Avery Homes WSM Limited

Acer House Care Home

Inspection report

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Ratings

Overall rating for this service	**Requires Improvement**
Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Overall summary

We carried out this inspection on the 12 and 18 March 2015 and was unannounced. At our last inspection in April 2014 no concerns were identified.

Acer House Care Home provides accommodation for up to 60 older people who require personal and/or nursing care. At the time of our visit there were 52 people living at the home. Acer house is set over two floors. The ground floor is called 'Milton' and the first floor is called 'Memory care. The first floor provides care to people who have dementia. It had visual objects outside people's rooms. This related to their life history. There was access at both ends of the corridor to hats and coats. Both floors have access to two passenger's lifts, a care's station and communal areas including a lounge, dining room and kitchens and quiet sitting rooms. There is a central laundry area and main kitchen on the 2nd floor where the food gets prepared and cooked.

The home at the time of the inspection did have a registered manager however shortly after the inspection they deregistered. There is currently no registered

Summary of findings

manager in post. 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 responsibilities for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The senior manager was present during the inspection.

Risks relating to swallowing difficulties were not always accurately identified in peoples care plans and risk assessments. Where one person required a thick and easy prescription to be added to their fluids we found this was not added to the person's drinks every time.

This was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe and they confirmed staff knew them well. Most staff had received training in safeguarding adults and were able to confirm what abuse was and what they should do if they suspected abuse.

There were emergency evacuation plans in place. These had up to date information relating to the person and what help they required in the case of an emergency evacuation. The fire alarm sounded on the second day of the inspection. We found the home's procedure was not followed and people were left unsupported by the appropriate staff. Training was identified and arranged immediately.

We heard call bells being answered quickly and people we spoke with confirmed there were enough staff to help them when they needed it.

Medicines were administered and stored safely and those staff who were responsible for medicines had received training. Staff had a good knowledge of administering medicines

People who did not have the capacity to make specific decisions did not have the principles of The Mental Capacity Act 2005 code of practice followed. This was because best interest decisions and who had been involved in these were not evidenced as required by The Mental Capacity Act.

This was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 11(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS are an amendment to the Mental Capacity Act 2005, which allow the use of restraint or restrictions but only if they are in the person's best interest. All staff we spoke with confirmed no one was subject to any restraint. We reviewed the Deprivation of Liberty (DoLS) applications made by the home. Paperwork we saw confirmed the home was making applications as required by the Law.

There was a comprehensive induction for staff. Staff we spoke with were happy with the training they received. We found not all staff had received supervision in the last 12 months but staff meetings held every two weeks allowed staff access to raise any concerns they had. Staff had access to regular appraisals.

All people we spoke with confirmed how they enjoyed the meals. People had access to different meal options and an alcoholic drink if they wished.

We saw there was a good range of activities within the home. Examples included local garden visits, schools and shops. People we spoke with confirmed how they enjoyed the choice of activities. We observed people taking part in these activities and saw the choice available.

Staff interacted with people in a polite and caring manner. We saw staff responded quickly and appropriately where there was an incident between two people they quickly calmed the situation down.

Care plans included information relating to the person's life history. This included what they liked to do including social activities and their past occupation.

The service displayed in the reception area who was on duty that day. There were pictures of the staff on duty also available behind the carers station.

Not all care plans confirmed when people's representative or relative should be contacted and in what circumstances. One care plan identified when the

Summary of findings

person's spouse should be contacted for example when the person deteriorated but it failed to identify if their spouse required an update in between or what the previous deterioration was.

The evaluation section of the persons care plan failed to trigger and update the main section of to the person's needs and the delivery of care. This is important so that information and changes are not lost over time.

There was a complaints procedure in place and we saw complaints were responded to as required by the home's policy. There was also a suggestions box in the reception area that people could use to make comments about the care they received and make suggestions about improvements.

We found care plans were not used to ensure people received care that was centred on them as an individual. This was because risk assessments and care plans were not being reassessed and amended when there was a change to people's care needs and treatment. This could mean people are put at risk of receiving care and treatment that is not appropriate.

