Mr & Mrs B Peggs

Beechwood Gardens

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 1 and 4 February 2016 and was unannounced.

Beechwood Gardens is a care home which provides residential care for up to 20 people who live with dementia. During our inspection there were 17 people who lived at the home. Bedrooms were on the ground and first floor and there was a combined lounge and dining area on the ground floor which was split into two areas for people with differing stages of dementia.

The home had a registered manager in place. 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.

Most staff ensured they maintained people's privacy and dignity and treated people with compassion and respect. However, we observed two occasions where this was not the case.
Weekly menus were planned that met people's nutritional needs however people did not always have a choice of meals.

The service was not consistently responsive to people's needs. Although people's choices were respected and listened to, people who had difficulties communicating had limited stimulation and opportunities for their social care needs to be met.

Background information about people's interests and preferences was recorded but was not always included in people's daily care. This meant there were people who did not experience person centred care.

People we spoke with told us they liked living at the home and felt safe. There were sufficient numbers of staff to meet people's needs on the day of our visit. New staff went through recruitment checks to ensure their suitability prior to working with people in the home.

People received their medicines as prescribed and checks were undertaken to ensure they received them in a safe way.

Mental capacity assessments were completed when needed and specified the nature of the decision the person was being asked to make. This demonstrated that the provider was following the principles of the Mental Capacity Act (2005). When people had a DoLS authorisation in place for continuous monitoring, it was reviewed within the specified time frame to ensure that people were not being deprived of their liberty unlawfully.

Individual risk assessments were completed and reviewed regularly to help prevent avoidable harm to people who lived in the home.

People were supported to maintain relationships with people important to them.

There was a system to record complaints and people told us they felt able to approach the manager if they had any concerns.
We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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?

Good

This service was safe.

Staff were aware of how to identify risks to people and mostly knew what actions to take to reduce these risks. People who lived at the home told us that they felt safe. People's medication was administered and stored safely . Staff were available when people needed them.

Is the service effective?

Requires Improvement

This service was not always effective.

Staff received accredited training. Some people who lived at the home did not receive effective care and support because staff did not always have the skills and knowledge to meet their needs. People told us they enjoyed the food but they were not offered a choice. The home was working within the principles of the Mental Capacity Act. People had access to health professionals when this was required.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People and relatives were positive in their comments about the staff. Staff were mostly friendly and caring in their approach to people. We witnessed two occasions when staff did not uphold people's dignity. People and relatives were involved in decisions about care provided.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Some people's preferences were being supported to enable them to maintain their independence. However, information in care records was sometimes not sufficiently detailed to enable staff to support all people's preferences to maintain their health and wellbeing. Some social activities were provided but they did not always reflect people's interests and needs . People and

relatives were not always aware of how to make a formal complaint.

Is the service well-led?

Good

The service was well led.

Relatives and professionals spoke positively about the service and stated that the registered manager was approachable. The provider completed quality assurance procedures to assess and monitor the quality and safety of the service people received.

Beechwood Gardens

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 took place on 1 and 4 February 2016. The visit on 1 February was unannounced and the visit on 4 February was announced. The inspection was undertaken by one inspector and an Expert by Experience (ExE). An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

We spoke with four people who lived in the home, and seven relatives, to gain their views about the quality of care provided. We observed how people were cared for and interactions with staff. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at information received from statutory notifications the provider had sent to us and commissioners of the service. A statutory notification is information about important events which the provider is required to send to us by law. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority or the NHS.

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. The information provided in the PIR reflected what we found during our inspection.

We spoke with the provider, registered manager, deputy manager, four members of care staff and the cook. We reviewed seven people's care records to see how their support was planned and delivered.

We reviewed five staff files and training records for all staff. We reviewed records of the checks the staff and management team made to assure themselves people received a quality service.

Good

Is the service safe?

Our findings

A person who lived at the home told us, "I feel safe, I've never felt unsafe." Relatives told us that they had no concerns about the safety of people living in the home.

Staff had a good understanding of how to keep people safe and told us they had received training about how to keep people who lived in the home safe. Staff went on to tell us that from the training they felt confident in being able to recognise signs of abuse. One member of staff told us "If I had any concerns I would go straight to my manager."

The registered manager told us they understood and followed safeguarding procedures. In the 12 months prior to the inspection there had not been any safeguarding concerns but the registered manager informed us that if there was they would contact the local safeguarding authority and send an appropriate notification to the CQC.

