M D Homes

Carrick House Nursing 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

Summary of findings

Overall summary

The comprehensive inspection of Carrick House Nursing Home took place on the 5 and 6 April 2018. The first day of the inspection was unannounced.

Carrick House Nursing Home is a 'care home' it provides nursing care and accommodation for a maximum of 24 people. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission [CQC] regulates both the premises and the care provided, and both were looked at during this inspection. During our visit there were 21 people using the service, some of whom were living with dementia. People's bedrooms are located on two floors. There is a passenger lift to assist people to access their bedrooms located on the upper floor. People have access to safe outdoor space and the home is located close to shops and public transport.

At the last inspection 27 June 2017 we rated the service requires improvement. We found improvements could be made in the quality monitoring systems, and we made two recommendations. One referred to reputable guidance about ways to decide appropriate staffing levels for the service and the second was about improving the environment to make it more suitable for meeting the needs of older people including those living with dementia.

Following the last inspection the provider informed us about the actions that they were taking to make the necessary improvements to the quality of the service. We found during this inspection that improvements to the service had been made and some were in the process of being achieved.

The service does not have a registered manager. A registered manager is a person who has registered with the CQC 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. The manager has been in post since December 2017. She has started the process of registering with us.

Arrangements were in place to ensure that people received the medicines that they were prescribed. However, we found some shortfalls in the management of people's medicines.

It was not evident that all the people using the service were supported to take part in a range of preferred and meaningful activities.

Some people were very dissatisfied with the meals that were provided by the service.

The service had clear procedures to support staff to recognise and respond to abuse and keep people safe. Staff had completed safeguarding adults training and knew about the whistleblowing procedure. They knew how to identify abuse and understood the safeguarding procedures they needed to follow to protect people from harm.

Risks assessments were carried out. These identified potential risks to people and strategies were in place to manage these risks to minimise the risk of people being harmed. Staff understood their responsibilities to deliver safe care and understood their duty to report all potential risks and other safety concerns so people were safe.

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. Staff gained people's consent before providing personal care.

Staff knew people well. People's care plans were up to date and included details about people's individual preferences and other information that staff required to provide people with the care and support that met their individual needs.

People's healthcare needs were assessed and monitored closely. The service worked with healthcare and social care agencies to ensure people's needs were met.

Staff understood the importance of treating people with dignity and protecting people's privacy.

Staffing levels and skill mix provided people with the assistance and care that they needed. Appropriate recruitment procedures including a range of checks were in place to ensure that only suitable staff were employed to provide care.

Staff received an induction and the training and support that they needed to develop their skills and to carry out their roles and responsibilities.

People and their relatives had opportunities to provide feedback about the service, which the manager used to drive improvement. The provider had a process for dealing with complaints.

There were systems in place to assess, monitor and improve the quality of the services provided for people.

Some areas of the interior surroundings had been improved but there were areas which remained tired looking.

We found two breaches of regulations relating to the management of medicines and to do with the activities provided by the service.

We have also made a recommendation that the provider seeks advice and guidance from a reputable source about ways to improve and develop the meals provided by the service so each person including those living with dementia received food and drink that met their needs and preferences.

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

Further information is in the detailed findings below.

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 not always protected by the proper and safe management of medicines.

Systems were in place to keep people safe and protect them from the risk of abuse.

Risks to people were identified and measures were in place to minimise the risk of people being harmed. Learning from incidents took place.

People were supported by staff who had been carefully recruited.

Is the service effective?

Requires Improvement

There were areas of the service which were not effective.

Alternative food choices were available to meet people's preferences. However, some people were not satisfied with the meals provided by the service.

People received support from staff who were appropriately trained and supported to perform their roles and responsibilities in meeting people's individual needs.

Staff sought people's consent before providing care and support.

People were supported to access advice and treatment from a range of healthcare professionals to ensure that their health needs were met.

Is the service caring?

Good

The service was caring.

People were treated with kindness and respect.

