Bluebell Care Homes Limited

Warren Drive

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?	**Good**
Is the service well-led?	**Good**

Summary of findings

Overall summary

The inspection took place on 17 October 2016. Warren Drive is a residential care home that provides accommodation and personal care for a maximum of 29 older people. There were 26 people living in the service at the time of our inspection, some of whom lived with dementia.

There was a manager in post who was registered with the Care Quality Commission (CQC). 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.

Staff knew how to recognise signs of abuse and how to raise an alert if they had any concerns. Risk assessments were centred on the needs of the individual. Each risk assessment included clear measures to reduce identified risks and guidance for staff to follow or make sure people were protected from harm.

Accidents and incidents were recorded and monitored to identify how the risks of recurrence could be reduced. However, the provider had not ensured that all environmental risks and fire risks had been assessed, identified and mitigated.

There was a sufficient number of staff deployed to meet people's needs. Recruitment procedures were in place which included criminal records checks and the checking of references.

Medicines were stored, administered, recorded and disposed of safely and correctly. Staff were trained in the safe administration of medicines and kept relevant records that were accurate.

Staff knew each person well and understood how to meet their support and communication needs. Staff communicated effectively with people and treated them with utmost kindness and respect. Staff received essential training, additional training relevant to people's individual needs, and regular one to one supervision sessions.

People's mental capacity was not assessed when necessary about particular decisions and meetings were not held to make decisions in people's best interests, as per the requirements of the Mental Capacity Act 2005 code of practice.

The staff provided meals that were in sufficient quantity and met people's needs and choices. People told us they enjoyed the food and their meal times. Staff knew about and provided for people's dietary preferences and restrictions. People's individual assessments and care plans were person-centred, reviewed monthly or when their needs changed. Clear information about the service, the facilities, and how to complain was provided to people and visitors.

People were promptly referred to health care professionals when needed. Personal records included

people's individual plans of care, life history, likes and dislikes and preferred activities. The staff promoted people's independence and encouraged people to do as much as possible for themselves.

A range of meaningful activities and outings were provided that was suitable in meeting people's social needs. People were consulted in the planning of activities and their suggestions were taken into account.

Staff told us they felt valued and supported by the manager, the management team and the provider. The manager was open and transparent in their approach. They placed emphasis on continuous improvement of the service and promoted links with the community. There was a system of monitoring checks and audits in place to identify any improvements that needed to be made. However, the quality assurance system had not been consistently effective as not all the shortfalls that needed to be remedied had been identified.

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

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 consistently safe.

An environmental fire risk assessment of the premises had not been carried out.

There was a sufficient number of staff deployed to ensure that people's needs were consistently met to keep them safe. Staff knew how to refer to the local authority if they had any concerns or any suspicion of abuse taking place.

Medicines were administered safely. There was an appropriate system in place for the monitoring and management of accidents and incidents.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were asked to consent to their care and treatment. However there were no clear procedures in place relevant to the Mental Capacity Act (MCA) 2005 code of practice for staff to follow, nor a suitable recording system to assess people's mental capacity.

Staff were appropriately trained and had a good knowledge of how to meet people's individual needs.

People were supported to be able to eat and drink sufficient amounts to meet their needs and were provided with a choice of suitable food and drink.

People were referred to healthcare professionals promptly when needed.

Is the service caring?

Good

The service was caring.

Staff communicated effectively with people and treated them with kindness and respect.

Staff promoted people's independence and encouraged them to do as much for themselves as they were able to. They respected their privacy and dignity.

Appropriate information about the service was provided to people and visitors.

Is the service responsive?

Good

The service was responsive to people's individual needs.

People or their legal representatives were invited to be involved with the review of people's care plans. People's care was personalised to reflect their wishes and what was important to them.

The delivery of care was in line with people's care plans and risk assessments.

There was a suitable amount of daily activities that were inclusive, flexible and suitable for older people and people who lived with dementia or memory loss.

Is the service well-led?

Good

Emphasis was placed by the management team on continuous improvement of the service.

A system of monitoring checks and audits identified any improvements that needed to be made and action was taken as a result. However the audits had failed to identify some shortfalls and we requested the registered manager to take action.

