Defiant Enterprises Limited

The Laurels Care Home

Inspection report

The Laurels
West Carr Road
Attleborough
Norfolk
NR17 1AA

Tel: 01953455427

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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

Summary of findings

Overall summary

The Laurels Care provides accommodation and personal care for up to 52 older people, some whom live with dementia. There are external and internal communal areas for people and their visitors to use.

We carried out an unannounced, comprehensive inspection of this service on 1 December 2014. As a result of our findings we found a breach of two legal requirements. We asked the provider to make improvements to ensure people received sufficient food and drink and that suitable arrangement were in place for obtaining lawful consent in accordance with the Mental Capacity Act 2005 (MCA). The provider's representative wrote to us detailing how and when improvements would be made.

This unannounced inspection took place on 23 May 2016. There were 41 people receiving care at that time.

We found that sufficient improvements had been made to ensure people received enough to eat and drink. We also found that some improvements had been made towards compliance with the MCA.

The service 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.

Staff were only employed after the provider had carried out comprehensive and satisfactory pre-employment checks. Staff were trained, and supported, by the registered manager. There were sufficient staff to safely meeting people's needs. However, staffing levels limited the choices people were able to make and how individualised their care was.

Good infection control procedures were not always followed and people were not always cared for in a hygienic and fresh smelling environment. There were systems in place to ensure people's safety was managed effectively. Staff were aware of the procedures for reporting concerns and of how to protect people from harm.

People received their prescribed medicines appropriately and medicines were stored safely. People's healthcare and nutritional needs were effectively met. People were provided with a balanced diet and staff were aware of people's dietary needs.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and report on what we find. We found that there were formal systems in place to assess people's capacity for decision making. The registered manager had prioritised the applications that needed to be made to the authorising agencies for people who needed these safeguards and had an action plan in place for achieving this. Staff respected people choices and decisions. Staff had received training in the MCA and DoLS, but this knowledge needed embedding.

People received care and support from staff who were kind, caring and compassionate to the people they were caring for. People had opportunities to comment on the service provided and people were involved in every day decisions about their care.

People's care records were brief and did not provide staff with sufficient guidance to ensure consistent care to each person. Care was often task orientated. There were opportunities for people to participate in activities. However, these were limited, particularly for people who required one to one staff support.

The registered manager was supported by a staff team that included a deputy manager, team leaders, care workers, and ancillary staff. The registered manager was approachable. People and relatives were encouraged to provide feedback on the service in various ways both formally and informally. People's views were listened to and acted on. Concerns were investigated and improvements made. However, the quality assurance system had not identified all areas where improvements were needed

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.

Good infection control procedures were not always followed and people were not always care for in a hygienic and fresh smelling environment.

There were systems in place to ensure people's safety was managed effectively. Staff were aware of the actions to take to report their concerns.

Staff were only employed after satisfactory pre-employment checks had been obtained. There were sufficient staff to safely meeting people's needs. However, staffing levels limited the choices people were able to make and how individualised their care was.

People were supported to manage their prescribed medicines safely.

Is the service effective?

Requires Improvement

The service was not always effective.

The design, layout and decoration of the service did not aid people's ability to orientate themselves.

People's rights to make decisions about their care were respected. Where people did not have the mental capacity to make decisions, they had been supported in the decision making process.

People's health and nutritional needs were met and monitored. People were provided with a balanced diet and staff were aware of people's dietary needs.

People received care from staff who were trained and well supported.

Is the service caring?

Good

The service was caring.

People received care and support from staff who were kind, caring and compassionate.

People were involved in the planning and delivery of their care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care was often task orientated. There were opportunities for people to participate in activities. However, these were limited, particularly for people who required one to one staff support.

People's care records were brief and did not provide staff with sufficient guidance to ensure consistent care to each person.

People were confident their concerns would be acted on and complaints were investigated.

Is the service well-led?

Requires Improvement

The service was not always well led.