People were respected and involved as far as possible in planning and making decisions about their care. Staff knew people well and understood their preferences and individual

needs.

People's dignity and privacy were respected.

People's relationships with those important to them were supported.

Is the service responsive?

Requires Improvement

There were areas of the service which were not responsive.

It was not evident that people had the opportunity to take part in a range of preferred activities that met their preferences, minimised the risk of social isolation and enhanced their well-being.

People's needs were assessed with their involvement before they moved into the home. People's care plans were reviewed regularly to ensure they continued to meet people's needs.

People and their relatives were listened to and their concerns were taken seriously and addressed.

Is the service well-led?

Requires Improvement

There were areas of the service which were not well-led

There were a range of processes in place to monitor the quality of the service and drive improvement. However, some improvements to the service were needed and shortfalls had not been identified by checks carried out by the service.

The manager was new to the role of running the service. They understood their role and responsibilities and was in the process of making a significant number of changes to improve the service.

The manager provided staff with the support and direction that they needed to meet the needs of people using the service.

Carrick House Nursing 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 was a comprehensive inspection: It took place on the 5 and 6 April 2018. The first day of the inspection was unannounced.

The inspection was carried out by one inspector, a specialist nurse advisor and one expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we looked at information we held about the service, including statutory notifications that the provider had sent to us; a statutory notification is information about important events which the provider is required to send us by law. We also reviewed information sent to us by others, including local authorities that commissioned care services for people from the provider.

Due to us changing the inspection date we did not ask the provider to complete a Provider Information Return [PIR]. However, the service had completed a PIR in 2017. The PIR 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.

During the inspection we observed interactions between staff and people who used the service on both floors of the Carrick House Nursing Home. As some people were not able to tell us about their experiences, we used the Short Observational Framework for Inspection (SOFI) in the lounge area of the home. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

During the inspection we spoke with the manager, a provider representative, three nurses, cook, ten people using the service, one senior care worker, four care staff and three people's relatives face to face and four via the telephone.

We also reviewed a variety of records which related to people's individual care and the running of the service. These records included care files of nine people using the service, four staff records, audits and policies and procedures that related to the management of the service.

Requires Improvement

Is the service safe?

Our findings

A person using the service told us, "I feel safe as I'm in bed a lot of the time and getting medicines on time."

Nurses administered people's medicines. They told us and records showed that nurses administering medicines had their competency assessed to ensure that people's medicines were managed and administered safely. We saw that when administering people's medicines nurses explained what they were doing, were patient and provided people with a drink and other support they needed. A person's relative told us, "I believe they are giving medicine to [person] on time."

People's medicines were stored safely and medication administration records [MAR] showed that people had received their medicines as prescribed. Information about each person's medicines was gained during their initial assessment and any allergies were recorded in the person's care plan and MAR. However we found some shortfalls in the management of people's medicines. We noted that some people who had been prescribed a medicine to have 'when required' [PRN] had a written protocol in place which included guidance for nurses to follow to ensure medicines were administered safely, but there were four people who did not have written PRN protocols for five PRN medicines. These were completed during the inspection. We also noted that a running total of the stock of a PRN medicine was incomplete, which meant that there was not a clear audit trail for each of the PRN doses of that medicine. Such an audit train would to confirm people had always received their prescribed dose and that each tablet had been accounted for.

We identified that another person was prescribed a medicine administered topically via a patch. Each patch dose needed to be administered on a different area of the person's skin to minimise the risk of the skin being harmed. The nurses had recorded when they had changed the position of the patch, but there was no record on a body map or detailed record to show exactly where the patch had been positioned and so minimise the risk of the patch being administered in the same area of the body. Records were not provided to confirm that the previous patch had been removed and show that there was no risk of the person receiving more medicine than prescribed. Two people's MAR did not record the maximum dosage within 24 hours for two PRN medicines, which could mean people were at risk of receiving an unsafe amount of the medicine. A person prescribed medicine for a medical condition was having their blood sugar monitored but it was not clear what action needed to be taken if the blood test indicate a high or low blood sugar level. The recent medicines audits carried out by the service had not identified these shortfalls.

