Roseberry Care Centres GB Limited

Hylton View

Inspection report

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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?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

Hylton View is a purpose built care home which provides nursing and personal care for older people, some of whom may be living with dementia. It is registered to provide up to 40 places. All of the bedrooms are for single occupancy and are en-suite. At the time of this visit there were 37 people living at the home.

The last inspection of this home was carried out on 3 January 2014. The service met the regulations we inspected against at that time.

This inspection took place over two days. The first visit on 23 June 2015 was unannounced which meant the provider and staff did not know we were coming. Another visit was made on 29 June 2015.

The previous registered manager had left the service in April 2015. A new manager commenced work at the home in May 2015 but had not yet applied for registration. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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

During this inspection we found the provider had breached a regulation relating to the prevention and control of infection. This was because some areas of the premises could not be kept fully clean, especially in bathrooms and toilets, because they had surfaces that were not sealed. Several armchairs that people sat on only had foam pads which were not covered so could not be kept clean. This compromised the control of infection as well as the dignity of the people who lived there.

The provider had also breached a regulation relating to personalised care because people's individual care records were not always complete or up to date. This meant that it was not always possible to be clear if a person was appropriately cared for and supported in the right way.

The provider had also breached a regulation relating to quality assurance. This was because its quality assurance system had not been followed as there had been no visits to monitor the service since December 2014. Internal audits had not identified shortfalls, for example to care records and infection control, so they had not been effective in addressing areas that needed improvement.

You can see what action we told the provider to take at the back of the full version of the report.

The accommodation was not specifically adapted for people living with dementia, even though the home purported to provide a dementia care service. We have made a recommendation about this.

People said they felt safe and comfortable at the home. For example one person told us, "I'm safe as houses here." Staff knew how to recognise and report any suspicions of abuse. Staff told us they were confident that any concerns would be listened to and investigated to make sure people were protected. Potential risks to people's safety were assessed and managed. People's medicines were managed although plans about 'as and when' medicines could be more specific.

People told us there were enough staff to meet their care needs. Care professionals told us it was a better service when agency staff were not used as they did not know people's individual needs. People felt staff came "quickly" or "quite quickly" when they asked for assistance. The manager was going to look into how staff were deployed at mealtimes as several people needed support at those times. Staff were recruited in a safe way so that only suitable staff were employed.

The manager understood the Mental Capacity Act 2005 for people who lacked capacity to make a decision and deprivation of liberty safeguards to make sure they were not restricted unnecessarily. Staff were to receive additional training in this area so that they understood people rights to an independent lifestyle, unless it was in their best interests to be safeguarded. People told us staff always asked for their consent before carrying out care tasks. They told us they made their own choices over their own daily lifestyle.

The people we spoke with felt staff were competent in their roles and they supported them in the right way. Staff had training in health and safety as well as care. The manager was arranging further training to make sure staff were fully up to date with the latest standards in care.

People were supported to eat and drink enough to meet their nutrition and hydration needs, although records about this needed to be more meaningful. The menus were repetitive, and did not include many options for vegetables, salads or fruit but people told us they could ask the cooks for alternative meals if they did not fancy the two main dishes. Dietetic and speech and language professionals told us they had no concerns at this time with the way people were supported with their nutrition.

People and relatives made many positive comments about the "caring" attitude of staff. One person told us, "The staff are smashing." Another person commented, "Staff are lovely. When I'm feeling down they come in and help put a smile on my face."

Relatives said there was a good atmosphere in the home and staff were friendly. One relative commented, "You are always made to feel very welcome here and staff are very obliging." Staff were helpful and encouraging when assisting people.

People had opportunities to go out on local trips from time to time. There were also daily in-house activities and occasional entertainment. People had information about how to make a complaint or comment and these were acted upon.

Summary of findings

People and relatives said the new manager was approachable. They felt they were asked for their views and opinions and there were regular residents' meetings.

Staff told us they felt the manager was approachable and open to their views. There were regular staff meetings for staff to be kept informed of the standards of care and expected practices.

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. Some parts of the premises were in an unsatisfactory state so they could not be kept sufficiently clean to help in the prevention and control of infection.

People and relatives felt there were sufficient staff on duty, but the service was not personalised when agency staff were used.

People said they felt safe living at the home. Staff knew how to recognise and respond to abuse.

Requires improvement

Is the service effective?

The service was not always effective. The home had no special design to support people living with dementia to find their way around.