Risk assessments were in place for people who lived in the home and were updated monthly to reflect a person's changing needs. A risk assessment is an assessment that identifies any risks to a person's health, safety, wellbeing and ability to manage daily tasks.

Staff were aware of people's individual risks associated with their care and support and were able to describe how these were managed. For example, one person was identified as having skin damage on their heel. A member of staff told us, "[Name] has to rest their foot on a stool to stop them making it worse by banging it on the floor." We saw the person used a footstool with a pillow to rest their foot on in the lounge area.

A template format was used in assessing environmental risks. However, , the actions identified for a person assessed as being at low risk were identical to the actions for a person identified as high risk. This showed that the actions were not specific to the individual and may result in safety measures not being effective. The actions included not having a call bell due to the risk of strangulation and instead an alert pad was placed beside the bed which would alert staff if a person left their bed. We discussed this with the registered manager who told us that they were confident that risks to people who lived in the home were managed safely.

We saw people were able to move around the home and that corridors and rooms were kept free of clutter to reduce the risks of falls. People who had been identified as requiring walking aids were seen using these when they walked.
The manager recorded any accidents and incidents on a spread sheet which allowed any trends to be analysed. The registered manager had not identified any themes or trends therefore further actions had not been required.
We checked whether medicines were managed safely. A person told us, "They give me my pills; I always seem to get them." We saw that medicines were stored safely and procedures ensured people received medicines as prescribed. Care files showed us that people's medicines were regularly reviewed by their GP

to ensure that it remained suitable for the person. Staff who administered medicines received training and had their competencies in this area regularly assessed by the registered manager.

Audits of medication charts were completed daily by senior care workers and any refusals of medication were highlighted. This was then audited monthly by the deputy manager to check that any medication returns to the pharmacy correlated with the daily records.

The provider had a protocol (medicine plan) for medicines prescribed 'as and when required', for example medicines prescribed to relieve pain or for people who sometimes had difficulty sleeping. However this was a standard document and was not individualised for each person. This meant instructions did not inform staff about signs people who could not communicate verbally may show to indicate they needed medication for pain relief.

One person was administered medicines which were crushed. Their GP had written to the home and agreed that some could be crushed because the person had difficulty in taking them. The information did not contain clear guidance about which ones could be crushed and how they could be given.
This was brought to the registered manager's attention before the end of our first day's visit. By the time we returned on the second day the GP had visited the home and had updated the details for this person's medication and provided staff with clear guidance. By including the additional information it ensured staff were able to give the person their medication in a safe way.

We asked people if there were enough staff on duty to meet their needs. A person who lived at the home told us, "There are always carers around when I need them," and a relative stated "I'm amazed at the number of staff. They are well staffed". Staff were available to support people's needs throughout the home during the day. A member of staff told us, "We stagger our breaks to make sure that there are always people available. We always have at least one person in the lounge to make sure people are safe." During our visit we saw a constant staff presence in the lounge area to assist people.

Another member of staff told us, "There are enough staff unless someone phones in sick. We don't use agency staff so the manager phones around people on their days off to cover shifts." The staff member continued to explain it was beneficial to the people who lived in the home to receive care from staff they knew rather than having a member of agency staff who was unknown to the person.

We saw that there were sufficient staff to keep people safe. We asked the manager how this was calculated and the registered manager told us this was based on numbers of people living in the home. A dependency tool was not used to calculate the number of staff required based on people's needs. The manager told us that the number of staff was based on the number of people who lived at the home, however we saw that there were enough staff on duty to meet people's needs.

A member of staff spoke about their recruitment process which included an interview, references from previous employers and a DBS (Disclosure and Barring Service) check. The DBS is a national agency that keeps records of criminal convictions. The checks were completed to ensure people who were employed were of good character. This was in line with the provider's recruitment policy.

The provider had made plans for the event of emergencies, for example in the event of a fire. Emergency evacuation plans provided details of what support people would need. These plans were kept in a folder near to a communal area which enabled staff to get to them quickly in the case of an emergency.

Staff completed checks to make sure people were safe in the home. Regular maintenance checks were

undertaken on equipment used in the home to ensure equipment was in good condition and safe to use with people who lived there. Additional environmental checks were regularly completed to maintain the safety of people; these included checking the temperature of the water to reduce the risk of scalds.

Requires Improvement

Is the service effective?

Our findings

People and relatives told us they thought staff had good skills to support people in the home. One relative told us "They [staff] have NVQ's, we hear them talking about them. As far as I know things are done quickly and properly." An NVQ is a nationally recognised qualification that assesses a staff member's competence and application of knowledge in regards to health and social care.