The above is evidence of a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Systems, processes and practices to safeguard people from abuse were in place. Staff knew about different types of abuse. They told us that they would report any concerns about people's well-being or safety to the manager. They also knew that they could report allegations and suspicion of abuse to the host local authority safeguarding team, police and the CQC. Records showed that staff had received training about safeguarding adults. A member of staff told us about the safeguarding adults training that they had received. The contact details of the host local authority safeguarding team were displayed in the home so the

information was accessible to people and staff.

The service did not manage people's finances. People's relatives or local authorities managed people's monies. Information about those who had Lasting Power of Attorney and could legally make decisions about people's finances and health on their behalf was available. Some people chose to manage small amounts of their own cash and this was documented in their care plan and risk assessment.

Accidents and incidents were recorded and addressed appropriately. Staff understood their responsibilities to report and record incidents. Records showed that the manager regularly reviewed incidents and took action to minimise the risk of similar incidents recurring. The manager told us that lessons were learnt from incidents and informed us that there had not been any falls within the home for several months.

Risks to people were identified and managed so that people were safe. Risk assessments related to a range of areas to do with people's care and safety. They included risks of people falling, use of bedrails, smoking, behaviour, wandering and moving and handling. People's risk assessments included preventative actions that needed to be taken to minimise risks and detailed measures for staff to follow on how to support people safely. Risk assessments were regularly reviewed. Some people who did not require bedrails had them on their beds, which could be of risk to their safety if they were used without a bedrail assessment having been completed. During the inspection the manager was responsive in taking action to ensure these bedrails were locked or removed.

There were effective recruitment and selection procedures in place to ensure people were safe and not supported by unsuitable staff. We checked four staff's records, which showed appropriate checks had been carried out. These included criminal record checks, references and proof of identify and right to work in the UK.

We looked at the arrangements in place to ensure there were sufficient staff on duty so people received the care and support that they needed and were safe. Night and day staff we spoke with told us that although they were busy at times they felt that there were sufficient numbers of staff on duty to ensure people's needs were met. A care worker told us, "Sometimes it can be short here but we work as a team." People told us that there were times when staff were particularly busy. They commented, "The care is good, the staff are very caring but sometimes they are very busy or not sufficient in number" and "There are enough people here to look after me." They also told us that they sometimes had to wait after pressing their call bell, "because they [staff] may be busy with other patients."

Throughout the inspection call bells were answered promptly and there was no indication that people's needs were not being met by the service. Staff supported people with their meals and personal care needs. The atmosphere was calm and people were not observed to have been rushed by staff. The manager told us that she ensured the staffing numbers were kept under review and additional staff were provided when people's dependency needs increased and when people needed staff to accompany them to an appointment.

Systems were in place to monitor the safety of the service. Records showed necessary checks such as gas checks, fire checks and electrical checks were carried out. The service had an up to date fire risk assessment. Routine fire safety checks and fire drills took place. People had personal emergency and evacuation plans (PEEP) which detailed the support people would need if the building needed to be evacuated in an emergency. The service had a business contingency plan which specified the arrangements in place for responding to a range of emergency events such as gas and water leaks.

The home was clean and was free from unpleasant odours. We reviewed the systems that the service had to ensure people were protected from the risk of infection. Staff had completed training on infection control and food hygiene. To minimise the risk of cross infection, protective clothing including disposable gloves and aprons were used by staff when assisting people with personal care and when working in the kitchen. Hand gel dispensers were located throughout the home. We noted that in a bathroom there was a bottle of hand soap. Ensuring that hand washing solution is only accessible in appropriate dispensers minimises the risk of people using the service drinking the contents. The manager told us that due to people's current needs there was little risk of people being harmed and after our visit informed us that they had addressed the issue.

An environmental cleaning schedule and regular cleanliness checks were carried out. Where areas required attention, records showed actions were put into place to address deficiencies.

Requires Improvement

Is the service effective?