The service had an effective quality assurance system and some improvements had been made. However, the quality assurance system had not identified all areas where improvements were needed.

The registered manager was approachable and people were encouraged to provide feedback on the service in various ways. People's comments were listened to and acted on.

The Laurels Care Home

Detailed findings

Background to this inspection

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

This unannounced inspection took place on 23 May 2016. It was undertaken by two inspectors 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 looked at all the information we held about the service including notifications. A notification is information about events that the registered persons are required, by law, to tell us about.

We asked for feedback from the commissioners of people's care and Healthwatch.

During our inspection we spoke with eight people and six relatives and friends of people using the service. We also spoke with one visiting healthcare professional, the two directors for the provider, one of whom was the provider's representative, the registered manager, the deputy manager, four care workers, a cook, a domestic and a maintenance person. Throughout the inspection we observed how the staff interacted with people who lived in the service. We looked at four people's care records, staff training records and other records relating to the management of the service. These included audits, staff rotas and meeting minutes.

Following our inspection four other healthcare professionals provided us with feedback about the service provided. The registered manager also sent us additional information about staff training and staff meetings.

Requires Improvement

Is the service safe?

Our findings

People receiving the service said they felt safe. One person told us, "I do feel safe here, they [staff] do everything you ask them to do." A relative said, "I've seen it [the service] over [several] years, and I've never seen any [staff] being nasty."

Staff told us they had received training to safeguard people from harm or poor care. They showed they had understood and had knowledge of how to recognise, report and escalate any concerns to protect people from harm. Staff told us, and the provider's recent staff survey showed, they were confident the registered manager would address any concerns they raised. One staff member said that if they had concerns, "I'd tell the [registered] manager], she'd be there like a bullet. [I could escalate the concern] to the owners." Another staff member said they would make sure the person was safe and, "Report to a senior or the [registered] manager." They went on to say they knew they could report concerns directly to the local authority safeguarding team. They said, "I know I can phone safeguarding myself."

Environmental risk assessments, fire safety records and routine safety checks of the building were in place to support people's safety. People's risks were assessed and measures were in place to minimise the risk of harm occurring. People had individual risk assessments and care plans which had been reviewed and updated. Risks identified included assisting people to move, and for those people at an increased risk of falls, and poor skin integrity. Measures were in place to support people with these risks. For example soft food or pureed diet as well as guidance on safe moving and handling techniques. One relative told us their family had a, "lower bed to minimise the risk of falls." They said their family member had not fallen since the new bed had been in place. However, we noted that in some instances only total 'scores' were recorded when risk assessments were reviewed and not the breakdown of how the risk had been assessed. This made it impossible to see what factors had changed and whether the guidance for staff addressed all the factors to reduce the risk of harm occurring.

Our records showed that, compared to other similar services, there was a high incidents of serious injuries occurring at this service. Staff were aware of the provider's reporting procedures in relation to accidents and incidents. Accidents and incidents were recorded and acted upon. For example, measures had been put in place to monitor people more frequently or check on their wellbeing more often. We saw that this was often after consultation with other healthcare professionals, such as the team who were specialists in helping to prevent falls.

Staff told us that the required checks were carried out before they started working with people. These included two written references, proof of recent photographic identity as well as their employment history and a criminal records check. One staff member told us, "[The registered manager doesn't] allow anyone to start until all the checks are back." This showed that there was a system in place to make sure that staff were only employed once the provider was satisfied they were safe and suitable to work with people who used the service.