People said they enjoyed their meals but there was no joint work between care staff and cooks when people needed fortified meals.

Staff received training and supervision to support them in their roles.

Requires improvement

Is the service caring?

The service was caring. People and relatives said staff were friendly and welcoming.

People felt they were supported in a caring way and that they were treated with dignity.

The people we spoke with said that their choices were respected.

Good

Is the service responsive?

The service was not always responsive. Care records were not always completed, kept up to date or reviewed. This meant some people might not always get the right support when they needed it.

There were in-house activities, social events and some opportunities to go out into the local community.

People and their relatives said they would be comfortable about making a complaint if necessary, and they had information about how to do this.

Requires improvement

Is the service well-led?

The service was not fully well-led. The provider had not carried out regular monitoring of the service and had not made improvements when needed. The routine checks carried out by home staff did not always identify shortfalls.

People, relatives and staff felt the manager was approachable.

Requires improvement

Summary of findings

People were encouraged to make comments and suggestions about the running of the home.	

Hylton View

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 started on 23 June 2015 and was unannounced. The inspection team consisted of two adult social care inspectors, a specialist adviser 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. A second visit was carried out on 29 June 2015 by one adult social care inspector which was announced.

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. Before our inspection, we reviewed the information included in the PIR along with other information about any incidents we held about the home. We contacted the commissioners of the relevant local authorities before the inspection visit to gain their views of the service provided at this home. We contacted the local Healthwatch groups to obtain their views. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During the inspection we spoke with 10 people living at the home and three relatives and friends. We also spoke with the manager, deputy manager, two nurses, six care workers, an activity staff member and two members of catering staff. We observed care and support in the communal areas and looked around the premises. We viewed a range of records about people's care and how the home was managed. These included the care records of eight people, the recruitment records of four staff members, training records and quality monitoring reports.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We also joined people for a lunchtime meal in both units to help us understand how well people were cared for.

Requires improvement

Is the service safe?

Our findings

People who lived in the home were not always safe because there were a number of cleanliness shortfalls that compromised the control of infection within the home. In the first floor lounge the material covers had been removed from the seats of several armchairs. The manager stated these had probably been taken off to be cleaned. However the foam padding was left on these chairs for the full day without covers. These chairs continued to be used throughout the day by different people, some of whom had continence needs. This meant people were sitting on unprotected foam pads that could not be guaranteed to be hygienic. One chair had a foam pad that was partially covered by a black bin liner, which was inappropriate. This practice compromised infection control and the dignity of people who lived there.

In shared toilets there was no sealant around toilets; gaps between boxing and the walls; and in one bathroom there was exposed flooring that was porous. These issues meant toilets could not be kept hygienically clean. In one shared toilet there was a child's plastic bucket instead of a pedal operated bin for waste. Some practices did not support the control of infection. For example, we found unused, uncovered continence pads and boxes of protective gloves on the top of cisterns in shared toilets. This meant the sterility of these items could be compromised. In one bathroom there were unnamed toiletries including a razor. In a linen store cupboard there were clean duvets lying on the floor.

Some parts of the home had an underlying unpleasant odour, for instance the sluice room on the first floor smelt strongly of urine and had poor ventilation. In the domestic store room on the ground floor we noted a mop left in a bucket of dirty water. The domestic store did not contain a wash hand basin for staff to wash their hands. As a minimum hand hygiene facilities should include a hand wash basin, supplied with hot and cold water, (preferably via a mixer tap), liquid soap and disposable paper towels.

There was no designated infection control lead for the home at this time. The maintenance member of staff was described as the infection control 'champion' and he had carried out some infection control audits. However those audits had not identified the shortfalls we found during this visit, so were not effective. These matters meant the provider had not made sure the premises were kept clean and hygienic for the people who lived there. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

All the people we spoke with said they felt safe living at Hylton View. For example one person told us, "I'm safe as houses here." Another person said, "I like it here, everything is to hand. I've got nothing to worry about, it's all good." Both the relatives we spoke with also commented that their family member was safe at this home. One relative told us, "It's safe here, and my [family member] is very safe and secure."

Staff confirmed that they received training in safeguarding adults. Some new members of staff were not recorded as having received this, including some nurses who were responsible for leading shifts at the home. However the new manager was a trained trainer in safeguarding so all staff members would be able to have access to this training at any time. The safeguarding and whistleblowing policies were in the hallway for staff and visitors to access at any time.