Our findings

People spoke in a positive way about the staff and told us they provided them with the care and assistance that they needed.

People's care documentation showed that people had received a comprehensive initial assessment of their needs and preferences before moving into the home so the service could determine whether the needs of the person could be met by the service. Records showed that people and where applicable family members had participated in these assessments. The assessments included details of people's health and care needs, for example personal care, communication, religion, social interests and medical needs.

People's care plans and risk assessments were written based on the assessment. Staff told us they were provided with verbal information from the manager and nurses about the needs of people moving in to the care home. They were aware of how to access people's care plans when needed. A care worker told us that they wouldn't hesitate to ask nurses about people's care when they required more information about a person's needs. 'Welfare monitoring charts' showed people received a range of care from staff each day. However, records that showed people had received baths and/or showers and mouth care were incomplete. The manager and care staff told us that people received regular baths and mouth care and that they would develop the welfare monitoring records to include that information to ensure that it was evident people had received those aspects of personal care.

People's care plans included information about people's needs and preferences. Staff were aware of people's needs and wishes. They told us about how they supported people to make choices, which included when they wished to get up, what they wanted to do, eat, drink and wear. We heard staff offer people choices during the inspection.

Risks to people's skin integrity were identified and assessed; suitable pressure relieving equipment was used to reduce risk of pressure ulcers. Wounds were closely monitored and tracked for healing or deterioration and dressed in line with the wound care plan. Records showed that GPs and a tissue viability nurse had been involved in wound management and treatment. The manager had taken action to develop and improve wound care. Detailed wound care plans were in place. Photographs and body maps were used in the process of monitoring and treating wounds. The tissue viability nurse visited a person using the service during the inspection.

The home used a number of standardised evidence-based tools to assess people's nutritional needs and risk of developing a pressure ulcer. These assessments were reviewed at least monthly to check whether people's needs had changed. Regular reviews of people's dependency needs were also carried out. Care plans were put in place when these tools had identified a high risk of a person being malnourished or of developing a pressure ulcer. People had their weight monitored and any concerns were reported to a GP.

Records showed that people who lived with diabetes had care plans in place that included details of symptoms of the condition and guidance for staff to follow in response to these. The care plans described

the need for high fibre/low sugar diet and good foot care and regular eye checks.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA. We saw that people's capacity to make decisions about their day to day care needs were recorded and details about any difficulty people had in retaining information was documented. We saw a record of a decision about a person receiving care and treatment in the care home had been made in the person's best interest by family and staff.

Staff we spoke with had some knowledge of the MCA. They knew that decisions could be made by healthcare professionals with family and staff if people did not have the capacity to make particular decisions. Staff knew to report to nurses and/or the manager if they found people's ability to make day to day decisions about their care and treatment had changed. We heard staff ask for people's consent before providing support.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Records showed that seven DoLS had been authorised and that there had been further applications made.

Where a Lasting Power of Attorney (LPA) had been appointed to make certain decisions on a person's behalf this was documented so the service was aware of the people authorised to make decisions on behalf of people using the service when they were unable to make decisions themselves.

Staff told us that when they had first started work they had received an induction. They told us that they had shadowed more experienced staff and that the induction had been useful in preparing them for carrying out their role and responsibilities. A care worker told us, "I had a two week induction. It was good." Records confirming staff had completed an induction were available. The manager informed us that when new care staff were employed she would ensure that they completed the Care Certificate induction. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of care staff in the health and social care sectors.

Staff had received training relevant to their roles and responsibilities so that they delivered effective safe care. They spoke in a positive way about the training and learning that they received. A nurse told us that they received the training that they needed to remain a registered nurse and that they kept up to date with good practice. They spoke of having recently undergone a medicine competency assessment and received wound care training.

Some staff had completed, or were enrolled on a nationally recognised qualification in health and social care. The manager told us that they encouraged and supported care staff to achieve health and social care qualifications and informed us that four staff were currently in the process of completing them.