Staff told us that they had received some training to meet the health and social needs people who lived at the home. We saw staff put the training they received into practice, for example they used correct manual handling techniques when they assisted people to move from chairs to wheelchairs.

New staff employed by the service had an induction period, during which time they completed training and worked alongside (shadowed) other more experienced members of staff who worked in the home. This helped them to understand how to support people who lived at Beechwood Gardens.

Although the home had induction training which was in line with the Care Certificate this was not routinely used. The Care Certificate is the minimum standards that should be covered as part of an induction for new care workers. The registered manager told us that they used a range of different training which could reflect different learning styles. A person was undertaking the care certificate but had not yet completed it. There was not an expectation that all people were to complete all sections of the care certificate. The registered manager felt that the training provided was sufficient.

We looked at the training provided to staff to support people who lived with dementia. Staff told us they received basic training to understand how to support people who lived with dementia. This was provided by the registered manager. In addition some staff members had also received accredited training in dementia care. A member of staff told us, "It would be good if staff had better dementia training to help support people."

We saw that staff would benefit from further dementia training. This was because we saw people who lived with dementia were sometimes received information which caused them confusion. For example, a person was offered medication for pain relief but the person did not understand why they were being offered this and refused. This was followed by the person becoming agitated and was heard telling another member of staff "She said I was in pain." We discussed this with the registered manager who informed us that they had arranged further training for staff.

The cook told us they used to offer a choice of meals to people in the morning but by the time meals were served later in the day people had forgotten what they had ordered and would often want a meal that someone else had. They told us this would lead to people becoming upset and because of this choices were no longer offered. This demonstrated a lack of understanding on how to support people living with dementia. Good dementia care practice would suggest that people are offered a choice at the time with two plates or pictures of the meal.

Food was provided that met people's dietary needs. We saw information displayed in the kitchen about people's allergies, and medical conditions which required special diets and preferences.

Some people who had difficulties swallowing or were at high risk of choking had soft or pureed diets. The cook explained that people who required a soft food or pureed diet received the same meal as other people but that it would be blended to the appropriate consistency first. The cook also explained that people with specific dietary needs were not disadvantaged. The cook states that they would alter recipes to not include sugar or gluten for people with diabetes or coeliac disease.

A person who lived at the home told us, "We have a very good cook; the meals they turn out are very good." But went on to say, "You don't get a choice, you get what you're given." Other people and relatives that we spoke to agreed that the quality of the food was good however people were not offered a choice.

The cook told us they were aware of people's preferences and they had created a weekly menu around this. Photographic and written information was displayed next to the kitchen to inform people of what their next meal was going to be. This was not an effective way of displaying the information because we observed the majority of people stayed seated in the living area and did not walk towards the kitchen. We asked the cook what would happen if a person did not want the meal option.
They told us, "Alternatives are always available based on what people like." However people we spoke with were not aware that they could ask for an alternative and some people did not have the capacity to do so.

The provider was aware of current best practice and reviewed information form a range of sources including Stirling University with the aim of implementing this in the home. The provider explained that they used contrasting colours on doors and signs to help people to orientate themselves in the home. They told us that this was an example of where they had implemented best practice within the home.

The registered manager told us that they have made referrals to the Alzheimer's Society to support relatives of people who live in the home.
We saw that people were offered drinks throughout our visit. Fluid and nutrition charts were completed for all people who lived in the home however there was not a fluid total column which meant that it was not easily identifiable who needed to be encouraged to drink more to reduce the risk of dehydration .

People were weighed monthly to help identify if changes in their weight put them at risk. At the time of our visit nobody was considered at risk, but records demonstrated where people had previously been assessed as at risk because of weight loss, action had been taken. This included referrals to the person's GP and, or, a dietician.

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.

The registered manager told us that some of the people who lived at the home did not have capacity to make their own decisions. This meant they needed support to make decisions. Records demonstrated that people's capacity to make decisions had been assessed. Where people could not make their own decisions, records showed people such as family members and professionals who knew the person, had taken decisions in the person's best interest. This ensured that any decisions made would reflect the wishes of the individual if they had capacity to make the decision.