The staff members we spoke with knew what to do and how to report any safeguarding concerns if they thought someone was at risk of harm. For example one staff member said they had previously reported another member of staff for shouting at someone. They told us, "I would not hesitate to do it again. I keep thinking 'what if my own mam was in a care home', I would want the best for her." Another staff member said, "I would report anything immediately. I have no problem with this; I want to protect people no matter what."

Earlier this year there had been a number of safeguarding and whistleblowing concerns raised about the service at Hylton View. The provider and the local authority carried out a joint investigation and action was taken to make sure that the matters were addressed. One of the outcomes was that all staff were offered a confidential survey by the provider to express any concerns in confidence, and this also reminded staff of their responsibility to raise any issues. The commissioning and safeguarding officers from the local authority told us they had no current concerns about the service at Hylton View.

Risks to people's safety and health were assessed and recorded in each person's care files. There were risk assessments about people's care needs, for example the

Is the service safe?

potential for falls, pressure damage to their skin and using moving and assisting equipment. For instance, people assessed as being at risk of possible skin damage had pressure relieving mattresses on their beds and used pressure relieving cushions on their chairs. Others at risk of falling had floor mats next to their beds with integrated sensory devices linked to the nurse call system to alert staff if the person got out of bed and required assistance. We saw that staff used lifting equipment appropriately and confidently when needed. The risk assessments were supposed to be reviewed each month, but we found several instances where people's individual risk assessments had not been reviewed for two months.

The provider had a computer-based reporting system in place to analyse incident and accident reports in the home. The manager completed the analysis on a monthly basis and forwarded this to the provider. This was to make sure any risks or trends, such as falls, were identified and managed. There were records of 'personal emergency evacuation plans' (PEEPS) in place which included information on each person's mobility and immediate needs as well as any specialist equipment that might be needed to support an evacuation.

The provider had a system to check that the premises and equipment were safe. A maintenance person was employed full time. A daily list of tasks were recorded in the maintenance book by other staff members. These included the replacing of light bulbs, repairing door locks or items of furniture. Records showed regular health and safety checks were undertaken and were up to date. This included checks on electrical safety and electrical appliances, water temperatures, lighting, ventilation and windows and call bell and alarms systems.

The people and relatives we spoke with felt there were enough staff on duty most of the time to support people in a timely way. One person told us, "The buzzer [call bell] is answered quickly." Other people confirmed that call bells were responded to "quickly" or "quite quickly". During this visit there was a timely response to call bells, although there were very few occasions when they rang. The nurses we spoke with also felt there were enough staff on duty "on the whole" to meet people's needs.

At the time of this inspection there were one nurse and three care workers to support the 18 people accommodated on the first floor nursing unit. There was one senior and two care workers on the ground floor to support the 17 people living on the residential unit. Night time staffing was one nurse and three care workers (that is, two staff on each floor).

We discussed how staffing levels were calculated with the new manager. He stated that the organisation had a staffing tool that determined staffing levels but that this was a complicated equation. We asked how staffing for Hylton View had been decided. The manager stated this was based on the number of people who required two staff to support them, for example with mobility and personal care. The manager also stated that the ratio of care staff on duty would rise when occupancy reached 38 people (which it did by the second visit and an additional care staff was rostered).

There was a visible staff presence on both floors at most times of the day. The staff were not always deployed in an efficient way at mealtimes. For example we noted that staff were not always able to support people in the dining room because they were also trying to assist some people who were confined to bed with their meals. The manager agreed to review the timing of the meal service to dining rooms and individual people in bedrooms so that staff could be better deployed.

The new manager was able to describe the on-call and contingency arrangements. He confirmed that agency nursing staff had not been used for some weeks but that agency care staff were being used for night shifts. Staff told us that they tried to ensure the same agency staff members were used so that there was some degree of familiarity and continuity of care for people.

Some people felt there was a "divide" between the level of service people received depending on which floor they were accommodated. Some people and care professionals felt this was due to times when there had been a lack of experienced staff on the first floor. A care manager told us, "There appears to have been a heavy reliance upon bank nursing staff in the past." A speech and language therapist told us, "It is more difficult to work as effectively with bank or agency staff who may be unfamiliar with the resident's needs."

We looked at the recruitment records of four staff members. We found that recruitment practices were satisfactory and included applications, interviews and references from previous employers. The provider also

Requires improvement

Is the service safe?

checked with the disclosure and barring service (DBS) whether applicants had a criminal record or were barred from working with vulnerable people. This meant people were protected because the home had checks in place to make sure that staff were suitable to work with vulnerable people.