Staff told us, and records confirmed that they received regular supervision. Supervisions were used to discuss with staff members their understanding of their role, training and any concerns they may have to do with the service. Best practice in a range of topics that included; record keeping, dignity and respect, pressure ulcer management and person centred care had been discussed with staff during these meetings.

Staff told us that they were able to contribute to team meetings, speak up about any issues to do with the service and raise any topics that they wanted to. A member of staff told us that they had received an appraisal in 2017 of their performance and development needs. Staff told us that they received the support they needed. A member of staff told us, "I feel well supported." Another member of staff told us, "I am very happy."

People's care plans and other records included information about each person's health needs and showed that people's healthcare needs were monitored by staff and community healthcare professionals that included GPs, chiropodists, dietitians, and opticians. Each person was registered with a local GP. Records showed that GPs regularly carried out visits to the service to review people's needs and provide advice and treatment when needed. People told us that staff would contact the GP when they were ill. A chiropodist and a tissue viability nurse visited the service during the inspection.

There was a menu and details about the meals of each day were written on a notice board in the communal dining room/lounge area. We noted that people had time to eat their meal at the pace that they wished. Regular hot and cold drinks were served throughout both days of the inspection.

The cook was knowledgeable about people's particular dietary needs including their dietary cultural preferences. People's food allergies and/or food intolerances were identified and communicated to kitchen staff who displayed the information for all staff.

Records showed that people were offered alternative meals that met their preferences and cultural needs. For example on the 2 April 2017 six people had received an alternative to the supper menu. A relative told us, "My [relative] likes their food." However, a person's relative and three people we spoke with were not happy with the quality of the meals and told us that there was a lack of choice. One person complained about the lunch they received and was offered an alternative. Two other people were critical about the meals and told us, "Food isn't good," and "I don't like their food too much carbohydrate and less protein." The cook told us that they asked for feedback from people after meals but they were unable to provide us with records of people's feedback or of any action taken to address any negative feedback about the meals.

We noted that people either ate in their bedrooms or in the lounge and not at the dining room table. Staff told us that people preferred not to eat in the dining room but we did not hear this choice being offered during the inspection.

Following the inspection the manager told us that they had reviewed and improved the menu and had included nutritional advice from a dietitian. The manager supplied us with some pictures of the meals from the new menu which they planned to display so people who found difficulty in reading could gain information about the meals by looking at the pictures. The provider's representative told us that he would ensure that a comprehensive review of the meals was carried out and action would be taken to ensure all the people using the service were happy with the meals.

We recommend that the service seek advice and guidance from a reputable source about good practice that ensures people including those living with dementia received food and drink that met their needs and preferences.

The home was warm and well maintained. Toilets had raised seats and hand rails to help people maintain their independence. There was picture signage that indicated the use of each room, however these signs were small and were not always positioned so people could read them easily. The manager told us that she had recently ordered new better signage.

Some redecoration had taken place since the last inspection and the flooring in two people's rooms had recently been renewed. However, a person's relative told us they felt that the carpet in the person's bedroom needed replacing and we observed that there were some areas of the home including some people's bedrooms that were tired looking, lacked colour and other features that could promote people's well-being and be more suitable for people living with dementia.

The manager also told us that they planned to introduce memory boxes for each person which would include significant personal items to do with their life to help them recall a range of memories.

The manager told us about the imminent plans to update and improve the reception and lounge and dining areas. The provider's representative confirmed that the planned improvements would be made this year. Following our visit the manager supplied us with photographs which showed some improvements had been made to the décor of the reception area and layout of the dining room since our visit.

Good

Is the service caring?

Our findings

People's relatives told us that they had no concerns about the way staff engaged with people. Relatives also told us that the staff kept them informed of any changes in people's health or wellbeing. Comments from people's relatives included, "The standard of care here is okay," and "I am satisfied with their service."

A person told us, "This is my home, I am happy with the staff, they are very helpful. I don't have any problem." Another person told us, "The staff are okay."