We checked whether the service was working within the principles of the MCA. Staff demonstrated a good understanding of the principles of the Act. A staff member told us the MCA "…is about people's capacity to consent to things, it's about trying to make the person aware of what's going on and not take their independence away from them. If they don't have capacity it's about ensuring anything we do is in their best interest and we speak to the family about what they would like." We saw staff asked people for their consent before moving them from chairs in the lounge to the toilets. However, people told us that they were not always asked for consent. One person stated "They never ask my consent for anything, in the morning they come and get me up, I can't stay in bed. I don't think they would want me to." This demonstrated that whilst staff had the knowledge to ask for consent this was not always put into practice. We fed this back to the registered manager at the end of our visit who told us that she would follow this up with staff.

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).

There were some people who lived at the home who had a DoLS in place. The DoLS authorisations were reviewed regularly and this ensured that people's freedom was not being deprived unnecessarily. This showed that the provider was following the correct procedures if a person's liberty was restricted.

People were supported to maintain their health and were referred to healthcare professionals, such as GPs, dieticians and district nurses, when needed. A relative told us that their family member saw health professionals when it was needed and they had recently seen an optician and chiropodist.

Health records showed that people had seen health professionals when required. We were told by staff that a district nurse visited the home three or four times a week and they were also able to request additional visits when necessary.

The registered manager and the provider told us that they were proud that the home offers "A home for life" for people who live there. They went on to explain that by this they meant that people who had deteriorating health needs were rarely transferred to a hospital or unknown environment which could cause confusion. The registered manager stated that they would liaise with health professionals who would visit the home to provide care and people would only be transferred to a hospital in the case of medical need, for example if they experienced a fracture.

Requires Improvement

Is the service caring?

Our findings

People who lived in the home told us staff were, "Very caring and respectful." We saw staff mostly spoke kindly and respectfully to people, and acted on their requests. For example, we saw one member of staff sat down next to a person and waited until they had their attention before they started to speak with them.

All visitors we spoke with agreed the culture at the home was welcoming and positive. One healthcare professional had left written feedback to the home which said, "Beechwood [Gardens] is a caring, well run home, it is clean and its residents are well looked after."

A member of staff told us "All the staff here are brilliant; we all get on amazingly with the residents. It's like having 20 Nans!" Another member of staff spoke about a person who lived at the home and who was receiving end of life care. The member of staff told us "I got on well with [Name], I stayed with them overnight, not to be paid but because I wanted to be with them." This showed that staff developed close relationships with the people they supported.

Staff demonstrated knowledge of people's life histories prior to them moving to the home and used this information when speaking with them. Staff told us that one person used to run a business in another country and they would often speak to them in this language. Another member of staff told us "[Name] used to be a dress maker, I like to talk to her about it and we look at dress designs together."

Staff told us that it was important to them to maintain people's privacy and dignity when they were supporting them. A relative told us ,"We are always asked to leave the room before staff change or clean [Name]" One member of staff said, "When I take [Name] to the toilet she is able to take her clothes down by herself. I ask if she wants me to stay with her otherwise I wait behind the toilet door to give her privacy." Another member of staff explained that, "If a person is being hoisted we put screens around them so other people can't see." A screen would protect a person's dignity if the straps of a hoist caused a person's clothing to move and expose the person. This showed that staff understood how to uphold people's privacy.

We observed that staff did not always use language which supported people's dignity at meal times. One member of staff said to the cook "We're ready when you are for them to have their feeds." Another member of staff was supporting a person with their meal and was heard to say to another member of staff "Are there any more feeds?" Referring to meals as feeds is not dignified. . We fed this back to the manager at the end of our inspection. The manager stated that she had previously spoken to staff to be mindful of the volume and what they say whilst working and that she would speak with them again.

At lunch time people who required a pureed meal had their meal pureed in one bowl. This is not a dignified way for people to receive their food and the multiple textures and flavours can be off-putting.

Staff told us that they respected people's confidentiality by not discussing people's care in front of other people and keeping their records secure. We saw that care records were kept in lockable cupboards which

were not accessible to members of the public or other people who lived in the home. However we saw one interaction between two members of staff which did not uphold a person's dignity. One member of staff called to another member of staff across a communal area where people who lived in the home were present, "Has she had cream put on her bottom?" The second member of staff clarified the name of the person they were talking about and replied that cream had been applied. This demonstrated a lack of consideration of the person's right to their personal information remaining confidential. We brought this to the attention of the registered manager who agreed that she would speak with the staff involved about appropriately sharing information.

Staff supported people to be as independent as they wanted to be, and provided assistance when required. A member of staff gave an example of how they supported one person's independence. They said, "[Name] can't tell me what she wants to wear but she can point to what she wants if I show her a choice of outfits." The deputy manager told us that another person who lived at the home liked to undertake housework tasks and so would make their own bed each morning with assistance from staff, and hang washing out in the garden which staff supported them to do.

