Old Farm House Care Limited

The Old Farm House Residential Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 9 and 10 October 2018 and was unannounced. This was the first rating inspection for this service since its new registration under a new provider in October 2017.

The Old Farmhouse is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

This is the first time the service has been rated Requires Improvement.

The service is a residential service for up to 26 older people some of whom had dementia and physical disabilities. At inspection there were 24 people in residence. Accommodation is arranged over two floors with most bedrooms having an ensuite facility, the service is fully accessible to those in wheelchairs or with mobility problems and the first floor is accessed by a passenger lift.

There was a registered manager at the home. 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.

Incident and accident records showed that during a two-week period when the registered manager was on leave two people had experienced falls resulting in admission to hospital for treatment of serious injuries, staff ensured people received the treatment they needed. The registered manager understood that these events should have been notified to the Care Quality Commission, and had done so with other incidents. She agreed to ensure that people covering for her absence were made fully aware of their responsibilities around this. This is an area for improvement.

People, relatives and staff told us that there were enough staff on duty, staff rotas informed us that all shifts were covered. However, the pool of staff available to cover shifts was small and vulnerable to unplanned staff absences, The registered manager agreed to review the overall staff complement to improve flexibility and availability to cover for staff absences. Policies and procedures were in place for staff but those viewed lacked important detail to inform and guide staff practice and ensure this was in line with current best practice guidance and legislation, these were amended at inspection.

A range of audits were in place to enable the registered manager to monitor service quality but there was no mechanism to provide oversight of all shortfalls identified within the audit processes and to monitor their completion or progress, the registered provider and Registered manager agreed to implement a development plan to keep track of progress on meeting shortfalls. The registered provider and area manager had a visible presence at the service, visiting frequently, but did not keep records of what they looked at during these visits. These are areas for improvement.

Medicines were stored and administered safely, individual 'as and when required' medicine guidelines would benefit from additional information to aid and inform consistency in administration.

The premises were well maintained and clean. Staff understood how to protect people from abuse and harm. They had been trained to evacuate people safely in the event of a fire. Equipment was tested, checked and serviced at regular intervals to ensure this was in a safe working order. Accidents and incidents were recorded, reported and acted upon, the registered manager analysed these to implement changes and reduce further risk of harm occurring.

Training records showed that staff had completed an induction to their role and essential and specialist training in a range of areas that reflected their job role, this helped them understand how to provide effective care and support for people.

People told us the service was a happy place to live. They said they felt safe and happy living there. Relatives were also satisfied with the level of care their loved ones received and spoke positively about the kindness and attitudes of staff and the leadership of the registered manager.

People and their relatives told us that they knew how to complain and if they had any concerns they were confident these would be quickly addressed by the registered manager.

Risk assessments were in place to identify environmental risks that could affect everyone and individual risks that may be involved when meeting people's needs.

The provider operated safe recruitment procedures.

Staff knew people well and had a good knowledge of their needs. They treated people with kindness. People were encouraged to do what they could for themselves, but support was available when they needed it. People were encouraged to make their own decisions and choices and staff promoted their independence.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

The food menus offered variety and choice. They provided people with a nutritious and well-balanced diet. The cooks prepared meals to meet people's specialist dietary needs.

People and relatives were involved in the development and review of care plans. Staff supported people with health care appointments and visits from health care professionals. Care documentation was updated to reflect any change in health needs. Care plans were routinely reviewed to keep them updated.

People's needs were fully assessed with them before they moved to the home and thereafter to make sure that the home could meet their needs. People were encouraged to take part in activities and hobbies and interests of their choice. People were supported to practice their beliefs, and their end of life wishes were recorded so that staff knew people's preferences around this.

Staff understood their respective roles and responsibilities. Staff told us that the registered manager was very approachable and understanding.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was not consistently safe.

There were enough staff to meet people's needs.
As required medicine protocols needed review, otherwise medicines were safely stored and administered to people.

The registered manager and provider had ensured staff received appropriate training and awareness to protect people from abuse.

Risks to people's safety and welfare were assessed and managed effectively.

There were effective recruitment procedures and practices in place and being followed.

Is the service effective?

Good

The service was effective.

New staff received induction to their role and ongoing training to enhance their knowledge and skills.