During general observation and SOFI we saw positive interaction between staff and people using the service. Care workers spoke kindly and sensitively with people, while they assisted them with their meals and care. We heard staff say good morning to people and ask them if they were all right and whether they wanted any assistance. However, most interaction between staff and people was tasked based, there were not many occasions when we heard staff have more than a few words conversation with people.

We spoke with staff about whether people could choose whether to get up early. A night care worker told us about how they listened to people's views and respected their choices. The care worker told us that they always asked people if they wanted help with personal care when they woke up early morning. They told us that when people were unable to verbally communicate their choice they knew the people using the service "so well" that they were able to determine the person's decision from their gestures and behaviour. They also told us, "I know some people like to have their curtains drawn early morning and get up." When we started the inspection at 7.10 am three people had been supported with care. One person nodded when we asked them if they were happy with getting up early.

People were given the time they needed to communicate their requirements and eat their meals. Staff had a good understanding of what privacy and dignity meant in relation to supporting people with their care. We saw staff ask people if they required support, for example with personal care, in a discreet way, respecting people's dignity. Staff knocked on people's bedroom doors and made sure that doors were always closed when people were receiving assistance with their personal care. A person told us, "They always knock on my door and ask if they can come in."

Two bedrooms were shared by people. Records showing that they had consented to sharing a bedroom were not available. When we asked a person if they were happy sharing a room they told us that they were. The manager told us that the people concerned had shared the rooms for some time and after our visit told us that their consent to continue to share a room had been obtained and recorded.

Staff were aware of the importance of confidentiality. They knew not to speak about people to anyone other than those involved in their care. People's care records and staff records and other documentation were stored securely.

Staff were aware of the importance of respecting people's diversity and human rights. The staff handbook included information for staff about 'Valuing diversity and dignity at work'. The manager told us that she

planned to complete an equality and diversity learning set with staff to update their knowledge and understanding of it. People and staff confirmed that festive occasions and people's birthdays were celebrated by the service. A representative of a place of worship regularly visited the home

People were supported to maintain relationships with family and friends. Staff told us that they provided people with emotional support when they needed it such as when people experienced difficult significant events in their lives. The manager spoke of the emotional support that the service had provided a person when they had to cope with a significant event in their life.

People's independence was supported. Staff told us that they encouraged people to do things for themselves but always provided people with the assistance when they needed it. Most people had significant mobility needs and were unable to walk. However, we observed people who wanted to mobilise independently, were supported by staff to do so. Wheelchairs and walking frames were available to support people to move about within and outside of the home.

Requires Improvement

Is the service responsive?

Our findings

People's care plans included specific information about their individual needs and preferences including, personal care, continence, communication, social and religious needs. They contained guidance for staff to follow on the support people needed. However, the amount of detail about people's backgrounds varied in detail, and it was not evident that people had always been asked for their feedback during the monthly review of their care needs. The manager told us that she would ensure people were asked about their care during the monthly reviews, and was in the process of reviewing people's care plans to ensure that they were more person centred. Care plan records confirmed this. A person told us, "Treatment is excellent"

A clinical nurse had recently been appointed to monitor nursing care and provide clinical support to nurses. Staff were aware of the care and support people needed and told us that they were kept updated about people's needs by the nurses and the manager. Staff knew the importance of following guidance to ensure they were consistent and responsive in the way that they cared for people. Records showed that they carried out regular checks of people during the day and night. Records showed that staff had been responsive by making a referral to a community health professional when they had found that a person's health needs had changed. The community professional visited to assess the person's particular health need during our visit.

Care staff completed 'daily' monitoring records about the care people had received during each shift. The nursing staff recorded significant information about people's nursing needs. This helped ensure that care staff shared information about people so were aware of people's current needs and could provide the care that they needed. We noted that care monitoring records were not kept in people's rooms so care staff could not easily complete them straight away after supporting a person with personal care. The manager addressed the issue quickly by putting each person's monitoring file in the person's room.

Staff had a 'handover' at the start of each shift. They completed a 'walk around' visiting each person and listening to the night report of each person's current needs being delivered by a member of the night staff.

