative] was not well. I mentioned this to the staff and they arranged for the doctor to come." This showed that although people did not always see a healthcare professional when they wanted to they did see one when they needed to.

Good

Is the service caring?

Our findings

People and their relatives we spoke with told us that the staff were kind and considerate. One person told us, "The main thing is the care. The carers are so kind." Another person said, "They are kind to us." A relative said, "I can't fault the carers. They are excellent in here. Really, really good and very caring." A member of staff told us, "I love the residents to bits." We observed the interaction between staff and people who lived at the home and found this to be friendly and caring

Staff we spoke with were aware of the life histories of people who lived at the home and were knowledgeable about their likes, dislikes, hobbies and interests. They had been able to gain information on these through talking with people and their relatives, and from the lifestyle profiles within people's care records, which included a sections entitled 'Things I Would Like You to Know About Me' and 'All About Me'. The lifestyle profiles had been developed in discussion with the people and their relatives to give as full a picture of the person as possible. A member of staff told us, "We get to build relationships [with people.] I get to know people by having one to one chats with them about what they like to do or not do, looking at their care plans and talking with other staff."

We saw that staff communicated appropriately with people and people told us that the staff protected their dignity and treated them with respect. One person told us, "They do respect my privacy and dignity, very much so. If you don't want a male carer you don't get one." Another person said, "The carers are all very good to me. They don't rush me and they treat me with respect and kindness." A third person said, "They are good, kind, respectful and pleasant." Staff members were able to describe ways in which people's dignity was preserved. For example asking quietly if they require personal care in communal areas, ensuring that doors and curtains were closed when providing personal care and covering people when helping them to wash. One person told us, "They do respect my dignity and kindness by placing a towel on my knees etc." A member of staff told us, "We always keep the door and curtains closed until the person is up."

People had their names on their different coloured bedroom doors, which gave the appearance of a street scene and had been encouraged to bring in items from their previous home to personalise their private room space. They told us that they were encouraged to be as independent as possible. One person told us, "I get myself dressed." Another person told us, "I was up and dressed this morning before they came this morning. They take me in my wheelchair into breakfast about 9.00am." People were encouraged to have visitors and make drinks for themselves and their visitors in the café on the ground floor. We saw people using electric wheelchairs and Zimmer frames to get around the home and access the garden and patio areas as they pleased. Communal areas were kept free of clutter to allow people to get around the home as safely and as independently as was possible.

Friends and relatives were free to visit people at any time. One relative told us, ""I come daily, the staff do acknowledge me. I do feel supported by the home. They will make me a drink they are welcoming and kind to me." Another relative told us, "We get on very well. It is very family orientated."

There was an information booklet about the care home available in the reception area. This included

information about the services provided and included inviting photographs of the cinema room, a sitting and dining area and the exterior of the building. It also provided contact details for the provider and the home and a map of the local area. Information was also provided on safeguarding, complaints and fire evacuation instructions. Information on the planned activities was also displayed on each unit to allow people to plan their time.

Good

Is the service responsive?

Our findings

People and their relatives told us that they had been involved in deciding what care they were to receive and how this was to be given. One relative told us, "We sat down with the manager in the beginning, to include it all in the plan. It has not been reviewed yet as far as I know."

People and their relatives told us that the care they received reflected their individual needs. The care records followed a standard template which included information on people's personal history, their individual preferences and their interests. One person's records showed that they could be very forgetful and did not like alcohol. The front cover of each care record included important information about the person, such as known allergies and medical conditions as well as a recent photograph and the name of their key worker. Where they were able to, the person had signed the cover to agree the care record. Each care plan within the care record was individualised to reflect people's needs and included clear instructions for staff on how best to support people with specific needs. One care record showed that the person became agitated if other people sat in the chair that had been purchased for them by a relative. The care plan identified how staff should prevent this from happening but also how to diffuse the situation should it occur. Another care plan for medicines advised that staff should give the person something to eat fifteen minutes before their medicines were due to be administered. A care plan for a person's personal hygiene stated that staff must not cut the person's toenails as they had diabetes and any wound would be difficult to heal. The person had regular appointments with the chiropodist who cut the nails for them.

People told us that they or their relative were involved in the regular review of their care needs. One relative told us, "I regularly talk about [relative]'s care plan." We saw that a care review had been completed for one person on the first day of our inspection during which their dietary requirements had been discussed in detail. Their relative, who had Power of Attorney for their health and well-being, provided the home with a diet that they wished the person to follow. On the second day of our inspection we saw that this had been included in their care plan. The diet had been provided to the chef manager and the person's meals were in accordance with it. The care records we looked at had all been reviewed on a regular basis and within the month prior to our inspection. We saw that the care plan for one person who had been discharged from hospital the prior to our inspection had been updated to reflect their revised care needs following their discharge. Relatives told us that they were kept informed of any changes to a person's health or well-being. One relative said, "They always ring me up to tell me changes in [relative]."

People told us that they were not always stimulated to maintain their hobbies and interests although the evidence we saw suggested that there were plenty of activities undertaken at the home. One person told us they did get very bored and that they were really hoping that the new activities coordinator could organise outings and more activities. The deputy manager told us that the planned activities for each unit differed to take account of what people on the units wished to do. When we looked at the weekly activity planner for two of the units however, we found that the proposed activities were the same. These included games, arts and crafts, a pub night and an 'all about me' session when people were encouraged to talk about themselves and their families. We spoke with one of the two activity co-ordinators. They explained that the co-ordinators led on activities held in the café area or the cinema room. Care workers provided activities on

the units in line with those planned although they had little time to do this. One person who was cared for in bed for a period for medical reasons told us, "I have been here for three weeks like this. I hate being isolated in my room like this." We did observe a care worker engaging with a group of people on one unit in a game of cards and another having a sing-a-long around a table. A relative told us that although their loved one could not participate in many of the activities they always went for the sing-a-long and participated in that. They had also been assisted to participate as much as they were able to in the celebrations the home had held recently for the Queen's birthday.