Staff received regular supervision from their line manager, and a programme of annual appraisal was in place.

People's rights were protected under the Mental Capacity Act 2005 (MCA) and best interest decision made under the Deprivation of Liberty Safeguards (DoLS).

People were supported appropriately and effectively with their health care needs.

People were given choices about the food they ate, alternatives were provided, those assessed as at risk were monitored to ensure they ate and drank enough.

Is the service caring?

Good

The service was caring.

The registered manager and staff demonstrated caring, kind and compassionate attitudes towards people.

People's privacy was valued and staff ensured their dignity was upheld.

People and relatives were as involved as they wished to be in making decisions about care and support.

People were encouraged to personalise their own rooms and visitor arrangements were flexible.

Peoples documentation was kept secure.

Is the service responsive?

Good

The service was responsive.

People's needs were fully assessed and comprehensive care plans detailed their specific preferences around how care was provided. People and their relatives could be involved in updating the care plan.

Staff were proactive in delivering a programme of activities for people but respected the choice of those who chose not to participate.

People were provided with information in formats they understood.

People understood how they could raise concerns if they needed to and felt these would be dealt with appropriately.

Peoples end of life wishes and preferences were recorded where these were known to inform staff.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider needed to ensure those in charge in the registered managers absence understood their responsibilities to report notifiable events to CQC.

Minor improvement was needed to the quality assurance system to make this more effective and provide better oversight for the registered provider and registered manager.

Staff were provided with policies and procedures to guide and

inform their practice.

The management team were approachable. Staff were supported by an open and transparent culture.

There was a clear staffing structure. Management and staff understood their roles and responsibilities.

The Old Farm House Residential 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 inspection took place on 9 and 10 October 2018 and was unannounced. The inspection team was made up of one inspector and an assistant inspector.

Before the inspection, the provider had already 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. This was the first inspection for this service following a new registration of an existing service under a new provider. We looked at any information received about the service since its registration including the details of any safeguarding events and statutory notifications sent by the provider. Statutory notifications are reports of events that the provider is required by law to inform us about.

We met and spoke with 11 people who lived in the service. People could tell us about their experiences and share their views. We made observations of people's interactions with staff and with other people. We observed staff engagement with people and each other when carrying out their care and support duties.

We spoke with the registered provider, registered manager, area manager, two team leaders, three care staff, and three ancillary staff. We spoke with three relatives at inspection and contacted a further four after the inspection. We received feedback from two social care professionals' and one community nurse.

We looked at five care plans and this covered associated health information, individual risk assessments, medicine records, and some operational records that included three staff recruitment files, records of staff training, staff rotas and supervision records, menus, accident and incident reports, servicing and maintenance records, complaints information, policies and procedures, survey and quality audit

information.

Good

Is the service safe?

Our findings

People were happy, chatty and smiling, some told us that they liked living in the service and having staff around all the time made them feel secure. Comments included, "I was falling a lot at home but I haven't fallen once since I have been here, I feel safer here."

Most people, staff and relatives said staffing levels were satisfactory, two people had noted that there were staff shortages at times and there had been some leave and sickness amongst staff recently. The rota showed that all shifts were covered. Four staff provided day time support during 12-hour shifts and two waking night staff were supported by a twilight carer between 8-11 pm. Tasks such as cleaning, laundry and cooking were the responsibility of a small ancillary housekeeping team. Although all shifts were covered from within the staff team the pool of available staff was small, therefore the staff rota showed that during weeks where there was planned and unplanned staff absence, there was an over reliance on a few staff working six or seven 12-hour shifts in one week. We spoke about this with the registered provider and registered manager and the need to review this as the staff team was small and vulnerable to staff shortages. The registered manager agreed to consider this.

Only minor improvement was needed to the management of medicines. Guidance was in place for the administration of 'as and when required' medicines, two guidelines were missing but everyone had capacity and could voice their requests for pain relief as and when they needed it. The registered manager replaced the missing protocols, all of which would also benefit from added detail to better inform, guide and aid staff consistency in administration. Administration records were completed well. Handwritten entries were countersigned by two staff and dated to ensure the accuracy of entries.