Five people were able to tell us that they got the right support with their medicines and at the right time. They said that staff stayed with them whilst they took their medicines. Some of the people living in the home took responsibility for their own medicines such as creams or ointments.

We looked at the medicines administration records (MARs) for six people using the service. We saw photographs were attached to people's medicines administration records (MAR) so staff were able to identify the person before they administered their medicines. Daily checks were in place to ensure that all MARs were coded to explain the reason why some medicines had not been administered. The checks had identified where there had been some issues regarding missing staff signatures documented on the MAR sheets, so these could be addressed.

Some people required 'as and when' medicines, for example for pain or for agitation. There were 'as and when' plans for staff to follow on these occasions. However the plans did not always identify at what point the medicines should be given or, if it was a variable dose, how many tablets a person should have. For example one person was prescribed either 0.5mg or 1mg of a medicine to help with agitation but their plan did not state what the trigger was for staff to administer the higher dose.

The storage of medicines was appropriate and checks were kept of the ambient temperature. Staff who were responsible for administering medicines had had training in this and a recent competency check. The manager had completed a competency assessor's course so he would be carrying out competency checks in the future.

Requires improvement

Is the service effective?

Our findings

The people we spoke with felt staff had the training "to do the job". One person said, "I am very happy with the care I get. Another person told us, "I am perfectly happy here. Staff are happy to help." A relative commented, "I come in every day and as far as I can see the staff are good, and I am very, very pleased with everything."

The staff members we spoke with confirmed that they received training in mandatory subjects such as moving and assisting, fire safety and health and safety. The staff training matrix record indicated that there were some gaps in training for example 11 staff had not had training in infection control and nine had not had training in the Mental Capacity Act 2005 (these included four new staff). The administrator explained that the training matrix record was not fully up to date so some training may not yet have been recorded. The new manager was a trained trainer in several subjects, including health and safety and dementia awareness, and had plans to make sure all training was up to date. New staff members described their induction training and stated there were plans for them to complete mandatory training within their probationary period.

We looked at how the provider supported the development of staff through supervisions. Supervisions are regular meetings between a staff member and their supervisor, to discuss how their work is progressing and where both parties can raise any issues to do with their role or about the people they provide care for. The staff members we spoke with said they received regular supervision from a senior member of staff and annual appraisals from the manager. A senior care staff member said, "We are well supported." Another told us, "I have regular supervision and there are always the seniors to go to if I'm unsure of anything, or I ask for support from colleagues."

Some people felt there was a "divide" between the level of service people received depending on which floor they were accommodated. Some people and care professionals felt this was due to times when there had been a lack of experienced staff on the first floor. A care manager told us, "There appears to have been a heavy reliance upon bank nursing staff in the past." A speech and language therapist told us, "It is more difficult to work as effectively with bank or agency staff who may be unfamiliar with the resident's needs."

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards (DoLS) and to report on what we find. MCA is a law that protects and supports people who do not have the ability to make their own decisions and to ensure decisions are made in their 'best interests'. The manager was aware of DoLS to make sure people were not restricted unnecessarily, unless it was in their best interests. There were 11 people with authorised DoLS and applications were being completed for more people who needed supervision and support at all times. This meant staff were working collaboratively with the local authority to ensure people's best interests were protected without compromising their rights.

We asked people if their consent was sought prior to any support being provided. The people we spoke with confirmed that staff seek their permission before carrying out any treatment or support.

During this visit we heard staff ask people before assisting them. The people we spoke with were aware of their care plan although only two people said that they had been involved in it. Both relatives said that they had been involved in the care plan for their family member.

People and relatives said they were satisfied with the quality of the catering. One person commented, "The food's not bad. If you don't fancy what's on offer you can ask for something else." One relative told us, "People are well fed here." Another relative said, "I've stopped bringing her cakes because she eats so well here that she's putting on weight."

The four weekly menu had recently changed for the summer. However we saw many meals were accompanied by chips and there were few opportunities for other vegetables or salad. At a recent residents' meeting people had requested more salads and fresh fruit but we did not see any examples of these on the menu. Catering staff said they would make people alternatives if they did not choose to eat their main meal and were familiar with people's individual preferences. For example, on the day of this inspection one person had chosen not to have either of the main choices at lunchtime so catering staff offered to make them toast and marmalade because that was a particular favourite of that person.