We found there were sufficient staff to safely meeting people's needs. However, the staffing levels limited the

choices people were able to make and how individualised their care was. People and their relatives had mixed views about whether there were sufficient staff to meet their needs. One person told us, "You never have to wait more than five minutes, and if you ring the emergency bell they come instantly." A relative said, "On the whole I think they've got quite sufficient staff, they're quite helpful." However, other people felt this was not the case. One person said, "Sometimes it takes one or two hours to be changed at night." Another person explained the staffing levels varied. They said, "The worst time is weekends, there's never enough staff and it affects us." The person told us how they liked to have a bath every day before they got dressed, but that they needed staff support to do this. They said, "At weekends sometimes it's quite late before [staff] can bath us …We have our breakfast in our rooms before we get dressed and then we're waiting around until they come to take us to have our baths." They went on to say, "A few weeks ago they were so short staffed we could only have a wash [that day]." Two healthcare professionals commented they had found it has sometimes taken them a long time to find a member of staff to assist them with their consultation when they visit people at the service.

Most staff told us they felt there were always enough staff on duty to safely meet people's needs. They told us that registered manager and deputy also regularly provided "hands on" care and were not usually included when the numbers of staff providing care were calculated. However, one staff member said that some people would benefit from more "one to one attention from staff" and that staff were sometimes "impatient about the care. If there was enough staff they wouldn't be."

The registered manager told us they did not use a formal recognised tool to assess people's dependency and the number of staff needed to care for them. She told us, that she and the deputy manager provided care and therefore continuously assessed how many staff were required to meet people's needs at different times of the day. The registered manager said that they occasionally used agency staff to cover staff annual leave or sickness, but that on these occasions the agency staff were usually familiar with people's needs. The registered manager told us the provider supported their decisions about when to change staffing levels if the number of people provided with the service, or people's needs, changed.

People said they were satisfied with the way staff supported them with their medicines. One person told us, "They give us pots with tablets in, they usually stop and make sure that we take them, but not always because they know us." Another person said, "If we're not here they won't leave [our medicines], they'll come and find us." People said staff provided them with pain relief if they required it.

We saw that people were safely supported with the administration of their medicines. We saw staff administer medicines. This was done in a calm, reassuring and unhurried manner. People were provided with a drink and staff ensured that the person had swallowed the medicines before completing the medicines administration record (MAR).

There were appropriate systems in place to ensure people received their medicines safely. Staff who administered medicines told us that they had received training and their competency for administering medicines was checked. Medicines were administered in line with the prescriber's instructions. Appropriate arrangements were in place for the recording of medicines received and administered.

Where people repeatedly refused their medicines we saw that their mental capacity to make decisions about this had been assessed and where appropriate, best interest meetings held. We saw that appropriate people, including the person's GP had been included in this decision. People's care plans reflected the decision made, including if medicines should be administered covertly. However, these care plans were brief and did not provide sufficient guidance on how staff should administer these medicines, for example whether they should be mixed with food. The deputy manager told us this information would be

incorporated into people's care plans following out inspection.

Medicine cabinets were kept locked when unattended and following a medicine round they were kept locked in the clinic room. However, we noted that the lock on one cupboard was broken and there was no restrictor on the ground floor window accessing this room. We brought this to the registered manager's attention and a new lockable cupboard and window restrictor were fitted later that day.

Senior staff regularly checked medicines and the associated records. This helped identify and resolve any discrepancies promptly.

Upon our arrival and at various times during the day we were aware of unpleasant odours in various areas of the service. These were most apparent in the communal areas. One relative commented on this and told us, "You get used to the smell." A healthcare professional who visited the service regularly told us that too smelled offensive odours, particularly from the sluice room. The provider's recent staff survey showed that two relatives had responded. One said the home was 'very' clean, and the other rated it as 'fairly' clean. One relative had commented that, 'There is often a strong smell of urine, the environment would improve if this were less prevalent at times.'

Carpets and flooring looked clean and a relative said, "I've seen the cleaners hoover and wash the carpets on a daily basis." Another relative told us, "The home is always clean and tidy every time we visit and [person's] bedroom is clean and comfortable."

Housekeeping staff told us that they completed cleaning schedules to ensure all areas of the home were cleaned regularly. They told us the provider ensure they had suitable equipment and products. One staff member said, "Anything we need, we bring up [with the provider, for example] a long cobweb stick, just ask for it and we get it."