The registered manager promoted an open and positive culture which focussed on people. They promoted links with the community.

Feedback from people was sought about the overall quality of the service. The provider and registered manager welcomed suggestions for improvement and acted on these.

Warren Drive

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 carried out to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection was carried out on 17 October 2016 and was unannounced. The inspection team included two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The registered manager had received and completed a Provider Information Return (PIR) at the time of our visit. The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. We took this into account when we made the judgements in this report.

Before our inspection we looked at records that were sent to us by the registered manager and the local authority to inform us of significant changes and events. We looked at six sets of records which included those related to people's care and medicines. We looked at people's assessments of needs and care plans and observed to check that their care and treatment was delivered consistently with these records. We reviewed documentation that related to staff management and five staff recruitment files. We looked at records concerning the monitoring, safety and quality of the service, menus and the activities programme. We sampled the services' policies and procedures.

We spoke with 12 people who lived in the service and four of their relatives to gather their feedback. We used the Short Observational Framework for Inspection (SOFI) because some people were living with dementia or memory loss and could not tell us about their experiences of using the service. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with the registered manager, the deputy manager, the administrator, the team leader, six members of care staff, the chef, a kitchen assistant, the housekeeper and the person responsible for the maintenance of the premises. We also spoke with a GP and a nurse who visited people in the service to

provide care and treatment. We obtained feedback about their experience of the service.

When we last inspected this service in July 2014, no concerns were identified.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living in the service. They told us, "It never occurs to me that I would not be safe, there are always other people and staff around", "They [staff] come quickly which is really good." A relative told us, "I am totally reassured knowing my mum is having round the clock attention and will be helped without delay when needed."

Although the fittings, equipment and portable electrical appliances were regularly checked and maintained, the premises were not safe for people because the risk of environmental hazards and of fire had not been appropriately assessed. There was a person responsible for the maintenance of the premises who carried out comprehensive checks on the condition of each bedroom and communal areas. These checks were recorded monthly and indicated that identified shortfalls, such as repairs or a window that needed replacing, had been remedied. Room checks included the flushing of water outlets in unoccupied rooms. However no Legionella risk assessment had been undertaken; there were no environmental risk assessments concerning the interior of the premises, except one about the laundry equipment. There was a sheet for recording patio door alarm tests; however these had not been completed for several months. We were told that people were free to use these doors to access the grounds and staff needed the alarms to know when the doors were used, so they could check on people's safety and re-set the alarm.

There was a recorded programme of weekly and monthly fire precautions and alarm checks. However there was no fire risk assessment that had been carried out for the premises. There was a contingency plan for staff to follow in case of power failure, heating failure and lift breakdown. The plan did not identify a safe location where people could be relocated during an emergency if they needed to be evacuated. People had personal evacuation plans that described the help they needed in case of an evacuation. However, these plans were stored in a cardboard tube in the main entrance area and may not be in a usable format in emergency situations. Two members of staff were not aware of these plans nor where to find them.

The provider had not ensured that risks to the safety of service users were identified and mitigated. This is a breach of Regulation 12 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. We have requested the provider to take action.

Staff members had provided proof of their identity and right to reside and to work in the United Kingdom prior to starting to work at the service. References had been taken up before staff were appointed and references were obtained from the most recent employer where possible. Disciplinary procedures were followed and action was taken appropriately by the registered manager when any staff behaved outside their code of conduct. Criminal records checks were routinely made through the Disclosure and Barring Service (DBS). However one member of catering staff had started working at the service for one month before the results of the checks had been obtained and no risk assessment had been recorded to support this decision. We discussed this with the registered manager who told us that the person was not involved with people's care, that they were confident about their decision and will document the rationale behind their decision in the person's file.

There was a sufficient number of staff to meet people's needs in a safe way. Staffing rotas indicated sufficient numbers of care staff were deployed during the day, at night time and at weekends. The registered manager reviewed staffing levels regularly taking into account people's specific needs. Three care staff agencies provided cover when permanent staff were unable to do so and the service requested the same agency staff whenever possible, so to ensure they were familiar with people's needs. Additional staff had been deployed when necessary, such as when people's needs had increased and they had needed one to one support. While housekeeping staff were being recruited, cleaning schedules had been re-adjusted to add temporary cleaning duties for care staff at weekends.