Catering staff were aware of people's individual dietary requirements, for example if people were diabetic or

Is the service effective?

required soft foods due to poor swallowing. However in some people's care plans we saw they required a 'fortified' or 'high calorie' diet but catering staff were unaware of this and said that care staff dealt with fortifying meals. This meant there was a lack of collaboration between care staff and catering staff about people's food intake, as catering staff were not involved in fortifying foods for people who were at risk of losing weight.

A small number of people had recently lost weight but most were still within the accepted ranges for their height. Staff recorded people's weight, although sometimes not at the intervals required by their care plan. For example, one person's care plan stated they should be weighed on a weekly basis to check their nutritional well-being, however there were gaps of six weeks in these records.

A speech and language therapist who had visited the home on several occasions over the past year felt the service had made appropriate referrals for support when people had dysphasia (problems with swallowing). They felt that the care and catering staff who had attended training in dysphagia now had a better understanding of how to prepare foods to the right consistency to support people's well-being. A dietitian told us they had no current concerns about people in this home.

We saw care staff recorded quantities of food and fluid intake for people who required support with their diet and hydration. However the quantities of fluids were routinely recorded as full amounts, for example a cup of tea was always recorded as 200 millilitres even though the person may not have drunk the full cup. Also the total amounts each day were not calculated, so there was no indication if people were meeting a fluid target. The fluid records were not reviewed by nurses to check whether people's intake required any intervention. The manager stated he would make sure that fluid records included a target amount, would be calculated each day and be overseen by nurses in case any further actions were required to support people with their hydration.

Relatives felt people were supported with their health care needs. They told us that they had been contacted by Hylton View staff when there when their relative was ill. They also confirmed that they had been involved in the care planning for their relative. People's care records showed when other health professionals visited people, such as their GP, dentist, optician, podiatrist and dietitian. A speech and language therapist told us, "Hylton View has worked with [us] to put in place some new initiatives. Staff have an increased awareness and often refer appropriately and quickly when needed."

Although several people needed support with their mobility, at the time of this visit there was only one assisted bathroom in working order (on the first floor) and one working shower (on the ground floor). This meant people on either floor had no choice about whether to have a bath or a shower. The lift that served the two floors was at the front entrance (outside the main body of the home) so it would be difficult to preserve people's dignity if they were using the bathing facility upstairs then coming back down (and vice versa). The manager explained that the shower room on the first floor was waiting to be turned into a wet room.

The provider's 'statement of purpose' stated that Hylton View provided care for people with a range of needs including a primary need of living with dementia. However there were no specific design features in the home to support people who were living with dementia. The decoration did not help people to find their way around independently. There were no different colour schemes or signs in different corridors for people to recognise. There were no pictures to identify different rooms such as dining rooms, lounges, bathrooms and toilets. Bedroom doors did not have any items of personal significance (such as pictures or mementos) to help people to find their own rooms. There were no objects of tactile and visual interest for the people who lived there. It was unclear how people on the first floor could access the secure garden area (accessible from the ground floor conservatory). The provider had commissioned a 'dementia design' audit in 2014 which scored the home less than 50% for its arrangements to support people living with dementia. However no further work to address this had been carried out.

One member of care staff had been selected to be a 'dementia champion'. (A dementia champion is someone who encourages others to make a positive difference for people living with dementia.) However staff had no clear knowledge of an overall 'vision' for dementia care in the home.

We recommend that the service explores the relevant guidance on how to make environments used by people living with dementia more 'dementia friendly'.

Good

Is the service caring?

Our findings

People and relatives made many positive comments about the "caring" attitude of staff. One person told us, "The staff are lovely." Another person commented, "The staff are a smashing bunch - all of them". People expressed the view that staff were caring, helpful, supportive and empowering.

Relatives commented that there was a good atmosphere in the home and staff were friendly. One relative commented, "I'm made to feel welcome." Another relative told us, "You are always made to feel very welcome here and staff are very obliging."

The atmosphere within the home was welcoming and friendly. During this visit staff and people interacted well. The people we spoke with said staff chat when they can and regularly check to see if they are alright. One person commented, "Staff are lovely. When I'm feeling down they come in and help put a smile on my face."

Staff were helpful and encouraging when assisting people. We noted one isolated instance where a care worker was patient when supporting someone into a lounge to sit down, but did not talk with them or another person who was sitting there.