Relatives told us they had been involved in decisions about people's care. One relative told us that before moving into the home, "We did a summary of their likes and dislikes. Their favourite biscuits are custard creams and they have them." Not all people living in the home had capacity to be involved in reviewing their care plans, and when this was the case we saw details of best interest decisions and capacity assessments. We asked staff how they would update records if people's needs change and a member of staff told us, "I tell the senior who will ask for the care plan to be updated."

We observed that there was little interaction from staff to people who lived in the home and what interactions were had were mainly task led rather than person centred. We observed one staff member cleaning a table after lunch whilst people who lived at the home were still sat there, the staff member worked around the people with no conversation or interactions.

Staff and relatives told us that people could visit at any time they wanted. Family members told us that they could visit their relatives in the communal areas or go to their bedrooms. This helped people to maintain relationships that were important to them in settings where they felt at ease.

Requires Improvement

Is the service responsive?

Our findings

Each person who lived at the home had an individual care plan which detailed their health needs, likes and dislikes and personal histories. This included information about people who were important to them. Staff told us that they would read the person's care plan if they had not previously supported them so that they understood their individual needs. We saw that life history work had been completed to varying degrees but this had not been used in to support people's day to day experiences. The registered manager explained that the amount of life history included was due to how much information an individual could provide. By including people's life histories in their daily activities it would enable people to complete meaningful activities which could promote memories and reminiscence.

Care plans for people who lived with dementia gave staff little information about how the person's dementia affected them or how to support them to live well with dementia. People's care plans objectives were not always personalised. In one person's care plan it stated "I use a Zimmer frame for short distances but I need a wheelchair for longer distances." Whilst in other's the objectives were standardised for example "To maintain hygiene and comfort and enable independence" but did not elaborate on how the person could maintain independence or to what degree.

People did not feel they had sufficient activities to meet their social needs, or support to undertake hobbies and interests. They told us "I just sit here all the time, I don't do anything." "We have people come in to entertain us sometimes. They have young chaps coming in and playing the guitar, nothing else. I don't do anything otherwise" and when asked about hobbies or interests another person stated "I don't have any. The carers don't talk to me really."

A relative told us "[Person] likes card games, I do it with [person] but the staff never do. I think there should be more staff resources for stimulation and one to ones." Another relative told us "They used to do jigsaws with [person] but it's more difficult now so they don't do anything." The relative explained that it was more difficult due to her relative's deteriorating health. Another relative stated "[Person] doesn't have any hobbies. I haven't seen carers talking to her." Staff told us "We have a daily routine and we don't always have time for individual interactions but when we have time we try to plan activities around people's interests."

During our inspection visit people were sat in the two joined lounge areas. The registered manager explained to us that people with more advanced dementia sat in one lounge and people with less advanced dementia sat in the other. The registered manager explained that a member of staff was always present in the lounge where people had more advanced dementia to offer additional support. During our visit we saw that there was always a member of staff in this area.

In the morning of the first day of our visit, music was playing in the lounge for people with less advanced dementia but in the lounge for people with more advanced dementia there was no activities or entertainment. We asked if any activities had been planned for this lounge and we were told that people were not able to participate in activities.

Some individual activities were provided for people in this lounge but they were not always supported by staff to have a beneficial impact. In the afternoon of the first day in the lounge for people with more advanced dementia two people who lived at the home were each given a simple jigsaw to play with but there was no interaction from staff to support them or encourage activity. On the second day of our visit we saw one person using a 'Twiddle Muff' which is a woollen mitten with buttons on it. This is designed to stimulate the person's senses and can offer comfort and activity to people with restless hands. The registered manager told us that they had purchased "canvas like painting outlines" for one person to use and which the person had enjoyed. They went on to explain that this was no longer used due to deteriorating health.

The registered manager told us that they had two regular activities a week which were armchair aerobics one afternoon a week and on a different day a person came in to play guitar and sing songs. We were told by staff that people enjoyed colouring in using adult colouring books and we were shown a copy which pictures were photocopied to be given to people. We were also told by staff that people had their hands massaged or nails painted but these activities did not take place during our visit. In the care plans we reviewed we could not determine whether people had an interest in these activities and we were unable to ascertain if these had been requested by people who lived in the home.