Staff told us that training in the prevention and control of infections formed part of their induction training. Staff commented on the importance of hand washing. One staff member spoke in detail about the personal protective equipment they used and said that a trolley was loaded with all the things they needed. This included disposable aprons, gloves, wipes and appropriate colour coded bags for incontinent materials and laundry. We saw these in use during our inspection. However, we also saw good infection control procedures were not always followed. For example, we saw that soiled linen was left on a trolley in a communal area. We saw a staff member disposing of a used continence pad, that had been left in a bin in a person's room, with household rubbish. We also saw that a staff member was going to reuse a bin liner which had contained the used continence pad. They replaced this with a fresh bin liner only after a person requested this. We spoke with a member of the domestic staff about this who confirmed that the service's procedure for the disposal of continence pads had not been followed on this occasion and that they would speak with the staff member.

Requires Improvement

Is the service effective?

Our findings

At our inspection on 1 December 2015 we found that there was a lack of suitable arrangements for obtaining lawful consent to care, acting in accordance with the Mental Capacity Act 2005 (MCA). This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider sent us an action plan that detailed the improvements they planned to make. They told us these improvements would be made by February 2015.

During this inspection on 23 May 2016 we found that some improvements had been made towards compliance with the MCA.

The 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 found the service was working within the principles of the MCA. We saw that assessments and decisions to restrict people's liberty had been properly taken and the appropriate applications made to the relevant authority. This showed that consideration had been taken to ensure the service provided was in people's best interest and was provided in the least restrictive manner. We found that the registered manager had an understanding of the principles of the MCA. Staff had received training in, and were aware of, the MCA and DoLS. However, they needed to further embed this knowledge.

Where people had been assessed as not having the mental capacity to make specific decisions, we saw that decisions were made in their best interest. For example, where the person was refusing to take medicines. Records showed that the views of appropriate people had been taken into consideration. This included people who knew the person well or the person's legal representative. We saw the registered manager had obtained copies of any legal representative's authorisation, such as power of attorney. This showed that consideration had been taken to ensure the service provided was in people's best interest and was provided in the least restrictive manner. However, we noted that that one person's relative was making decisions about their care but may not have had the legal authorisation to do so. The registered provider told us they would follow this up to ensure authorisation had been obtained. We also noted that some mental capacity assessments were generic and did not relate to specific decisions. The registered manager told us they would review these assessments.

At our comprehensive inspection on 1 December 2014 we found that people did not always receive the support they needed to help them eat and drink enough. This was a beach of the Regulation 14 of the

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider sent us an action plan that detailed the improvements they planned to make. They told us these improvements would be made by 19 May 2015. Following this inspection on 23 May 2016 we found that sufficient improvements had been made to ensure people were supported to eat and drink enough.

People and relatives told us that the quality and choice of food had improved. One person explained, "[The food is] a lot better than it used to be. I can't fault the food, I really can't." Another person praised breakfasts in particular. They said, "Breakfasts, you can have whatever you want, I have eggs and bacon." However, people had mixed views about the teatime menu. One person said, "Tea, the sandwiches are repetitive... tinned or stewed fruit and cakes." Other people told us there was a good choice of food available at teatimes. One person said, "There's always something like quiche, scrambled eggs, cheese on toast, bacon sandwiches…The cook will come in shortly and ask what we want."

People were offered choice at mealtimes and menus were displayed on the walls of the dining room. Staff told us, and we saw, people could request other options. One person told us, "We've got a menu now, we always have two lots of vegetables, roast or mashed potatoes, beef, pork, turkey, chicken with gravy. You can ask for more." One relative explained, "I've seen that one cook in particular is very good with people, if they say 'I don't like that' the staff would offer them an alternative. I've seen that loads of times."