Staff who worked in the service understood the procedures to follow for reporting any concerns. All the staff we spoke with were able to identify different types of abuse and were clear about their responsibility to report suspected abuse. Their training in the safeguarding of vulnerable adults was up to date. They had access to the service's safeguarding policy that reflected local authority's guidance; however this policy was last reviewed in November 2012 and needed updating. We discussed this with the registered manager who told us the updating of policies was in progress. Staff were aware of the whistle blowing policy and told us they would feel confident that any reported concerns would be addressed appropriately by the management.

Accidents and incidents were appropriately managed to ensure people were safe in the service. Care plans were reviewed after each incident and the registered manager audited accidents and incidents monthly to identify any trends or patterns in order to identify and minimise future risks.

Individual risk assessments were centred on the needs of the individual and were reviewed monthly, or sooner when people's needs changed. Staff were aware of the risks that related to each person. There were specific risk assessments in place for people who may experience choking, skin damage and who were at risk of falls. A person at risk of falls had been provided with a sensor alarm to alert staff when they got up at night so they could be helped if needed. Another person whose skin was at risk had been provided with a special mattress and staff ensured they were repositioned at regular intervals when they remained in bed. Each risk assessment included clear measures for staff about how to keep people as safe as possible, taking into account their circumstances and preferences.

All aspects of people's medicines were overseen by the home manager who was the lead person for medicines in the home. They carried out six monthly audits with the deputy manager to ensure medicines were managed safely. The deputy manager was qualified to train staff in the administration of medicines. They carried out annual competency checks that included observations to ensure staff maintained good practice. All records relevant to medicines were checked to ensure they were appropriately completed and no medicines errors had been recorded in the last twelve months. Appropriate records were kept for people who needed certain medicines in relation of their blood test results; who used topical creams; or who self-medicated. The administration of PRN medicines (to be taken as required) was guided by comprehensive protocols and also appropriately recorded. People had their medicines at the time they were to be taken. Systems for ordering, stock control and returns of medicines were orderly. The room and fridge in which medicines were kept were checked daily to ensure the correct temperatures were maintained.

Requires Improvement

Is the service effective?

Our findings

People said the staff gave them the care they needed. They told us, "The staff are always going off for training, they seem hot on that sort of things here", "They call the doctor out for anything when I am not well" and, "You can ask for anything, it's like a hotel." Relatives told us, "I reckon all my mum's needs are met here" and, "All the staff go out of their way to please the residents; they seem very knowledgeable." Staff sought consent from people before they helped them move around, before they helped them with personal care and with eating their meals. One person told us, "All the staff are ever so polite, they always check with me before they do anything."

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. 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 are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

There was no appropriate system in place to carry out assessments of people's mental capacity when necessary. The service's policy on mental capacity and DoLS stated that all staff who made decisions for people who lack capacity had a duty to know about and follow the MCA's code of practice. However the registered manager and the staff we spoke with, who had been trained in the principles of the MCA, were unable to describe the steps that need to be taken according to the MCA code of practice.

There was a list of people's names where care plans were kept, that indicated whether they 'had mental capacity' or not with a 'yes' or a 'no'. This statement was generic and not based on any individual assessments of people's mental capacity and was not relevant to specific decisions. As these assessments were not carried out, meetings were not held with appropriate parties to reach a decision in their best interest when necessary. The registered manager told us that there had been no cause to carry out mental capacity assessments. However, some people who lived in the service had a cognitive impairment and no system was in place to appropriately record any assessments of their mental capacity and best interest meetings should the need arise. The registered manager located and showed us one assessment of a person's mental capacity that had been carried out in December 2015 that was not decision-specific and that was inappropriately completed.
The registered manager understood when applications to restrict people's freedom needed to be submitted to the DoLS office for people who needed continuous supervision in their best interests and were unable to come and go as they pleased unaccompanied. They told us there had been no cause to lodge such applications to date. However, assessing people's mental capacity is an associated part of this process.