The home did not have a robust system in place to monitor the quality of the service. This included having an audit that identified missing incidents and accidents, incomplete records, and care plans that contained out of date information.

This was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People at risk of not consuming enough food and fluids did not have their charts accurately filled in. This was because charts had missing information relating to totals, dates, and amounts along with being completed in a timely manner

This was in breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not all staff felt able to approach the manager and deputy. Staff had access to the home's whistleblowing procedure but not all staff felt confident they would be supported if they ever needed to use this.

Not all staff were aware of their responsibilities and accountabilities. This was in relation to communication. We found one member of staff thought it was the responsibility for the unit manager to update a family member. The unit manager confirmed this was not the case.

The home had a system in place to review the maintenance of the home. This included equipment, water temperatures and tests, passenger's lifts and the internal call bell system. We saw these were completed and up to date.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People were at risk of receiving care and treatment that was inappropriate and unsafe. This was because people who were at risk of choking did not receive the care that had been assessed.

Records relating to people's care and treatment were not accurately filled in. Food and fluid charts missed having totals and dates and were not filled in accurately putting people at risk.

People told us they felt safe. We saw staff had received training in safeguarding adults and knew what to do should they have any concerns.

Medicines were administered and stored in a safe and appropriate way. Staff responsible for administering medicines had received training and demonstrated a good level of understanding in the administration of medicines.

Is the service effective?

Requires Improvement

The service was not always effective.

The principles of The Mental Capacity Act 2005 were not being followed. This was because those who lacked capacity did not best interest decisions made in consultation with relevant others as required by The Mental Capacity Act 2005.

Staff had regular meetings and appraisals but did not always receive regular supervisions. Staff we spoke with felt they received enough supervision.

People had the choice to either have their meal in the dining area or have it in their room. All people we spoke with were happy with the meal time experience.

Is the service caring?

Good

The service was caring.

We found care was provided in a respectful and dignified manner. People told us they were happy with the care that was provided.

Care plans contained personal information in relation to the person's life history.

There was a staff board updated each day with which staff were on duty and their role.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Summary of findings

We found care plans were not used to ensure people received care that was centred on them as an individual.

Care plans did not always confirm who should be contacted and in what circumstances.

Care plans were evaluated each month and information was added into the evaluation section but was not always updated in the main body of the care plan.

There was a complaints policy in place and we saw complaints were handled through the home's complaints procedure.

Is the service well-led?

Requires Improvement

The service was not well lead.

There were not robust audits in place that identified incidents and accidents. The audits of care plans failed to identify shortfalls and have a clear action plan to address these shortfalls.

Staff had varying experiences from the management. There was a feeling of uncertainty with who was actually in charge. Although the home had a whistleblowing policy in place not all staff felt confident they would be supported should they raise any concerns.

Acer House 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 checked 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 was an unannounced inspection that took place over two days on the 12 and 18 March 2015. It was carried out by three inspectors and an expert by experience on the first day and an inspector on the second day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We spoke with 22 of the 52 people living at Acer House care home, two visitors and six relatives, about their views on the quality of the care and support being provided. We also spoke with the senior manager, one unit manager, two senior care staff, nine care staff, one chef, two activities co-ordinators and two administrators. We spoke with two health care professionals to gain their experience and views of the service.

We looked at 11 people's care records and documentation in relation to the management of the home. This included seven staff files including supervision, training and recruitment records, quality auditing processes and policies and procedures. We looked around the premises, observed care practices and the administration of medicines.

We undertook a Short Observational Framework for Inspectors (SOFI) on the Connect floor. This floor cares for people who are living with dementia. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

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 previous inspection records, intelligence and notifications we had received. Services tell us about important events relating to the care they provide using a notification.

Requires Improvement

Is the service safe?