Staff were responsive to suggested improvements to medicine practice from external pharmacy audits. Only trained staff gave people medicines. Their training was updated annually, and their competency was assessed through observations of their practice by senior staff. Appropriate systems were in place for the ordering, booking in and disposal of medicines. Medicines were stored securely in a medicines room and this room and medicine fridge temperatures were monitored to ensure these remained within acceptable levels. Medicines requiring stricter storage and administration requirements were managed safely. Medicines audits were conducted monthly and medicine balances checked to ensure people had received all their medicines.

The premises were well maintained. The new provider had resourced the upgrading of décor and furnishings in communal areas and in some bedrooms. Equipment needed to help people get up and move about including the lift, had been serviced at regular intervals. Electrical and gas installation and portable electrical appliances had been serviced. The fire detection system, emergency lighting and fire extinguishers were visually checked and tested at weekly and monthly intervals by staff with regular servicing contracts in place. A maintenance person undertook minor repairs and staff said these were dealt with in a timely way, water temperatures were checked to ensure these did not place people at risk, and water quality was checked annually to test for legionella. Fire drills were held monthly. We drew to the registered managers attention several staff who were still to participate in a fire drill within a 12-month period, the registered

manager agreed that they would ensure the highlighted staff took part in future drills. People told us repairs were fixed quickly - "Somebody comes straight away to see what needs doing. "Another person told us that new boilers had been put in recently and that the radiators had been switched on for winter.

Staff were aware of actions to take in the event of a fire emergency but were unaware of what they needed to do in respect of other emergencies that may affect the service operation. They had not heard of a business continuity plan although one was in place. The plan was well written but there were gaps in some telephone numbers that needed completion, the registered manager addressed this and agreed to place the continuity plan where staff could view it easily and make all staff aware of its purpose and location. This is an area for improvement.

The Provider information form told us that staff had received training to understand and be aware of abuse that people in care settings can experience. The registered manager and staff understood their responsibilities to act on any suspicions of abuse they may have and to report this. They understood how to escalate concerns both inside and outside of the organisation if needed and were confident of using the providers whistleblowing policy if their concerns related to another staff member.

Staff said t they had confidence in the registered manager taking appropriate action if they raised concerns and that their confidentiality would be maintained so as not to affect their working relationships within the team.

A good standard of cleanliness was maintained in the service, which was tidy with no odours. There were two cleaning staff; people told us that cleaning at weekends was to an irregular standard. In response, the provider had recruited a weekend cleaner and they were currently undergoing recruitment checks. Cleaning staff were provided with schedules so that they ensured all areas of the service were cleaned in rotation. Cleaning staff had appropriate resources to carry out their work. Staff had received training in infection control. Supplies of gloves and aprons were observed around the service and staff were seen using them when going about their tasks. The registered manager conducted an infection control audit monthly, this highlighted any shortfalls and action was taken to address this. People told us from their experiences that their rooms were cleaned daily. They said they found the home clean. A laundry person had been employed and people felt this had improved the service they received "The home is very clean, everyday it is done," and "Laundry is good. Has improved a lot". Another said "If an item goes to laundry one day, it comes back the next day. The laundry used to be an issue but is not now."

The registered manager had developed risk assessments for the environment. These were generic because the risks could impact on people as well as staff and visitors. These assessments were kept under review and updated. Individually people were assessed in respect of the risks they may be subject to through falls and poor mobility, risks from poor nutrition or hydration, risks to their skin integrity, or because of a specific condition such as Asthma. Risks identified for individuals described clearly the risks to the person, and guidance staff needed to be aware of and follow to reduce the likelihood of risk and how staff should implement risk reduction measures, including what level of support people needed from staff.

The registered manager analysed every incident/accident which mainly comprised of slips trips and falls. Analysis showed outcomes for each incident/accident with suggested risk reduction measures, these corresponded to updates to risk and care plan information to ensure these measures were implemented. This included the use of alarm mats and alarms on cushions to alert staff to people getting up on their own who needed assistance, checking people had the right footwear, and the type of walking equipment they used was still correct. Referrals to health professionals were completed when needed. Equipment to aid mobility and skin integrity was made available and staff practices helped to reduce risks through

repositioning people in their beds if they were at risk, ensuring skin care featured in delivery of personal care, and equipment was checked and maintained so that it remained safe. Air mattress settings were checked daily by staff to ensure they were correct. We discussed the current recording system for air mattress settings and how this could be improved to aide staff, the registered manager agreed to implement this.