The registered manager and staff were not knowledgeable of the relevant processes to follow in regard to

assessing people's mental capacity. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have requested the provider to take action. Subsequently to our inspection, the provider has sent an action plan to us outlining the remedial action they planned to take to address this breach of regulation. We will check to see how relevant new processes have been embedded in practice at our next inspection.

Staff received essential training to enable them to carry out their roles effectively. New staff received a thorough induction that incorporated the Care Certificate during the first twelve weeks. This certificate was launched in April 2015 and is designed for new and existing staff, setting out the learning outcomes, competencies and standard of care that care homes are expected to uphold. Essential training was provided that included the principles of the Mental Capacity Act (MCA) 2005, infection control, safeguarding, manual handling, fire and first aid. The registered manager and deputy manager attended a training programme provided by the National Golden Standards Framework (GSF), the UK's leading provider of training in end of life care.

Additional training that was relevant to people who lived in the home was offered and delivered to staff, such as dementia awareness and care planning. There was an effective system to record, monitor staff training and remind staff when refresher courses were due. The staff we spoke with were positive about the range of training courses that were available to them. They told us they were supported with their training needs and received regular one to one supervision sessions when they could discuss any problems they may have. During these sessions, their knowledge was tested in specific areas to check that their training was effective. All staff were scheduled for an annual appraisal of their performance.

The registered manager carried out unannounced spot checks and observations of staff practice out of hours to ensure good standards of practice were maintained. As a result of an observation of practice, a member of staff had received additional support regarding pain they experienced during manual handling procedures.

The provider encouraged staff to progress their careers through the service. All staff were enabled to enrol in a programme of studies and gain qualifications in Health and Social Care. Several members of staff had gained diplomas at Level two and three. One member of staff who experienced a learning difficulty had received additional support with their studies.

People were involved in their day to day care and in the reviews of their care plans when they were able to and when they wished to be. The registered manager, the deputy manager and the team leader sat with people and reviewed their care plans in partnership with them. There was a key workers scheme and people we spoke with knew who their key worker was. A key worker is a named member of staff with special responsibilities for making sure that a person has what they need.

There was a system of communication between staff to ensure effective continuity of care. Information about each person's care was handed to the staff on the next shift twice a day. Information about new admissions, accidents and incidents, referrals to healthcare professionals, people's outings and appointments, medicines reviews, people's changes in mood, behaviour and appetite was appropriately shared by staff at handover sessions and recorded in a diary and a communication book. Follow up action was taken from one staff shift to another.

People told us they enjoyed the food they had and told us they were satisfied with the standards of meals. They told us, "The food is delicious and you get a choice", "Lovely meals." However, four people told us the food was sometimes cold. We discussed this with the registered manager who was aware of this feedback

and who was in the process of exploring how cooked meals could be kept hotter from the kitchen to the dining room. Several people had their breakfast late in the morning as they preferred, and cooked breakfasts were available when requested.

The lunch was freshly cooked, well balanced, well presented and in sufficient amount. People were consulted when menus were planned and completed food surveys that were taken into account. They were able to alter the menu to include whatever they wanted once a week and could request an alternative at any meal. The chef told us, "Our residents can have what they like, it only takes a minute to do an omelette or something on toast, it is their home and that is what I am here for." A lighter cooked meal was served at supper time and people were served a selection of refreshments, home-made cakes, biscuits and fresh fruit salad or sandwiches twice a day between meals. The kitchen assistant told us, "The residents can have a drink at any time, tea, coffee, juice or wine; a couple of men like a glass of wine." The catering staff were aware of people's dietary restrictions and requirements. One person needed a dairy-free diet and this was provided.

People were weighed monthly or weekly when there were concerns about their health or appetite. When fluctuations of weight were noted, food and fluid intake charts were completed so staff could monitor what they consumed and refer them to the GP or a speech and language therapist (SALT) when necessary. Health care professionals' recommendations were followed in practice, such as providing people with fortified drinks. A person had been referred to a SALT when they had experienced a sore throat and swallowing difficulties.