Our findings

People did not always receive care and treatment appropriate to their needs or that was reflected through a relevant assessment of their need. This was because risks relating to pressure ulcerations, skin deterioration, moving and handling, behavioural and eating and drinking were not clearly assessed and recorded within three care plans. For example for one person whose health had deteriorated there was no information or new assessment that related to how often they should be turned or what to do if their skin was marking. Staff we spoke with gave varying responses. These ranged from the person being turning hourly to two hourly. The main section of the care plan confirmed the person required 4 hourly turns. Other records we looked at confirmed 2 hourly. Turning charts confirmed on one day turns had been provided on the hour, every three hours and every four hours but there was no consistent approach. The care plan did not confirm a relevant assessment of why they had received this inconsistent care. One member of staff we spoke with was unable to confirm why this person was receiving this support and asked the inspector if they needed turning so often. The senior member of staff confirmed the person was being reviewed on every turn and was being turned more if they saw their skin marking. This meant care and treatment was being reviewed when the persons care needs changed but there was no relevant assessments that confirmed this need.

The main section of one person's care plan did not accurately reflect the risk of choking or difficulties swallowing. The care plan confirmed the person had a modified diet with a supplement prescription to help with swallowing their fluids. We found this information had been written into the care plan but the original risk assessment confirmed the person was not at risk of choking and had no difficulties swallowing. We observed the care provided to this person. We found this prescription was not added on three occasions on the second day of our inspection. We spoke with one member of staff who confirmed "X has thick and easy in their juice". This meant the person was not receiving care and treatment as required to met their personal needs.

One risk assessment did not provide current information relating to the persons care and treatment whilst having their care needs met in bed. Staff confirmed this arrangement. The person's risk assessment made no reference to this support or what techniques and equipment staff were using. The main section of another person's care plan identified they could get aggressive but there was no supporting risk assessment in their care plan under behaviour to what staff should do or how they should support this person should they display this known behaviour. We spoke with staff about this persons known behaviour. They confirmed their awareness and how they supported this person. However some people could be at risk of receiving poor care and treatment in relation to their behaviour due to lack of up to date risk assessments although this was reduced by staff knowing people's needs well.

We found that the registered person/provider had not protected people against the risk of receiving care and treatment that was inappropriate or unsafe. This was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9(1)(3)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a system in place for recording verbal and physical altercations. Staff confirmed they would complete an incident form. Staff confirmed what techniques they used to support people and how they would manage the situation. We observed one incident where one person was upset and started to raise their voice with another person within the service. Staff quickly responded to the situation, de-escalating the incident and reassuring the person who was crying and upset after the incident. Staff had a good understanding of dementia and many had become Dementia Friends.

People, relatives and visitors told us they felt safe. They confirmed that staff knew them well, are kind and know what they are doing. They told us, "I feel very safe living here, the carers are nice and kind and know what they are doing". One person told us "the best home in Weston we looked at so many before we chose this one". Relatives we spoke with told us "Things are safe here, the way my relative is looked after is just great, I have not come across a situation yet where staff have not dealt with things, they are so helpful here".

We reviewed the training staff had received in safeguarding adults. We found most staff had received this training. Staff we spoke with confirmed they felt people were safe. They

Requires Improvement

Is the service safe?

were also able to clearly confirm what abuse was and what they would do should they suspect abuse. The manager confirmed one example where there had been concerns raised and how they had worked with the persons Social Worker to ensure the person and other people were safe. They confirmed they attended safeguarding meetings and there was one on the first day of our inspection. This meant the home was liaising and ensuring where there were concerns in relation to safeguarding actions were taken.

There was a business continuity plan in place in the event of an emergency situation such as a fire. They had a reciprocal arrangement with another local home. The contingency plan identified key actions and contact telephone numbers that may be needed. This demonstrated that the provider had considered in detail what actions would be required in the event of an emergency and had appropriate plans in place.

The home had an emergency bag in situ with all associated items staff might need in the event of an emergency happening. Contact details relating to next of kin and employee details, a map of the fire zones and emergency plans were in situ. People's individual personal evacuation plans contained up to date details and what support the person required.

We observed staff responding to the home's fire alarm during our second day of inspection. The service failed to respond according to the home's policy. For example there was very little communication to people and visitors whilst the alarm was sounding. The fire emergency plan for the home confirmed on hearing the alarm the senior carer on each floor is to go to the fire alarm panel located in the foyer area. Other staff to remain on the floor until it is established if there is a fire. This practice was not undertaken. We found most staff located themselves in the foyer area and the senior care staff were not in attendance. This meant people were left unsupported by care staff and there was no clear direction being taken due to lack of senior staff. People could therefore be at risk. The reception member of staff confirmed after the fire alarm all staff have now been put forward for fire training as it identified that not all staff knew what was required when the alarm sounds.