People's specific dietary needs were catered for. For example, one relative told us that the service provided desserts suitable for those on a diabetic diet. Another relative told us that they were aware their family member was being offered a high calorie diet because they had been losing weight. Staff told us that care was taken with the presentation of food to make it look appetising. This included food for people who required a soft or pureed diet. For these meals, each food was processed separately so the flavours were distinct.

People were supported to have enough to eat and drink. In addition to meals, we saw that a range of drinks and snacks were available throughout the day and night. Staff offered people support with their meals and drinks, if they needed assistance. This was offered in a calm way and the person at their meal at their own pace.

People's weights were monitored monthly, or more frequently if they were deemed to be at high risk of malnutrition, and people were referred to a dietician when needed. We saw staff monitored people's food and fluid intake where they had identified people were at high risk of malnutrition of dehydration. Appropriate guidance was provided for staff. For example, each person's target fluid intake for the day had been calculated. Where a person had not reached their target intake, we saw that staff communicated this information to each other to ensure the person was encouraged to drink more. This showed that people at an increased risk of malnutrition or dehydration were provided with meal options and fluids which supported their health and well-being.

People were supported to access see appropriate health care professionals including the community nurse, the falls team, and the dietician. This was to support people with the management of their health. One person said that when they were unwell "You just tell the carer and she'll say the doctor will come." A relative told us that staff had responded quickly when their family member had a sudden onset of an illness, "[The staff] got the GP out straight away." Another visitor said, "As soon as [person] needs a doctor. [The staff] call him straight away and then tell us. They are really looking after [person's] welfare."

One healthcare professional said that staff referred people to them as soon as the staff suspected their

intervention may be necessary. Healthcare professionals told us they repeatedly spent time reminding staff about good practice in areas such as skin care and the use of equipment, to ensure they understood it. They said that they felt staff did then follow their guidance. Following our inspection two healthcare professionals raised concerns about staff member's knowledge about catheter care and that staff were not always aware of people's current needs. For example, the current equipment the person used to assist them to mobilise. We passed this information to the registered manager for them to follow up.

People were also supported to receive routine health checks. One person told us, "The optician comes here about every six months or so. They're very good, ever so thorough… I [see] a chiropodist, I should say about every two or three months." A person told us, , "The chiropodist comes in every five weeks." They went on to tell us that in addition to seeing the chiropodist they also saw the optician on a regular basis.

People told us that they felt that staff were able to meet their needs and were competent. One person told us, "I think [staff] know what they're doing." A relative told us, "[Staff] training seems to be ongoing here."

The registered manager told us that staff received an induction when they first started working at the service. This involved a briefing in key topics and introduction to the service. Staff then worked alongside more experienced care workers until they were deemed competent to provide care alone. One person told us, "Staff will introduce new carers [to us]." Another person said, "We've had two new staff in the last fortnight, they've all shadowed [more experienced staff]."

The registered manager told us that staff were supported to achieve nationally recognised qualifications in social care. We saw that new staff were working towards the Care Certificate and that nine of the 29 care staff had completed a national vocational qualification (NVQ) level two or three in social care. Another staff were working towards these.

Staff that had responded to the provider's survey said they felt the training they received was 'about right'. Staff told us they were trained in the subjects deemed mandatory by the provider such as assisting people to move, fire safety and safeguarding people from harm. Staff made positive comments about the training they had received. One staff member said there had been, "Lots of ongoing training throughout the year." Staff were also supported to receive other training relevant to their roles. For example, staff talked about some specialist dementia training they had received and found useful. One staff member said, "The dementia training really opened my eyes about all the various types of dementia that people lived with."

Staff members told us they felt supported. One staff member said they found the registered manager and other staff to be "very supportive" and often saw the provider's representative around the home. Another staff member said that they had received spot checks from the registered manager. They said supervision sessions were "infrequent" but said they felt supported by the registered manager and senior staff. Staff received two formal supervision sessions and they were observed providing care at least twice during each year. The registered manager told us they had started staff annual appraisals and that these would be completed by the end of June 2016.