We discussed the Accessible Information Standard [AIS] with the manager. The Standard was introduced by the government in 2016 to make sure that people with a disability or sensory loss were given information in a way they could understand. It is now the law for the NHS and adult social care services to comply with AIS. Information about the service was in mainly written format. The activities timetable was in written and picture format but was small and could for some people be difficult to read. The manager told us that she would look into ways of making information as accessible as possible to people. Following the inspection the manager sent us pictures of meals from the menu which they told us would be displayed on a daily basis so information about the meals was accessible to people.

People were supported to take part in some activities. Recent photographs showed people participating in planting bulbs, making Easter cards and a biscuit baking session. On the day of inspection the activity coordinator carried out some activities with people, which included involving people in making biscuits. A person using the service told us, "I take part in activity in the lounge like puzzles."

However, during our general and focused observation we noted that when those activities were not taking place people spent long periods sitting in the lounge looking around the room not engaged in meaningful activities. Music was playing at the same time as the television being on. Staff were on occasions heard saying a few words to people but there was not much conversation between people and staff. Several people spent their time in their bedrooms. Staff told us that they ensured people who chose to spend their time in their bedrooms were not isolated and made sure that they were checked upon frequently by staff. However, it was not evident during the inspection and from records that these people had the opportunity to take part in activities other than watching television or listening to music.

Records did not indicate that people were regularly offered activities or participated in them. A person's relative told us, "There isn't any activity for [person], [they] just need someone to help them do exercise." Five people using the service that we spoke with were unable to recall having taken part in any recent activities. A person's records about activities included, 'Listening to music in lounge refused to be involved in activity,' 'Slept [all] day,' and 'watched TV in [person's] room did not want to be involved in any activity.' There was no indication from these records what activities the person had been offered and whether an alternative had been suggested. Another person's records also had no information about activities for several days in March 2018 and the activities that were recorded were to do with receiving visitors or listening to music.

Arrangements were not in place to ensure care staff and nurses initiated and organised activities when the activities coordinator was not working so that there was a service approach to supporting people to participate in activities of their choice. Following our visit the manager told us people had been spending more time outside in the garden. Photographs confirmed that.

The above is evidence of a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The home had a system for recording and dealing with complaints appropriately. The complaints procedure was displayed. People's relatives knew who to contact if they wished to make a complaint. Records indicated that there had been three complaints during the last twelve months. A member of staff told us, "We always encourage our residents to say if they are not happy and can advise them on what to do if they wish to complain."

People had advanced care plans in place, which included information about their care and treatment. These care plans had been developed with the involvement of family and the person. They included detail about the person's religion and also their preferred place of care if their condition deteriorated. However, they lacked detail about whether the person had any particular wishes such as music, whether they wanted a religious representative visiting them and details of whom they wanted to be with them at the end of their life.

A nurse told us that when people required end of life care they made a referral to the community palliative care team who supported them in providing the person with the care that they needed. The nurse told us, "They come and give advice."

The manager told us that they were in the process of completing an End of Life Champion course and that three staff had recently completed an end of life training module. They told us that they planned to ensure that all staff received end of life training. Following the inspection the manager told us that arrangements had been made for a nurse from a local hospice to carry out a learning session with staff about good end of life care and would also provide advice about improving people's end of live care plans.

Requires Improvement

Is the service well-led?

Our findings

A person told us, "I am satisfied with the service; people are good and helpful with everything."

People's relatives told us that the manager was pleasant and they could approach them with any concerns they had. They told us that they were kept informed of any concerns to do with people's care. A person's relative told us, "I know the manager, she is very good."

At the time of the inspection the manager was not registered with us. A registered manager is a person who has registered with the CQC 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. The previous registered manager had left the home at the end of 2017 and the current manager commenced managing of the service at that time. The manager told us that they had started the process of registering with us.