One health care professional told us, "During my visits, I have seen variable levels of compassion and caring. With care staff who know the residents well, I have seen good rapport with residents and good examples of kindness, compassion, dignity and respect." However they said that with bank or agency staff there was "a lack of compassion and understanding of [people's] needs".

The people and relatives we spoke with said staff treated them with respect and dignity. They also said that staff listened to them and would pass the time of day with them.

People told us that staff knocked on the bedroom doors and awaited a response from them before entering their rooms. One person told us, "All the staff are good, but some are more patient."

During this inspection staff were seen to treat people with dignity and respect. We observed how staff spent time chatting with people and were quick to support people if they appeared distressed or anxious. Staff also responded in a timely way to people's requests. For example two people in the lounge asked a staff member for a mug of coffee, a cup of tea and a biscuit, which they received immediately. One person said "I love this milky coffee, it's so nice." The staff member said, "[The person] loves her coffee that way. It's about giving people what they have been used to and having a caring approach."

We joined people for a lunchtime meal in both the dining rooms. We saw staff adopted a sensitive approach and gave people the time they needed to eat their food. There was a choice of meal, choice of juices or hot drinks and a choice of pudding. Two people did not like either of the pudding choices and they were offered a range of alternatives.

The people we spoke with said that their choices were respected. For example whether they chose to spend time in their bedroom, and where they preferred to have their meals. Relatives told us they were made to feel if was the people's own home. One relative said 'They always offer me a cup of tea and I've even had lunch here'. Another relative told us, "I always get offered a cup of tea; I've brought in my own mug."

Staff confirmed there was a positive atmosphere in the home. One staff member described the atmosphere as "really good - nice and relaxed". A relative commented, "The staff seem happy here, and my family member likes it."

Requires improvement

Is the service responsive?

Our findings

We looked at the care records of eight people to see if these set out their individual needs and how they required assistance in a personalised way. The care plans did not always fully reflect the specific needs and support that people required, which meant that people's needs may be missed or overlooked. For example, one person's care plan stated that staff should monitor the person's behaviour and body language to check for pain, but the plan did not describe what their behaviour would be like if they were in pain. The last pain record for this person was recorded in February 2015.

Some people's needs were set out in a care plan but were not reviewed or acted upon. For example, one person had a care plan about managing pain which said the person would rather experience pain than take medication. A pain scale record was to be recorded monthly or more frequently, but we saw only one completed pain record in the past few months. The last review of this care plan was in April 2015.

For several other people we saw that monthly reviews of the care plans had not taken place between March and June 2015. Where monthly evaluations were recorded these were repetitive and uninformative about how people's needs were progressing. These included, for example, "needs are unchanged at the time of the evaluation" or "care plan remains unchanged this month". This meant it was not possible to confirm from people's records whether their care plan was working to ensure they achieved their identified goals.

Handover notes were brief and the information was about the basic care delivered, rather than people's well-being. Records that would be used if people needed to transfer to hospital were incomplete, so if people needed to go to hospital in an emergency the details of their needs would not be available to hospital staff.

There was not enough detail in the care records we saw to make sure that people received personalised care that was tailored to their specific needs. The lack of guidance about how staff should support people could lead to inconsistent practice. This meant it was not always possible to be clear if a person was appropriately cared for and supported because care records were not always accurate and complete. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager was aware of some of the shortfalls regarding care records, and had begun audits of care files for key worker staff who were responsible for their upkeep. The manager explained that a new system of care recording was to be implemented but acknowledged that in their current incomplete state the existing care records needed to be brought up to date before the transfer of any information to a new system.

The home employed a member of staff to arrange and co-ordinate activities. At the time of this inspection the activities co-ordinator was on sick leave so a temporary activity staff member was covering. People described various activities, entertainers and trips that they had enjoyed.

The home shared a minibus with other homes operated by the provider. At the start of this unannounced inspection a small number of people were on their way out on a trip to visit a local museum and to have a picnic on the beach. They were supported by an activity staff member and the maintenance staff member who was driver for the minibus. The staff told us weekly trips were arranged to local places of interest. Staff were also planning to arrange a holiday for a small number of people to Blackpool.

Lounges had a TV, music players, a range of DVDs, magazines and board games. During this visit some people spent time in the lounge areas taking part in some activities, such as playing dominoes, listening to music, watching TV or reading the paper. There was a noticeboard on the first floor with a diary of the activities each day. Staff member told us the activities tended to be group events such as games or singing and dancing sessions, but that there were some individual activities such as manicures.