We found the design, layout and decoration of the service did not aid people to be able to orientate themselves. This was especially for people who were living with dementia or sensory impairment. Corridors and hallways were painted in a calm neutral colour, with flooring and handrails in contrasting colours. However, we noted that the walls of corridors and hallways throughout the building were painted in a uniform colour. There were visual signs for communal rooms and toilets, but there was little other use of decoration to help people orientate and find their way around the service. People's rooms benefited from name plates and room numbers but there was no memory signage providing guidance for people living with

dementia or sensory impairments.

We observed that several people benefited from beds that could be raised and lowered. One relative used the handset to raise the person's bed to make them more comfortable. Another relative told us that since the person had got a new bed the number of falls the person experienced had reduced.

People and relatives told us they had seen improvements in the environment. One person told us, "You can see that [owner's] trying to make things better." They gave an example that they had suggested toilets had seat supports. They said, "The toilets were so low I couldn't get up or down. Now all the toilets have them". A relative commented, "They're undergoing quite a significant refurbishment."

Good

Is the service caring?

Our findings

People and their relatives were complimentary about the staff. One person said, "I really can't fault them (staff), they understand me, they all know my name." One relative told us, "I think [staff are] quite supportive and compassionate." Another relative said, "Every single [staff member], from cleaners to laundry to carers, have given over and above the care expected… You have to have a vocation [to work here]. [Staff] care, that shows."

Our observations showed the staff were kind and caring to the people they were caring for. Staff spoke in a calm and reassuring way. We saw one person became distressed after spilling a drink. One staff member cleared the spillage while another sat with the person and reassured them. The staff member told the person, "You don't need to worry about that, don't get upset." Their approach was very gentle and understanding. One relative told us, "There's a couple of very difficult people [living] here. [Staff] always try to reassure them, avoid them getting upset. They try and diffuse the situation as quickly as possible." A person told us they experienced panic attacks. They told us staff comforted them. They said, "[Staff] come and get hold of me, reason with me." However, we also noted occasions when staff missed opportunities for positive engagement. For example, we saw a staff member place a person's walking frame beside them, but did not speak with them.

People and relatives told us that most staff were respectful and treated them with dignity. For example, staff called people by their preferred name. One person told us, "[Staff] respect us, call us by our Christian names. We are part of a family here. They're all good to us." A relative described occasions when their family member wanted to stay in bed and displayed this through their behaviour. The relative said staff encouraged their family member to get up, but remained "calm and respectful…They coax and cajole… They understand [my family member]." However, some people gave us examples of when people were not treated with dignity. For example, one person told us that staff picked up sandwiches with their fingers before giving them to the person. They said, "I think they should use tongs." We noted that the black fabric placemats were stained and the cutlery marked.

Relatives told us that they could visit whenever they wanted and were made welcome. One relative described staff as, "Always welcoming, warm and friendly."
Another relative said, "We visited the home before [my family member] moved in. [Staff] made us very welcome and gave us lots of information about the home."

Relatives said staff kept them informed of changes in the person's health or wellbeing. One person said, "[My relative] discusses our health needs with [registered manager], and our dietary needs, [The staff] always ring our [relative] if we have the doctor in." Another relative said, "Communication is brilliant. [Staff] communicate with us all the time." They went on to give us an example that their family member hadn't eaten very much that day, so when they visited, staff asked if they could encourage the person to eat.

People told us they were involved in the planning and delivery of their care. For example, one person told us that explained that their relatives sometimes take them out to lunch. They told us "We can ask if we can

have an early bath, [staff] always do it." A relative said "[My family member is] making their own choices by far. The number of times [staff have] encouraged them to go out [of their room], but it's their choice." One relative told us, they were "always involved" with person and the registered manager in any reviews of the person's care. However, we noted that choices were not always offered in the most appropriate way for each person. For example, we heard staff ask people what they would like for their main meal, offering chicken pie or chicken curry. For some people this proved a difficult choice to make, and some meals had to be changed once people could see what was on their plate.