People's wellbeing was promoted by regular visits from healthcare professionals. People were able to retain their own GP or were registered with one of three local GP surgeries. A chiropodist visited every three to six weeks to provide treatment for people who wished it. An optician service visited twice yearly or sooner when needed. A local dentist visited upon request when people were unable to go to the dental surgery. People were offered routine vaccination against influenza when they had consented to this. When people had become unwell, they had been promptly referred to healthcare professionals. A GP and a nurse who visited people to provide care and treatment in the service told us, "They are good at calling us in without any delay" and, "They always ask for guidance and react quickly when a resident is unwell." During our visit, a person felt unwell and the GP was called in to visit within two hours. Therefore staff responded effectively when people's health needs changed.

The accommodation was spacious, comfortable and welcoming. There were quiet spaces where people and their visitors could sit and relax, including two lounges, several patio areas and a summer house. There were three communal bathrooms and all bedrooms had a basin and toilet facilities, 13 of which included a shower or a bath. There was a hairdresser's room, and a small shop where people could buy miscellaneous items. The grounds were attractive and well maintained by a gardener, with attention to detail. There was a notice board with staff photographs displayed, and a few people who may need help locating their room had their photographs or appropriate signage displayed on their bedroom doors. The menus and activities programmes were in pictorial form to ensure people who may have visual or cognitive impairment could understand them effectively.

Good

Is the service caring?

Our findings

People told us they were very satisfied with how the staff cared for them. They said, "It's not my home but it's the next best thing", " The staff are lovely" and, "Everyone is ever so kind." A relative described the staff as, "kind and really lovely girls."

Visitors were welcome at any time without restrictions and were warmly greeted by staff. We spent time in the communal areas and observed how people and staff interacted. There was a homely feel to the service and a calm atmosphere. Staff and people interacted in a friendly and appropriately humorous manner. Staff addressed people respectfully by their preferred names and were knowledgeable of how they usually preferred to spend their day. Staff checked that people were appropriately dressed and all people were well presented with comfortable clothing and footwear. People were encouraged to personalise their bedrooms as they wished and bring their own articles of furniture to make them feel at home from the beginning of their stay.

People were able to have as many baths or showers as they chose. Staff wrote a bathing rota that took account of people's preferences. One person had a bath after supper before bed; another person had a daily bath in the morning. People told us that staff were mindful to respect their dignity and privacy. The deputy manager was a dignity champion and the importance of preserving people's privacy and dignity was discussed at team meetings. Staff had taken part in two 'Dignity Days' where emphasis was placed on providing respectful and empathetic attention to people. One person said, "The staff are very respectful, they understand how it feels and they cover me with a towel straight away." Two relatives told us, "They always knock and wait a little before coming into my mum's bedrooms" and, "The staff are always polite and considerate."

Staff knew how to communicate with each person. Staff were lowering their position so people who were seated could see them at eye level. They used people's correct and preferred names, spoke clearly and smiled to engage people who smiled in return. They showed interest in people's response and interacted positively with them. People had a specific information sheet in their files that informed staff how best to communicate with people. There were instructions for staff to be mindful of a people's sight or hearing impairment and use clear tones of voice or write in large format. One person needed staff to check their hearing aids regularly; another person needed staff to repeat themselves to ensure they understood and did not become anxious. We observed staff follow these instructions in practice.

Staff were careful to speak about people respectfully and maintained people's confidentiality by not speaking about people in front of others. People were given the choice of having their doors open or closed. People's records were kept securely to maintain confidentiality. A service that provided independent mental health advocates (IMCAs) was available to help represent people's views at best interest meetings when families were not available.

Staff encouraged people to do as much as possible for themselves. People washed, dressed and undressed themselves when they were able to do so. Several people held their own set of bedroom keys. People

followed their preferred routine, for example some people chose to have a late breakfast, remain in their bedrooms, or stay in bed. At mealtimes and during activities, people chose where they liked to sit. Staff presented options to people so they could make informed decisions, such as what they liked to eat, to wear or to do, to promote their independence. A person visited a day centre; another person was accompanied by a volunteer to attend a local church service.