Staff recruitment files showed that satisfactory processes were in place for the recruitment and selection of all levels of staff. Initial recruitment checks on the suitability of prospective staff included checks of previous employment history, proof of personal identity, satisfactory written references; a Disclosure and Barring Service (DBS) criminal record check; and a statement as to their current health. A record was kept of the interview process. These checks identified if staff were suitable, of good character and were not barred from working with people in care settings.

Good

Is the service effective?

Our findings

The provider information return told us that staff received an induction when starting work. They were also required to complete a programme of basic and specialist training courses to give them the knowledge and skills needed to support people safely. Newer staff told us that when they started work they completed an orientation day and a record of this was kept on their files. They also completed an induction of two weeks working as an additional staff member, shadowing other staff on shift before being assessed as competent to work unsupervised. Other than staff rotas that recorded staff on shadow shifts induction was not well recorded. We discussed this with the registered manager at inspection who immediately implemented an induction record for new staff to better record induction activities in future.

Staff new to care completed the care certificate during their first six months, they completed work books which were assessed by the registered manager to ensure they understood what they had learned and were competent. More than 50% of staff had achieved nationally recognised vocational qualifications in care. Staff were allocated training they needed to complete and the registered manager monitored that this had been scheduled or completed. Staff completed specialist training courses covering areas such as diabetes and dementia that affected some of the people coming to live at the service. This provided staff with additional knowledge to aid their awareness and understanding of these conditions. Staff said they learned from their training. They told us that recent moving and handling training had informed them of a better way to place straps on the standing hoist. This change made it safer for people and staff and all staff now worked to this practice.

People told us that they enjoyed their food, they commented positively about the quality of food. People told us that they were consulted about what they wanted each day, some knew there was a four-week menu cycle so the menu varied each week. People had capacity to make their own choices and to discuss with staff if they wanted something different. A menu board was provided in the dining room and no one had any communication issues identified that required them to receive this in a different format. The cook was made aware of people's preferences when they moved into the service and checked that the menu was inclusive to include some of their favourites. People said about the food "Very good and if there is something you don't like you just say and of you are offered something else."

People were assessed for any risks in relation to their nutrition or hydration. Following a previous incident all people now had their fluid intake monitored as a precautionary measure to reduce the likelihood of dehydration amongst other people. People and relatives said that their health needs were well supported by staff. "Honestly we are more than happy (name) is loving it and has settled well and has got back their mobility since moving there and feels more confident." People were supported by staff to see their GP if they felt unwell, staff worked in partnership with relatives to determine whether staff or relatives were supporting people at external medical appointments. The registered manager in consultation with the GP referred people for specialist input if a need was identified such as falls clinics, mental health teams. The community nurse also visited several days each week, to attend to skin tears from people who had fallen and to provide treatment for people with pressure ulcers. The community nurse said they had no concerns and that staff responded appropriately to advice and guidance discussed with them about peoples care during treatment

and after. People at risk of pressure ulcers were assessed and equipment such as air mattresses and air cushions put in place to reduce the likelihood of pressure areas developing. Staff monitored air mattress pressures. People told us that they were provided with access to specialist health appointments such as chiropody; "The chiropodist comes every six weeks and there is a queue for her. "and "I have lived here for five or six weeks and I've seen a chiropodist twice now."

People were supported for as long as their needs could be met in the service. When people experienced changes that brought about changes in their behaviour, staff had received training to manage this in the least restrictive way. Strategies were in place for all staff to follow, to monitor and record behaviours through the incident reporting process. Staff responses ensured that people remained safe during these incidents and that staff input was delivered in a consistent manner. Referrals for external medical professional support and advice were made and best interest discussions held as to the continued appropriateness of the placement. This was to ensure the person was offered the best possible support for their needs.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The Provider Information Return (PIR) and training records informed us that staff had completed training to understand the MCA and (DLS). In conversation staff understood what mental capacity meant and that some people may need some decisions to be made on their behalf in their best interest. Staff were aware of one person where this had taken place and that a DoLS application had been made and authorised on that person's behalf to keep them safe. Staff were working to the conditions of that DoLS authorisation. People could speak for themselves, staff were observed chatting in easy conversation with people, seeking consent in respect of support they were being provided with. A short mental capacity assessment was completed for each person to highlight if there were any areas where they struggled to make decisions about their care and support. Some people had given their relatives Power of Attorney (POA) and (LPOA) authorisations to act on their behalf should they lose capacity at a later stage to make financial and in some cases health decisions. The registered manager required proof that such authorisations existed and a copy was kept on file.