Call bells were answered quickly. People said they felt there were enough staff to help them when needed. Staff said there is generally enough staff and they try to cover shifts amongst themselves. They told us they felt at the weekends there is often less staff around. We spoke with the manager who confirmed each floor has one senior, four care staff and one host on throughout the day and two staff over night. The host was responsible for serving drinks and meals each day this was separate from the care staff rota. We reviewed the last 4 weeks of the staffing rotas. The rota confirmed the services set level of care staff but not the set level of hosts. We found 4 days out of 14 there was only one planned host on shift there was no additional staff confirmed on these days to support with drinks and meals. This meant rotas showed there were times that the service went under its set staffing levels for hosts. Therefore there was potential that people would not receive care and support they needed at an appropriate time on these days.

Recruitment procedures were robust and ensured that only suitable staff were employed. We reviewed seven staff files in relation to safe recruitment practices. We found all files contained two satisfactory references and current identification. All files contained confirmation of checks made to the Disclosure and Barring service (DBS) before employing the new member of staff.

people had their medicines administered safely and in a timely manner. Senior Care staff were responsible for the administering of medication and all had received training. Senior care staff we spoke with were all knowledgeable about their responsibilities. This training involved a formal assessment, observed practice and annual competency assessments to ensure continued good practice.

The home had a current medication policy. All medicines were stored securely and appropriately. Fridges were checked daily with the temperature recorded. These checks ensured that medicines were kept in optimum environmental conditions. We observed the ordering, storage, and disposal of medication was in adherence with the medicine policy. We found the number of drugs recorded in the scheduled drugs book matched the amount in the cupboard. All drugs in the medicine trolley were in date.

The medication audit identified shortfalls. Actions identified had clear timescales and confirmation of when completed. Most people we spoke with were happy with the administration of their medication. They told us, "I get my medicines on time, I'm well looked after and I am very happy here, I love it here," and "I get my medication on time," and "Yes they are very good". One person we spoke with told us sometimes their medication was late.

Requires Improvement

Is the service safe?

We were told two people self-medicated. One member of staff told us "We encourage and support people to be as independent as possible". They confirmed that their medication was kept in a locked cupboard in their own room. The home's medication policy supported people being independent. It stated people should be actively encouraged to administer their own medication and supported wherever possible to administer their own medication in order to maintain their independence. We were told that risk assessments for people self-medicating included if the person needed easy opening bottles, large print labels and other adjustments or support. This demonstrated that risks relating to medication would be assessed and people would be supported to maintain maximum independence in relation to the control and administration of their medicines.

Requires Improvement

Is the service effective?

Our findings

The principles of the Mental Capacity Act 2005 were not always being followed for those who did not have capacity to make their own decisions. This related to three people and four separate decisions. Staff were able to confirm how they gave people daily choice. They felt confident and knowledgeable about the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Care plans confirmed if people lacked capacity but did not record best interest decisions for three people. This is important as it is a requirement of The Mental Capacity Act 2005 (MCA). For example we found one person was receiving 'concealed' medication. This occurs when staff give a person their medicine without them knowing, such as concealed in food. A letter from the person's General Practitioner detailed the need to administer a particular medication in a 'concealed' way. Two other care plans failed to have best interest decisions recorded where staff were adding a thickener to the persons drink so that they did not choke. Both people lacked capacity and were unable to make decisions relating to the need to take this thickener. One person also required best interest decisions in relation to their care and welfare. We found no best interest decisions relating to their care needs and who had been involved in these. This meant the service was not ensuring for those who lacked capacity there was best interest decisions as required by The Mental Capacity Act 2005.