People who required advocacy were supported in a way which best met their needs. For example, relatives and people who knew the person well were consulted about people's care. Information was available in the service if people wanted or needed more formal advocacy. Advocates are people who are independent of the service and who support people to decide what they want and communicate their wishes.

We saw that people had brought in their own furniture and that rooms were personalised with pictures, photos and paintings. This was to help people orientate themselves as well as being personal to them.

Requires Improvement

Is the service responsive?

Our findings

People and relatives felt that staff understood and responded to people's needs. One person told us, "I feel we are looked after, I can't fault [the service]." A family member said, "I think [staff] know [people] well enough. [My family member] smiles at [staff]." Another relative told us they regularly visited the service at different times and found that the care and services provided were consistent. "The care is first rate and [my family member] is 200% better [here]."

People's care needs were assessed prior to them moving to the service. This helped to ensure staff could meet people's needs. This assessment formed the basis of people's care plans. Staff told us they were aware of the content of care plans and risk assessments. However, we noted that care plans were very brief and did not provide sufficiently detailed guidance to ensure that care would be provided consistently. For example, one person's care plan recorded the person was able to go to the toilet without assistance but they needed "prompting at times". The care plan provided no guidance to staff about the circumstances to remind or prompt the person. This meant that care may not be provided consistently. People's care plans were reviewed regularly and reflected people's changing needs. Following our inspection the provider told us that staff would receive additional training and all care plans would be reviewed by 30 June 2016.

People were supported to regularly reposition and prevent pressure ulcers from forming. Healthcare professionals told us that they provided advice to staff to ensure that people's skin remained intact. Relatives told us that, where appropriate, staff helped their family member to regularly reposition and prevent pressure ulcers from developing. Staff were aware of the frequency people required to be repositioned and told us that no-one at the time of our inspection had pressure ulcers. This showed that staff took action to prevent pressure ulcers developing.

The three staff who responded to the provider's survey said they would recommend the service. Most staff told us they would be happy with a family member receiving the service and one staff member said this was because, "The care's very good and I know they would get the care they need." Another staff member said, "The home is good and the care is good too."

We found much of the care provided was task orientated. Some people told us staff had time to chat with them but others said this rarely happened because staff were too busy.

The provider employed an activities co-ordinator who had put together a programme of events for people to join in with. This was advertised throughout the service. People spoke highly of the person who we saw engaging with people and encourage them to join in with activities. Visitors told us people had enjoyed the coffee mornings, summer fete and celebrations for the Queen's birthday. There were activities taking place during both the morning and afternoon of our inspection. However, we noted there missed opportunities to engage people in conversations and reminiscence during these activities.

People told us that there was a limited choice of activities which were dependant on the activities co-ordinator. One person told us that when the activities co-ordinator was not working, for example at

weekends and when they were on leave "there will be absolutely nothing to do." Another person agreed with this. They told us, "[The activities co-ordinator] has been ever so good to me. When I've been crying [they] make sure I've got something to do. If [they're] not here I'm lost." A third person said, "I sometimes wish there were more things to do. I go into the lounge if there's things to do. We might do colouring, and we have people come in sometimes, bingo… I like to answer things like quizzes – I think it's got worse recently [with less things to do]." One staff member told us they would not be happy with their family member receiving care from the service. They told us this was because, "The care doesn't flow. I would want [my family member to have] more time and attention, individual care."

People told us that their spiritual needs were met by a religious service which took place monthly. One person said, "I do go along… it's just a short service in the lounge once a month."

We found there was very little for people to do. For people living with dementia there were limited distractions, tactile objects for reassurance or things to occupy them. A staff member told us that they felt there needed to me more stimulation for people who needed to spend a lot of time resting in bed. They told us, "I think there needs to be more interactions in [bed]rooms. They're on their own so they sleep. People need more one to one attention." This showed there was a lack of stimulation.