People and relatives confirmed that an assessment of needs was conducted before a decision was made that these could be met within the service. Relatives thought their loved ones were appropriately placed and their needs were being met, "It's horrible putting someone into care. I didn't sleep well the first night but when we visited the next day they had already settled into a routine it seems very good there, we are generally satisfied, some improvements are needed but not big things."

People's protected characteristics under the Equality Act 2010, such as their race, religion or sexual orientation, were recorded during the assessment, and this was then transferred into the care plan. There were equality and diversity policies in place for staff to follow, and staff received training in this subject as part of their induction to inform their support of people. Once admitted people's needs were continuously assessed to ensure any changes in needs were picked up and that care needs could still be met safely.

The premises were appropriately adapted to meet people's needs. A lift provided access between floors, specialist equipment such as hoists were available to support peoples' day to day care needs which staff had been trained to use safely.

Good

Is the service caring?

Our findings

People told us they were happy living in the service. Comments included, "I am happy, it's more like home. I don't have to go to bed at a set time and l don't have to get up at a set time," "I couldn't be anywhere else, it is lovely here and the staff are so nice" and "It's not a miserable place to be in, it is a happy place." Relatives also commented on how well settled and happy their relative was in the service. One told us that "The staff were always happy and it was a nice place to live." They said that they felt reassured that any minor niggles they might have were insignificant compared to the overall wellbeing of their relative.

People were smiling, laughing and joking amongst themselves and with staff. Staff stopped to have conversations with people on their way through the lounge. People were spoken to in a friendly and respectful manner and asked for their choices and views. We observed staff demonstrating kind and observant care of people, adjusting a cardigan or other clothing to improve people's appearance and dignity. Commenting positively about someone's hair, showing fondness and warmth in their spontaneous contacts with people, by stroking hair or giving people a friendly pat as they went by, kneeling alongside or sitting next to people. All positive signs of respect and of valuing their engagement with people. We saw that staff spoke to people using their preferred names. People told us that staff protected their dignity by always shutting curtains and closing the door when they were supporting them with personal care. They felt comfortable with staff providing their personal care support.

Staff chatted with people engaging them in conversations about current news. A person offered their newspaper to a staff member to share with other people, the staff member approached people to see if they wanted to read it. Staff asked people about the weather and about favourite tv programmes, when collecting people's options for the lunchtime meal they initiated a conversation about puddings that everyone in the lounge joined in, calling out their personal favourites made by the cook. People told us "The staff are friendly, they're very good." "They are very kind and caring, sometimes I wonder where they get their patience from."

Staff were seen spontaneously doing things for people without being told for example a staff member noticed someone's wheelchair had crumbs in it once they had moved the person to an armchair so they took it outside to clean. A relative told us "I would recommend this home again to anyone, there were a few hiccups a few months ago but these were discussed at a relative meeting and sorted out."

We observed that relatives and visitors were made welcome and offered refreshments, condolences were offered to relatives coming to pick up belonging of someone who had died. Where they had travelled some distance were encouraged to take their time. Relatives felt able to approach the registered manager and any of the staff team, they felt that staff kept them informed of anything of importance.

Peoples rooms were personalised to reflect their specific interests and tastes, with small and larger possessions that made them feel more at home and helped them settle in better.

The registered manager and staff were supportive of people who wished to maintain their religious beliefs

and there was a religious service monthly for those that wished to participate. Staff were mindful of those who might not wish to be involved and offered a quiz or another distraction during the religious service. Some people liked the religious service because the people delivering the service "go around chatting to people afterwards." Some people would like the service more often but this was difficult to arrange with the people from the church, most people understood this. One person told us "I have been going to the same church service for ninety years."