We found that the registered person/provider was not following the requirements under the MCA. This was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 11(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS are an amendment to the Mental Capacity Act 2005, which allow the use of restraint or restrictions but only if they are in the person's best interest. All staff we spoke with confirmed no one was subject to any restraint. We reviewed the Deprivation of Liberty (DoLS) applications made by the home. Two applications had been made at the time of our inspection. One had been granted in the last 2 weeks and the other one was going through the application process. This meant the service was ensuring applications were being made if they considered the person was being deprived of their liberty.

Not all records were being completed accurately. People who were at risk of not eating and drinking sufficient amounts did not always have accurate charts. Information was missing which related to totals, dates, and amounts along with being completed in a timely manner. We found two food charts were filled in before the person had eaten their meal. For example we found one person still had all their food on their plate but the record confirmed they had eaten it all. We spoke with staff about the timely manner in which charts are completed. We had two conflicting responses. One said before the person had eaten and another member of staff said afterwards. We observed the recording of these charts and found that nearly all the recording of meals and snacks were completed after the person had eaten their food. This inconsistent recording meant people were at risk of having inaccurate information recorded regarding their intake of food.

Not all fluid charts had the total intake recorded for the day or were being completed in a timely manner after the person had consumed their drink. One person had been given juice and tea at 8am with their breakfast this amount was not added to the record sheet until 11:15am. We observed the person had received other drink in between this time but the amount consumed was not recorded until much later in the day. Most fluid charts reviewed had no totals relating to what the person had drank that day. This meant people were at risk due to records that were not accurate which also meant they could be at risk of not receiving adequate care and treatment due to poor record keeping.

The registered person/provider was not following requirements under accurate, complete and contemporaneous records. This was in breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed the results of a recent training audit. It confirmed that almost all staff had completed courses in behaviour management and persons centred planning. Personnel files showed most staff had previous experience

Requires Improvement

Is the service effective?

looking after older people and people living with dementia. Some had nationally recognised qualifications and some said they were doing further training with the support of the care home.

Training was managed well at the home. Staff confirmed they had attended a three day induction programme before they started working with people. This included health and safety, moving and handling and some training about people living with dementia. Following the induction programme staff undertook shifts shadowing care staff. They told us "I shadowed a member of staff and during that time we are considered supernumery" and "I had three days solid training before starting work when I first started". This allowed staff the opportunity to ask questions and review if there were areas for development.

The service had a comprehensive staff training policy dated October 2014. It gave details of what training should be undertaken and when this should occur. Overall the staff were happy with the training they had received. They told us "Out of all the homes I have worked in this one has given me the best training experience" and "Yes, it's fine no problems, we have face to face training in a group and I am up to date" and "I think the training is good, I'm doing a NVQ level 3 and the company are paying for me". Not all staff we spoke with confirmed they had received end of life training. Those staff who had received training confirmed what a benefit it had been to their practice. One member of staff said "I have visited a hospice for three day course". They confirmed how beneficial this had been to their development and practice. 14 care staff had attended end of life awareness training in November 2014 The manager confirmed more training was going to be available and that they would be ensuring all staff had access to training throughout the year.

Staff confirmed they had an annual personal development review (appraisal). The supervision matrix showed staff were receiving supervision. Most staff we spoke with confirmed they had received supervision recently and that they received enough supervision. There were themed supervision topics which the manager discussed with staff.

Staff meetings were held every two weeks for care staff. Minutes of the last staff meeting confirmed requests from staff for training and action required. Requested training included catheter care, pressure area care, Dementia, Parkinson's disease and first aid. Some actions were still outstanding we saw these had been added to the next meetings agenda. The manager had started to look at training dates available and would be letting staff know over the next few weeks. Staff had access to the Home's policy on pressure ulceration. Staff who had read the policy had also signed to confirm they had read it. This meant staff had access to information and policies prior to receiving formal training.

The home provided an environment that was appropriate for those it supported. Decoration was of a high standard throughout the building. There were two floors. People living with dementia lived on the first floor. This was called Memory Care. There were objects of reference outside of people rooms in a glass coloured box. This contained items that were personal to them. For example where one person had been a teacher there was an easel and for someone else there was a horse. At the end of each of the corridors there was a selection of hats and clothing. The unit manager told us people like to pick up the hats and walk around with them on. One room had vintage items such as an old school table, guitars and old pictures of the local area. There was a large lounge on each floor. There was another smaller lounge which had books and comfortable chairs in throughout the day people came and went throughout these different areas of the home.