The manager ran the service with support from the provider's representative, a deputy manager, nurses and senior care staff. Housekeeping staff and cooks were employed to carry out non care duties. Care staff were knowledgeable about the lines of accountability. They knew they needed to keep the nurses, the manager and other staff well informed about people's needs and of any issues to do with their care. The manager was very enthusiastic and keen to develop and improve the service. They told us about the action that they had taken to make improvements to the service since they started managing the service. These improvements included, reviewing and developing people's care plans, bedrail risk assessments, wound care and updating welfare monitoring charts, They informed us that they were aware that further improvements were needed and was taking action to address them.

Staff spoke frankly about the changes that had taken place since the manager started managing the service. They told us that it had not been easy and the changes were "stressful at times," but had recognised that the changes had benefitted people using the service. A member of staff told us that it was "early days," and they welcomed, "any changes." Another care worker told us, "It is best to be patient and think of the residents and what is best for them."

Staff told us that they felt supported and had been provided with opportunities to speak up about any concerns that they had and had felt listened to by the manager. They told us, "I can speak with the manager at any time and if she is not available I can speak with the senior" and "She [manager] is very good." All the staff that we spoke with told us that there was good team work. A member of staff told us, "The people I work with are supportive of one another." The manager told us that 'employee of the month' had recently been introduced. Staff could vote for the staff member that they felt deserved the award.

The manager spoke about having an "open door policy. They told us they had spent time getting to know people, their relatives and staff. Minutes of meetings showed that residents/relatives meetings had taken place to inform them of changes to the service and to listen to their feedback. Areas to do with the service discussed during a recent relatives/residents meeting included, food, activities, staffing, laundry and

personal care. A person's relative told us, "I missed the last relatives meeting but definitely I will attend next one."

The provider's representative told us that annual surveys for people who used the service and their relatives were undertaken, which were evaluated by the provider. They informed us that surveys had recently been sent to people and that their feedback would be reviewed and where feedback indicated that there were shortfalls, these would be addressed.

The manager liaised with local authority commissioning and quality assurance teams about people's care. Records indicated that the service had taken action to develop and improve the service in response to some deficiencies found from a quality check that had been carried out by a local authority in 2017. Two community professionals spoke of regularly visiting the service and that their experience of the home and engagement with staff was good. One healthcare professional told us that staff always followed their advice regarding people's care and treatment. Both community professionals told us that they had no concerns about the care home.

We looked at the arrangements in place for monitoring, developing and improving the quality and safety of the service. We found that the manager had improved and developed the range of quality checks since the last inspection to monitor, review and improve practice. A range of audits were regularly undertaken by the manager and nurses as part of the quality assurance and quality improvement process. These checks covered a range of areas of the service including medicines, care plans, cleanliness of the environment and kitchen safety. Comprehensive health and safety audits of the service were carried out by a service provider outside of the organisation. Action had been taken when deficiencies were found to make improvements to the service and to minimise the risk of them happening again. The manager had also carried out unannounced night 'spot checks' to review the quality of the service.

The provider representative visited the care home regularly and discussed the service frequently with the manager. He carried out monitoring visits of the service and records showed that shortfalls found had been addressed by the manager. The manager carried out comprehensive quality reviews of the service which were delivered to the provider as part of the quality monitoring and improvement process. These audits included reviewing and reporting about, safeguarding issues, complaints, activities, record monitoring checks and health and safety issues.

Whilst much progress was made to improve the monitoring of the quality of service delivery, we found shortfalls to do with the management of medicines and the provision of activities for people using the service. There were also other areas including the provision of meals and the environment where improvements could be made.

The service had a range of up to date policies and procedures in place. The policies included the guidance staff needed to follow and act upon in all areas of the service such us responding to complaints and health and safety matters. New staff received a handbook when they commenced work. The handbook included summaries of some policies such as confidentiality, dignity and respect, whistleblowing and fire safety that staff needed to know about.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider did not ensure that all people using the service had the opportunity to take part in a range of activities that met their needs and preferences and minimised risk of social isolation. Regulation 9 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who use services were not always protected by the proper and safe management of medicines. Regulation 12 (2) (g)