Peoples information was kept confidential and secure. Peoples records were electronic and password protected, each staff member was provided with their own login to the computer. A paper copy of the most up to date care plan was kept for each person in the manager's office for quick reference. The office was kept locked when the registered manager or deputy were not on site.

Good

Is the service responsive?

Our findings

Each person had an electronic care plan, a paper copy of the most updated version was also kept in the office for quick reference by staff if needed. People could not always remember if they had been involved in the development and review of their personal care plans. Other people and relatives told us that they were involved as much as they wanted to be, and documentation confirmed this. People told us, "Once a month staff meet with me and ask me questions about my care" and, "Yes, we get asked about the care plan and if we are happy with everything."

Care plans were personalised and focused on people's strengths and what they could do for themselves as well as what they needed support with. They covered all aspects of people's lives and areas where they had needs, to provide staff with a holistic picture of the person they supported and how they liked to live. They reflected people's personal preferences and communication needs. Individual care plans guided staff in respect of health conditions such as Asthma. Morning and night time routines were recorded to guide staff to support in accordance with people's individual preferences. Staff showed that they knew people well. A review of daily notes showed that staff were carrying out tasks in accordance with the care plans. Staff completed daily reports for each shift that reflected on each person's wellbeing throughout the day. Staff handovers alerted staff to any person who was causing concern so they could be monitored more closely.

People received a pack of information about the service when they moved in, this also provided them with information about the safeguarding and complaints process. The registered manager and the Provider Information Return (PIR) informed us that peoples communications needs were assessed before entering the service, if the need for information to be provided in different formats was identified during this process or subsequently this would be provided.

There were activities available for people to participate in. There was an activities programme but this was no longer facilitated by an activities co-ordinator. The provision of specific staff to undertake cooking, cleaning and laundry tasks had given care staff more time to spend with people. This had enabled care staff to get to know the people they supported well. Staff could understand people's specific preferences, what they enjoyed doing and facilitate this with them. Initially staff had been quite reserved about providing activities for people but had become more involved and enthusiastic. Some people chose not to participate for various reasons but staff took time to pass the time of day with people when visiting rooms to complete tasks. There was a regular group of people who enjoyed the activities on offer, we observed an armchair exercise group that people found funny and chuckled about, and we observed staff sitting with people watching a musical and encouraging people to sing along. People told us "The activities are fairly varied." Another person told us that "Staff do activities and external people come in to do activities." "A man comes in to do a quiz." "There is something different every day." People felt that there were more activities on offer now. One person showed us a copy of the old activities programme which showed there was an activity every few days or sometimes only once per week. The new programme showed that there was an activity daily. A person told us "There is only one activity per day, we never have two activities a day." They went on to say, "We are all quite old and we don't want to go to two things a day." Some people told us they preferred to spend time on their own in their rooms, they had visitors and enjoyed using their time how they

wished. Staff ensured they spent time with those people who chose not to participate in activities, whether for short or longer time dependent on each person's preferences. How much time, and the frequency of specific staff input for stimulation unconnected with task based activities was not currently documented, but people expressed no dissatisfaction with current arrangements which suited them..

A complaints procedure was in place, people received a copy of this in their welcome pack and it was also displayed on the information board. People and relatives said they had not had cause to raise a complaint and could speak to staff about doing things differently if this was the issue. They said they would have no hesitation in raising a concern if they felt it was needed. About the complaint procedure people told us, "There is one but I don't know it. I just speak to the manager and let them sort it out"; "I have never had to complain." Another person told us; "They have discussed the complaint procedure with me recently and left me the forms." A relative said "Mums happy if I had any concerns I would go straight to the registered manager." Another relative told us that they spoke to their relative up to four times per day and would pick up any issues quickly if they occurred, which they had not.

A small number of complaints had been received since the service was newly registered in October 2017. The majority provided evidence of a clear process and the outcome of the complaint with actions taken, recording on several lacked details but this had improved on more recent complaints. All complaints had been addressed and resolved. The latest survey feedback from people and relatives indicated that they had no concerns that their complaints would not be listened to and acted upon. Some people did say that minor niggles and irritations expressed to staff did seem to get overlooked, people and relatives thought this to be an oversight by staff who they described as lovely and kind, they said if they really wanted something done they reported it to the registered manager who attended to it straight away. The registered manager however had listened to feedback from people and relatives about staff not always acting upon minor issues they had been asked about. As a consequence, all staff had now been provided with pocket sized writing pads to carry around with them. These were to help remind staff about things they had been asked about so that these did not get over looked in future.