We observed people having their lunch in a relaxed and friendly atmosphere. People were supported to make choices and care staff were constantly chatting and engaging with people which made a pleasant atmosphere. The chef confirmed all food was prepared in-house using fresh ingredients where possible. They also confirmed they had records detailing specific dietary requirements for individuals including those with allergic reactions and diabetes. Specially prepared puddings were available and they confirmed fresh fruit was also an option. People were shown small display plates with the meal options so they could visually pick what lunch they wanted from these options. People had choice to either have their meal in the dining area or have it in their room. All people we spoke with were happy with the meal time experience. They told us "Good food and the most beautiful cakes, they really look after us well here" and "Food sufficiently varied, satisfying and presented in good shape". A group of people told us how much they enjoyed their meals and how important good food was to them.

People confirmed they valued their meal time experience. They told us, "'I enjoy sitting with my friends, we sit

Requires Improvement

Is the service effective?

together and have a good old chat, we have a glass of wine if we want and the girls look after us well" and "I really look forward to meal times it is a real social occasion". Visitors we spoke with also confirmed how happy they were with the food, they told us "they look after X well, good food". We observed drinks were readily available to people throughout the day along with fresh fruit in the communal areas.

Staff told us people had regular access to health professionals dependent on their needs. One member of staff confirmed how they access the district nurses. records confirmed visits made by three different professionals in relation to this persons health. If a person had more than three falls a request was made to the person's General Practitioner (GP) for a referral to the falls service. On checking a person's case notes we noted this had been done and that the GP had also requested a physiotherapy assessment. This demonstrated good communication and appropriate referrals when people fell.

Health needs in relation to a person's medication was being effectively handled. We found where a request had been made by a District Nurse to record one person's blood sugars this was recorded in the person's care plan. This had been done as required, apart from when the individual had refused. This demonstrated that professional requests in relation to medicines were being accurately communicated and recorded.

We spoke with one health professional about the communication and referrals they received. They felt communication was not as good as it could be as staff were not prepared for their assessment visit recently. This meant information was not easily available and had to be requested and found. They did confirm the referral made was appropriate and made in a timely manner.

Good

Is the service caring?

Our findings

Staff interacted with people in a kind, caring and polite manner. We saw a good rapport between staff and people that demonstrated staff knew people well and how best to support them. On the first floor 'Memory care' an incident between two people where they become upset with each other was managed well. The member of staff quickly responded and de-escalated the situation. The member of staff spoke sensitivity and in a calming manner which defused the situation and calmed the person down.

Staff were relaxed and gave people the time they needed to respond when talking to them. All staff treated people with dignity and respect. For example staff knocked before entering people's rooms they also provided assistance and support in a relaxed and quite way so that people's needs were respected.

Care plans included a section on the life histories of people. They also contained information relating to the persons likes and dislikes ranging from what they liked to eat, what time they liked to go to bed, their friends, social activities and how they preferred to communicate and by their preferred name. It also included their occupation if they had one. Staff were able to tell us about these preferences in a respectful manner and we observed this practice.

People said they were happy with their care and felt well looked after. They told us "well looked after" and "staff would always help if I wanted to do something" and "I am satisfied with my care here and with the care I get" and "the carers are kind and cannot do enough for me," and "Staff are always there to help, they come quickly if you need them." Relatives we spoke with also confirmed how satisfied they were with the care. They told us "very good care here, on the ball know what X wants" and "the staff are kind and go out of their way to give X the things they need and want. The way X is cared for is great".

People we spoke with throughout the day confirmed how they make their own choices. We observed carers spending time with people supporting them to make choices and decisions. The process was unhurried giving people time to think and talk about their wishes. When people were not able to make their views known we found care plans reflected information from those close to them. This meant people were supported to express their views and information in relation to their wishes had been gathered.