We found that people did not receive person centred care. People were not offered a choice of food and had limited choice of activities. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the beginning of each shift, staff met to 'handover' information about each person, so the new staff team would be aware of any issues or concerns from the previous shift. Records of these meetings were kept and we saw they included information about people's changing care needs. One person was identified as requiring cream applying to a sore area of skin throughout the day. Staff we spoke with were aware of this and medication records had been completed to show that the cream had been applied during the day.

People were supported to follow their chosen faith. A member of staff told us one person was Christian and was no longer able to visit their local church because of their health. A priest regularly visited them at the home. .

People were not always aware of the provider's complaints policy. A person told us if they had any concerns they would tell a member of staff. Relatives told us they would speak to the manager if they had any concerns but they were not aware of the complaints policy. We saw that there was a poster displayed by the entrance of the home with details of the complaints process and details of the complaints policy. People we spoke to were not aware that this was there and told us that they had not noticed it. We brought this to the manager's attention who told us they would consider changing the poster so that it was more noticeable. A copy of the complaints procedure was also kept in the care file for each person.

We reviewed the record of complaints held at the home and found that there had not been any complaints made within the 12 months prior to the inspection. The registered manager told us they had an "open door policy" which enabled anyone to raise concerns but they did not keep a record of these. The registered manager gave an example of a relative speaking to her about a lost cardigan and stated that staff were told and immediately looked for it. The registered manager told us that the cardigan had been found and returned to the person. The registered manager was unable to analyse any trends in concerns raised to them because records were not kept of each concern raised . Following the inspection the registered manager confirmed that from the information to date, no themes of concerns of complaints had arisen.

Residents and relatives meetings were not held at the home but relatives and professionals were invited to share their opinions using an annual customer satisfaction survey. Feedback from the survey was mainly positive, one relative wrote "I am very happy with everything about Mums care and involved in any decision making for her. I feel that her needs are met very adequately." Another relative wrote "We like the fact that staff have time to talk and interact with the residents." An area highlighted for improvement was in regards to stimulation and activities. One comment states "The one thing I feel there may be some scope for is that if there are times when staff are not occupied with residents physical needs they could perhaps engage proactively with those residents who are able to respond to mental stimulation e.g. games, conversations, encouragement, reading etc." The views of people living in the home were not sought.

Good

Is the service well-led?

Our findings

There was a registered manager in post at the time of our inspection who had been in position since December 2010. Relatives told us that "The manager and owners are always around" and "The manager is usually available, I rang once and she spoke to me."

A visitor told us that staff regularly contacted them and told them immediately if there was a change to their relative's health saying, "Mum was sick in the night, they called the doctor and then informed me."

The provider's policies and procedures were clear and comprehensive and were reviewed annually. However when we spoke with staff not all staff were aware of the provider's whistleblowing policy. The provider told us that all new staff were given a copy of this when they first started working at the home.

We saw that information in people's care plans varied in detail and that actions or objectives included in them were not always personalised. The deputy manager told us that care plan audits were not undertaken, however the information within them were checked on a regular basis during care plan reviews.

The provider told us that they did not complete any audits of the service because they were "here every day." They told us this enabled them to have a daily oversight of the running of the home and to identify any areas that required improvement. The provider explained that audits were completed by them, the registered manager and the deputy manager. This included checking bedrooms to ensure they remained suitable for people as well as checking that bedding remained of a good quality. The provider told us that staff were encouraged to make suggestions to improve the care provided in the home. They gave us an example of after receiving information from a relative that there was a lack of toilet roll in the bathrooms, all bathrooms were checked. During this, and subsequent, checks the provider did not find evidence that supported this concern; however the issue was followed up to ensure that improvements were not required. The provider told us about their plans to implement new auditing tools and that these are based on CQC's methodology. This demonstrated that the provider aimed to continually improve the quality of care people receive.

The registered manager told us Staff meetings were held regularly and in between these meetings information was shared with staff during 'hand over' meetings or in one to ones. Staff told us they understood their roles and were able to approach management if they needed guidance or support.

The registered manager told us that no changes have been made to the home following the feedback from the most recent annual customer satisfaction survey and the provider stated "We can only say we feel if there was anything that was justified we'd do something about it. We don't ignore them." The results of the survey were not displayed within the home. The registered manager and provider told us that although no changes had been needed to date they were open to feedback from relatives to improve the service.

The registered manager had a good understanding of their requirements to CQC and what she had to notify us of. In the previous 12 months the registered manager has sent notifications to CQC about deaths of

people who lived in the home and serious injuries.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People who lived in the home were not offered a choice of meals. People were offered a limited choice of activities.