People were encouraged to discuss their end of life wishes, where these had been made known they were recorded in each person's file. The registered manager knew this to be a sensitive matter for people and their families and said they would continue to raise this at review to ensure staff knew people's preferences should they pass away. Some people had made very clear instructions should they need end of life care, with advanced decisions in place. Peoples files contained appropriate documentation to instruct staff and healthcare professionals not to commence 'CPR' (Cardiopulmonary Resuscitation) should this be required. The form was a 'DNACPR'. This enabled people to make an active choice about their end of life wishes. The form was completed with the support and approval of a medical professional. We found three DNACPR that needed review with a medical professional as they were not completed correctly, the registered manager agreed to bring these to the relevant GP's attention for discussion with each person, or their representative.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post. During their recent absence two serious falls had occurred both requiring the people concerned to be admitted to hospital for treatment. Staff acted appropriately in seeking medical intervention for people in a timely way and people received the treatment they needed. The registered manager was aware of the need for these alerts to be made to the Care Quality Commission (CQC) but this had not happened during her absence and was an oversight. The Registered manager assured us that the person left in charge during her absence would receive additional support to understand their responsibilities to report notifiable events in future and this is an area for improvement.

There was an appropriate management structure in place with good support from both the registered provider and an area manager. Registered manager meetings were held where the registered manager could gain peer support and share good practice. The registered provider visited weekly but there was a need to develop better recording of what they looked at, who they spoke with what issues they found and what they had done about it, to demonstrate they had a good oversight of what was happening in the service and were aware of any outstanding actions. The Area manager also undertook regular visits but again their visits and what they did and found were not well documented to provide assurance that they were also monitoring aspects of the service. This is an area for improvement.

The provider had systems in place to assess and monitor service quality, on a weekly and monthly basis. Audits were made of health and safety of the environment, all aspects of medicines management, progress of repairs and maintenance, cleanliness and maintenance of infection control standards, and checks of changes to people's dependency levels and overview of their care documentation. We saw previous audits and noted these were being kept up to date. There was no mechanism for providing an overview to the provider or management team of shortfalls identified through audits, the setting of timescales for addressing these and monitoring of progress towards completion of shortfalls. The impact of not having a robust audit and monitoring system is that some issues may roll over without being resolved in a timely way. The registered provider and area manager were supportive of implementing an action or development plan and agreed to put one in place. This is an area for improvement.

Policies and procedures were in place. Our review of three procedures had highlighted issues with the safeguarding and medicines procedures; this lacked information to appropriately inform and guide staff in accordance with the latest guidance. We drew these to the registered managers attention and these were immediately updated following inspection.

The registered manager and staff were developing relationships with local health professionals such as the dementia team and community nurses. They sought out relevant advice and guidance and acted upon this to inform and improve their practice.

Staff said they felt supported by the registered manager and interactions observed between the registered manager and staff showed that the registered manager fostered an open, easy going inclusive relationship with staff. Staff showed that they were committed to providing a good quality service for people living in the

service. Staff could attend regular staff meetings to give them the opportunity to give their views on how the service was run. Staff thought meetings were informative and inclusive. Meetings were recorded and the minutes made available so that staff unable to attend could see what had been discussed.

Staff thought that communication between the registered manager and staff and between staff was good, daily handovers helped ensure that important information about people who may be experiencing changes in their need was passed on to staff coming on shift to enable them to monitor people's wellbeing if there were concerns, or to ensure appointments were attended.

The registered managers door was open and people and relatives were welcome to drop in to talk with the registered manager when they were available. People, their relatives, staff and professionals were encouraged to give feedback about the quality of the service. We viewed the most recent analysis of surveys conducted earlier this year, this was comprehensive and highlighted areas where actions needed to be taken in response to people's comments and ratings, a summary of the survey analysis was to be posted on the information board for people and relatives to see.

This was the first inspection of this service under its new registration therefore there was no previous rating to display.