There was a secure purpose built internal courtyard which provides people with the opportunity to go outside and we asked people if they were able to go outside. One person said, "[Staff] take me outside. I haven't been out there yet [this year] because nobody's come to escort me. I've got to have somebody with me all the time." A staff member told us that they "did not take people out of the home very much." This meant that people did not have the sufficient opportunity to go outside.

People and their relatives all told us that they felt able to raise any concerns with the provider's representative and / or the registered manager. One person told us "If there's anything we're unhappy about we talk to [the provider's representative] and he sorts it out. He's very good."

Staff had a good working understanding of how to refer complaints to senior managers for them to address. We found that complaints were investigated and dealt with appropriately and within the timescales stated in the complaints procedure.

Requires Improvement

Is the service well-led?

Our findings

One relative, told us "I've known [the provider's representative] for [a number] of years. I've always found them reassuring and got on well with them. He comes in regularly to see [my family member]". Another relative told us, "[The registered manager] is good and hands on."

The service had a registered manager in place. The registered manager was supported by a staff team that included team leaders, care workers and ancillary staff. Staff were clear about the reporting structure in the service. Staff told us that their handover meetings were important in helping them ensure they had the most up to date information about people's care needs. One staff member said, "We get lots of information at handovers." However, records showed the last meeting for care staff had been held in June 2015, 11 months before our inspection. Minutes showed a variety of issues raised and included managers cascading information and staff raising issues that concerned them. Staff told us they would welcome more frequent staff meetings and felt these would assist with better communication between staff in the service.

The registered manager was approachable. One relative told us, "[The registered manager and staff are very approachable and helpful." Staff told us they felt well supported and regular supervision and competency checks.

All the staff we spoke with were familiar with the procedures available to report any concerns within the organisation. They all told us that they felt confident about reporting any concerns or poor practice to more senior staff, including the registered manager. We saw that where issues of concern had been raised, these had been addressed. This had helped bring about improvement in the service. One person gave us examples of maintenance issues which had been addressed. They told us, "What I like is when you ask for something [the provider's representative] does it."

There were limited links with the local community. People told us that a religious service was held at the service monthly.

People and relatives felt the provider and registered manager had made improvements to the service over the past year. A relative said, "[The provider's representative] works to improve [the service] for the residents." We saw that some improvements had taken place. For example, staff ensured that people had sufficient to eat and drink and choices of menu had been increased. We also saw the provider made ongoing improvements to the building and the fire alarm system was being replaced during our inspection.

The registered manager and provider told us they sought feedback from people on a day to day basis, through care reviews and surveys. One relative told us, "We get feedback forms every six months [through the post] asking how they can improve the service." The 2016 survey had recently been sent to people, visitors and staff and the responses had started to be returned. The registered manager told us these would be collated into a report and shared in due course. The responses received at the time of this inspection were overall positive. Two staff responses had been received. They said they felt valued, were sufficiently trained and believed the care provided was good. Two relatives had responded and said they were "very"

and "fairly" satisfied with the service. One relative wrote that they were 'very pleased and impressed with how kind and caring the staff are. I would recommend [the service].' The other relative raised areas for improvement, including the malodour around the service and said they had 'noticed that [people's] hair and finger nails could be cleaner at times.' The registered manager told us that issues raised in the responses received would be addressed.

The registered manager and provider's representative conducted regular audits to check the service was meeting the standard they required. This included audits of medicines and care plans. Whilst we saw that actions were taken to address issues identified, we were concerned that other issues had not been identified. For example, the insufficient detail in people's care plans and risk assessments and the lack of engagement and individualised care.

Records we held about the service, and looked at during our inspection, showed that the provider had not sent all required notifications to the Care Quality Commission (CQC). A notification is information about important events that the provider is required by law to notify us about. However, the provider had recognised this and notified the CQC of a recent event appropriately.