The relatives we spoke with confirmed that they were aware of residents' meetings where people and relatives could make any suggestions about activities or trips out. They told us about regular newsletters which gave details of forthcoming activities at the home.

The people we spoke with said that they would have no concerns about talking to a care worker or the manager if they had a complaint or a concern. Most people said they just tell a member of staff if something was bothering them

Requires improvement

Is the service responsive?

and it was generally quickly sorted out. One person who lived at the home and one relative said that they had raised minor concerns with the former manager which were resolved quickly. Staff told us they would always try to support someone if they had a complaint and would let the manager know.

People had written information about how to make a complaint in their 'service user guide', which is an information pack given to people on admission to the home. The information was clear and included the telephone and contact details of the provider, local authority and other relevant agencies. (This needed some minor amendment to be brought up to date.) There was also a noticeboard in the reception area which displayed the complaints procedure and whistleblowing policy, and the staffing structure including photographs of each staff member.

The manager kept a log of any complaints and these were analysed for any emerging trends. There had been five recorded complaints in the past year, including a concern about the lift and some missing items from a bedroom. These had been looked into and resolved to the satisfaction of the complainant.

Requires improvement

Is the service well-led?

Our findings

The manager and staff carried out a number of internal audits. These included checks of infection control, catering, care records and health and safety. In some areas we found the audits did not reflect the actual situation at the home. For example the infection control audits had not identified the shortfalls in relation to the premises and practices that we found during this inspection.

The provider had a quality audit system that should include regular visits to the home by a senior manager to check the quality and safety of the service. However there was no recorded evidence of any quality monitoring visits by the provider in the past six months. Records of the last two quality monitoring visits (in October and December 2014) showed that senior managers had identified shortfalls in care records and actions had been set. However there had been no further checks to review whether any improvements had been made. We also found several shortfalls in relation to care records and in infection prevention and control. This meant the quality assurance system at this home had not been effective in making sure that improvements were made to address identified shortfalls. This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The previous registered manager for this home had left in April 2015. A new manager had been in post for eight weeks who was not yet registered, but stated his intention to apply for registration.

There had been several changes to senior managers within the organisation during the same period. The people and relatives we spoke with confirmed that they knew who the manager was and that he "seemed very nice". One person commented, 'He (the manager) walks around the corridors and he will say morning if you speak first." The people and relatives we spoke with felt the service was "well run".

Residents' meetings had been held on a monthly basis and offered people an opportunity to make suggestions and comments about the running of the service. For example at a recent residents' meeting people had asked for tables and chairs in the back garden so they could enjoy a cup of tea outside in better weather. These had been provided. The minutes of the most recent residents' meeting were displayed in the noticeboard.

The staff we spoke with felt the service was good at caring for people and including families in discussions about their care. For example, one staff member told us, "We're good at involving relatives and take their views on board." Staff we spoke with felt the areas for improvement included the premises, particularly bathrooms and shower rooms, and "paperwork".

There were opportunities for staff to give their views about the care delivered at the home. Staff told us regular staff meetings were held and we saw the minutes of the various meetings were displayed on the noticeboard in the reception area. Staff said they felt able to raise any views or concerns they had. One staff member said staff meetings were an opportunity to have an "open discussion". Another staff member said staff meetings were "laid back - I can ask anything". All the staff we spoke with felt able to give their comments and views at staff meetings. Staff said they were encouraged to be "open and honest".

Staff acknowledged that there had been a several challenges recently including vacant nursing posts and changes of management but felt they had pulled together as team. One staff commented, "It's been hard the past few months, but we just want the best for people." A senior staff member said, "The new manager and deputy have been very supportive. They take on board what staff and family members say to them, it's a positive team."

Staff confirmed there was a positive atmosphere in the home. One staff member described the atmosphere as "really good, nice and relaxed". Another staff member said, "I haven't got a bad word to say about the place." One staff member told us, "Ron [a senior manager] is always popping in and has a chat with residents and staff. He knows us by name and it makes me feel valued."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People were not protected against the risks associated with unsafe infection control and prevention practices.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People were not protected from the risks of unsafe or inappropriate care and treatment because a plan of care had not always been designed or kept up to date to ensure their needs were met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider's quality monitoring system was not effective in assessing or addressing required improvements to the quality and safety of the service.