People looked well presented. We saw them receiving help when it was needed. For example when in the dining room whilst having their meal and when walking throughout the home. People were given choices. For example, what time they got up, what help was required and what they had to eat.

We observed a board in the reception area that detailed who was on duty. It also confirmed the role of the staff on duty by the uniform they wore. This helped people living in the home to know the seniority of staff looking after them.

We were told the home had Dignity Champions. Information was taken from the Provider information return form (PIR). This confirmed the dignity champion's role was to act and influence others to understand the importance of respecting people in a dignified way. Not all staff we spoke with were aware of who the dignity champions were or their roles This meant although some staff were trained to challenge any poor practice and escalate concerns some staff were unaware this was in place.

Requires Improvement

Is the service responsive?

Our findings

We received information prior to the inspection that relatives were not always being contacted when required. We found care plans did not always confirm who should be contacted first and in what circumstances. Care plans contained clear details relating to the persons next of kin and other relatives. One care plan confirmed the person's spouse was to be contacted when there was a change to the person's condition. We spoke with staff about when they would contact this spouse. They confirmed they would contact them when the person deteriorated. Their care plan gave no guidance which related to what was defined as a change in their condition. We reviewed their records. Over a period of the last two weeks their condition had deteriorated significantly. There was no guidelines in place to identify what was a deterioration and when staff should trigger calling the relative. This meant relatives and significant others might not be contacted when required due to inadequate guidelines that clearly identify the circumstances when someone should be contacted.

Care plans had an evaluation section which showed monthly reviews had been undertaken. However we found these evaluation sections failed to identify where the main section of the care plans required updating and changing. Therefore although each section of the care plan was being reviewed it did not trigger amendments to the main sections of the person's care plan. This meant people's care plans did not accurately reflect their care needs.

Pre assessments were undertaken with people and their significant other. Care plans contained information from those pre-assessments. Staff told us that before people came to live in the home they were visited by the registered manager and a senior member of staff to complete the pre-assessment process and documentation. They confirmed this provided basic information for individualised care planning.

Staff told us that resident and relatives meetings took place every 6-8 weeks. Dates of these were displayed on the notice board. Dates were also circulated to each person via the newsletter which was distributed to their rooms. This ensured everyone was aware of the next meeting. where people had made suggestions at these meetings actions had been taken.

The home had a complaints policy in place and all complaints went through this process. People and relatives felt able to make a complaint and that it would be taken seriously. a suggestions box was in the reception area with cards that could be completed to give feedback. There was also a photo album and folder of letters and cards from people and their friends and families thanking the service for the support received.

There was an extensive activity programme. One dedicated member of staff was responsible for the activities and two other staff supported them. Activities reflected many people's likes and interests which were recorded in their care plans. Internal activities such as arts, theatre groups and the local chaplain were arranged by the home. Staff told us they are able to arrange different church visits should the need arise. External activities such as, garden visits, local schools, shops, church visits and attending the local stroke and dementia group were available. People took an active part in an art class and going out of the home to planned activities. External activities were facilitated by the home having its own minibus. People told us "activities nice music playing, very lovely here".

We observed a number of visitors at the home throughout the day and they were all made welcome by staff. We also saw a board in the reception area which had pictures of the different staff uniforms so that people could identify who was who. There was a named key worker system who was responsible for discussing any concerns and changes to that person's care needs and care plan.

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Our findings

There was a lack of robust audits which identified areas of concern. Areas of concern included missing incident and accident forms, records, mental capacity assessments, and care plans that reflected people's care and treatment. The manager confirmed they were responsible along with the deputy for undertaking all the audits within the home. The regional manager visited every month for a day or two. They would walk around on these days, speaking to staff and seeing what was happening in the home. They would also discuss any area of concern which had been raised through the home's online quality reporting system. If areas were identified on the reporting system or audits this would trigger a service action plan. We asked them for a copy of the recent audit completed prior to our inspection and three care plan audits and their action plans. We were sent confirmation that every care plan had been evaluated for the months of January, February, March and April 2015 but there was no audit for these three care plans. The manager confirmed care plan evaluations do not have action points obtained. This meant that the evaluation process had not identified areas of concern relating to people's individual care and treatment. The lack of robust quality audits meant there was no action plan in place to address these shortfalls or to ensure they did not happen again.