On both days of our inspection we noted that many people joined in the activities facilitated by the activities co-ordinators in the café area. On the second day we observed that over 20 people were taking part in board games, including scrabble and dominoes. Other people were sitting out in the garden or on the patio chatting. People appeared to be stimulated and engaged. The care records included information about people's hobbies and interests that enabled staff to encourage them in suitable activities. One record showed that the person liked to spend their day doing word searches and jigsaw puzzles. Another record showed that the person preferred to spend time alone in their room watching their choice of television programme. We saw evidence that a church service for all denominations was held on a monthly basis. These were advertised by signs within the lifts to remind people when the next service was to be held.

People were aware of the complaints system. One person told us, "There is a leaflet on how to make a complaint. It's accessible to everyone." Although none of the people we spoke with had made a complaint one person knew that a relative had complained on their behalf. They said, "They are better now than they used to be when you ring the bell. A lot better now my son has had a word." We saw other evidence that complaints were dealt with effectively. Following a complaint received from a relative about the care provided and initially dealt with by the deputy manager, the registered manager had met with the relative three days later and had agreed a plan to address the relative's concerns. This had included the production of a daily checklist for care workers to ensure that essential care needs, such as the check of their hearing aid batteries, toileting needs, dietary requirements and food monitoring were completed. We saw that this was in operation during our inspection. Another complaint had been actioned by making a referral to the local mental health assessment team.

The registered manager reviewed complaints received on a monthly basis to identify any learning from them. They told us that this would be shared with staff by way of supervisions and staff meetings.

Good

Is the service well-led?

Our findings

The manager had been registered with the Care Quality Commission in February 2016, having replaced the previous manager who had moved out of the area. They were supported by a newly appointed deputy manager and the managers of each of the five units of the home. People had confidence in the manager and deputy but had more contact with the manager of their unit. One person told us, "I can talk to her. I have not found any difficulties." However, another person said, "I know her to look at but she doesn't come up and speak to us. She comes down our corridor sometimes. We knew [name] the previous manager well." We saw that the registered manager's office was opposite the reception desk and people and relatives were able to enter and talk with the manager whenever they wished. One person was in and out of the office frequently throughout our inspection. When not in the office they were usually to be found sat outside the office door. It was clear that a good relationship had formed between the registered manager and this individual.

A member of staff told us that there was a good atmosphere at the home. They told us, "Staff are always smiling. We have a good team. Carers support each other and have good friendship bonds. They help each other out which boosts morale." They were able to tell us about the visions and values of the provider and said that these were in the staff handbook. They told us that they had been prompted to apply for employment with the provider as it was a "not for profit organisation and it is all about the residents not what is going in their pocket." They went on to say, "You wouldn't be in care for the money. It is not just a job."

The registered manager had introduced an incentive scheme in which people and staff nominated individuals as the 'employee of the month'. Nominations had to include the reason for the nomination and staff decided which of the nominees should be given the award, which was in the form of vouchers, during the monthly staff meetings.

The registered manager had introduced a series of customer engagement meetings on each of the units on a quarterly basis. People and their relatives were invited to discuss any matters about the unit or the home that they wished to be discussed. At a recent meeting relatives had requested that a support group meeting for relatives be set up. A relative told us that this had been done and the first meeting of the group had already been scheduled.

Staff were also able to contribute to the development of the service during the staff meetings. One member of staff told us, "We have a staff meeting once a month. We had the regional manager come to the last one when they discussed audits. We get to say how we think things can be improved. I said that I would like to see the [registered] manager out on the floor more and she has done it." Staff felt listened to in meetings. They said that they were able to make suggestions. Another member of staff said, "I suggested fundraising for a minibus and some activities towards this." The registered manager told us that fund raising activities had already raised a considerable sum toward a minibus and the local supermarket had made a significant contribution earlier in the week.

There was an effective quality assurance system in place. Quality audits completed by the registered

manager covered a range of areas and were submitted to the provider's regional manager. The audit completed in May 2016 had identified that improvements needed to be made to the meal experience for people. The registered manager had identified that people were not always provided with suitable hand hygiene before they ate their meals and that additional portions of food needed to be supplied to each unit so that people had a visual choice of meals. An action plan had been completed following this audit and actions had been signed off when completed. We saw that people were offered a visual choice of meals which showed that the action plan had been effective in that respect.

Unit managers also conducted monthly quality audits of their units which were reviewed by the registered manager. During these audits the unit managers reviewed care plans and completed meal time observations. The unit managers produced action plans to carry out improvements that were required and these plans were reviewed the following month. We saw that the actions identified by one unit manager in April 2016 had been completed by the May 2016 audit. The registered manager provided feedback to the individual unit managers on the quality of their audits. By reviewing the audits the registered manager was able to gain further oversight of the whole home.

In addition the registered manager carried out a daily walk through of the home during which they recorded their findings and identified any areas in which performance fell short of that expected. We noted that on one walk through the registered manager had identified that a memory box outside a person's room had not been filled and made arrangements for the key worker to assist the person to do this.

The provider also arranged for a member of their quality team to carry out an unannounced audit on a monthly basis and their health and safety manager carried out regular audits of the environment.

An audit of the service had recently been completed by a commissioner's contracts team which had resulted in a score of over 90% and an overall rating of 'Good'.

We saw that there were robust arrangements for the management and storage of data and documents. People's written records were stored securely and data was password protected and could be accessed only by authorised staff.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not protected against the risk associated with medicines because medicines were not always managed appropriately and had run out on a number of occasions.