Not all incidents and accidents were being logged through the home's online system. The manager confirmed all incidents and accidents should be logged and that this was their responsibility. We found two incidents relating to one person's physical behaviour were missing from the home's online recording system. One of these incidents should have been logged by the service as a significant event due to the nature of the event. We asked the regional manager what system they had to ensure all incidents were logged. They confirmed that incidents would be handed over on staff handover and that the manager would identify those missing when they undertook care plan audits. We were sent the quality indicators for the months of February, March and April 2015 and found these two incidents had failed to be identified and recorded through the home's recording system. No associated audits had been completed which meant that the areas of concern had not been identified. Due to the lack of Care plan audits, concerns such as people's changing needs, their assessments relating to risks of eating, drinking and swallowing along with lack of best interest decisions for those who lacked capacity had not been identified or did they have a clear associated action plan to address these shortfalls.

We found that the registered person/provider did not have robust systems in place that identified shortfalls and ensured the quality of care was maintained. This was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17(1)(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not all staff we spoke with were able to confirm the managements arrangements within the home. Staff had varying experiences and expectations of the management team. Some staff felt very happy to approach the manager and deputy manager others felt unsure of who was actually in charge. Staff told us "I would go to the deputy or manager, they are accessible" and "yes the managers are very nice". Others told us "I don't always feel I get support or know who to go to" and "sometimes I think more support would be nice from management" and "it is unclear who is actually in charge". External agencies that we spoke with confirmed the manager would be the person who they would go to should they need to discuss any area of concern within the home. There was a Manager and deputy manager at the home. The deputy manager was the Registered Manger with CQC. The Registered Manager applied to cancel their registration as Registered Manager during the inspection period. This has been processed and so currently there is no Registered Manager at the home. The manager explained that advertisements were in place for a new Registered Manager they would also have the managers job role.

Surveys were sent to people in order to gain their feedback about the service. This had last been collated in November 2014. Out of the 54 surveys sent 22 people had returned it. The questionnaire covered areas such as the transition to moving to the home, feeling at home, room temperatures, environment and if people and relatives were welcomed, laundry facilities and call times. Out of the responses collated 79% of those responses were in the good to excellent categories.

The home had a Facebook account. family and friends were kept up to date through this website. It allowed direct

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comments to be made. One relative commented in the annual survey that Facebook had allowed them to see what activities their family member had been enjoying this they felt was positive.

The service had on display in the staff room the homes whistleblowing procedure. Not all staff were able to confirm the home had a whistleblowing policy in place or felt they would be supported should they raise any concerns. We fed this back to the manager.

Not all staff were aware of their responsibilities and accountabilities. This was in relation to communication and keeping family members up date. We spoke with the unit manager about what the current arrangement was regarding communication with one person's spouse. They confirmed it would be the senior on duty that day to report any update to this person. We spoke with them regarding who they felt was responsible to communicating with the persons spouse they said they thought it was the unit manager. We fed this back to the unit manager who confirmed they would clarify to the staff member this was their responsibility.

The home had a system in place to review the maintenance of the home systems. This included moving and handling equipment, water temperatures and tests, passenger lifts and the internal call system. We saw the environmental audit identified where external paths required maintenance and clearing. There was a clear action plan with timescales set to achieve this work.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The registered person/provider must take proper steps to ensure that care and treatment of service users must be appropriate, meets their needs and reflect their preferences. An assessment of service users care and treatment as well as preferences must be in place. Regulation 9(1)(3)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The registered person/provider must make sure if the service user is over the age of 16 and is unable to give consent because they lack capacity to do so, the provider must act in accordance with the 2005 Act. Regulation 11(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person/provider must have systems or processes established and operated effectively to ensure risks relating to the health, safety and welfare of service users and others who may be at risk. Regulation 17(1)(2)(b) They must also ensure accurate, complete and contemporaneous records are in place for each service user. Including a record of the care and treatment provided to the service user. Regulation 17(2)(c)