Clear information about the service and its facilities was provided to people and their relatives. A welcoming pack included a 'Residents Guide', a booklet introducing Warren Drive retirement Home, the service's philosophy of care and care ethos, the service's statement of purpose, and an information sheet. The information provided was comprehensive and included the complaint procedures. People were provided with a weekly newsletter that presented planned activities, an interesting description of a foreign dish and its country, special events, people and staff birthdays, celebrations, poems, new staff, and people's personal quotes. The newsletter was written in large font to help people with visual impairment, including photographs and illustrations.

There was a website about the service that was informative, well maintained and user-friendly. There was a display of informative leaflets in the lounge about the Gold Standards Framework in care homes, the DoLS, and leaflets about how to access support for those who have lost a loved one. Keyworkers' names were displayed in each person's wardrobe to help them remember who they were.

People could be confident that best practice would be maintained for their end of life care. People or their legal representatives were consulted about how they wished the service to manage their care and treatment when they approached the end of their lives. The service had introduced 'advance care plans' (ACP) and were in the process of supporting people and family during the process. These plans give people the opportunity to let their family, friends and professionals know what is important to them for a time in the future where they may be unable to do so. This include how they might want any religious or spiritual beliefs they held to be reflected in their care; their choice about where they would prefer to be cared for; which treatment they feel may be appropriate or choose to decline; and who they had wished to be their legal representative. One person had a funeral plan in place, several people had expressed their wishes regarding resuscitation and this was appropriately recorded in their care files. The service was undertaking a rigorous accreditation process 'Going for Gold' with the 'Gold Standard Framework in Care Homes' (GSFCH). To qualify for this accreditation, care homes must have undertaken the full GSFCH training program over nine months, achieved at least 84% of the standards, and embedded this into their homes for at least six months.

Good

Is the service responsive?

Our findings

People gave us positive feedback about how staff responded to their needs. They told us, "They really want to know all about me, where I lived, what I did and even about my grandchildren, I like that", "They always ask me to join in the activities but I like my company best" and, "I can get up and go to bed when I like, I didn't expect it to be like that when I came here." A relative told us, "The staff always provide good activities every day and they adapt to the resident so they are flexible, always ready to change it if residents prefer to do something else at the time."

People's needs were assessed before they moved into the service by the registered manager or the deputy manager. These assessments indicated whether the service could meet people's individual needs. They gave a clear account of needs relating to medicines, communication, nutrition, skin integrity and mobility. Information was gathered on their life history, their interests, and special requirements about their routine. This helped staff understand their perspective. People were invited to stay for short periods before they made an informed decision about coming to live in the service. Risk assessments were carried out before people moved into the service, to ascertain control measures that could reduce those risks such as falls or skin damage. Equipment was put in place from the onset such as pressure relieving mattresses, sensor mats and walking aids.

People's care plans were reviewed and updated monthly or sooner when needed, for example following an illness, any incidents, a medicines review or a period of hospitalisation. The registered manager, deputy manager or team leader sat with people to involve them during the review of their care, when people were willing to do so. A comprehensive annual review of each person's care was carried out and people, their legal representatives and/or families were invited to attend and contribute. Relatives were asked from the onset how much they wanted to be involved with reviews of care plans.

People's likes, dislikes and preferences about food, daily activities and routine were taken into account. Staff were able to describe to us how several people preferred to spend their day, their favoured activities, how they liked their hot drinks, and what type of food they favoured. They were aware of people's history and of what was important to them. When staff became aware of a person having presided over a bowling club when they were younger, a bowling activity had been organised.

A wide range of activities that were suitable for older people and people living with dementia or memory loss was available. They included Indian head, foot and hands massage, reminiscence games, quizzes, arts and craft, gardening, sing-alongs, music, movies, pampering, 'social hours', 'Tai Chai' and light exercises. Communal areas displayed people's artistic creations. Entertainment was also sourced externally and an organist, a story teller, a guitarist, performers and a magician were regularly invited to the service. A 'Wild Science' and 'Zoo lab' presented snakes, tortoises, friendly rats and 'creepy crawlies' to entertain people.

Attention was paid to reduce people's isolation and promote people's social interaction. A series of outings was offered to people and they were encouraged to form friendships with others with common interests. Outings included visits to garden centres, animal farms, local shops and a vineyard where people could

enjoy a meal or tea and cake. Twelve people had been transported in a stretch limousine to visit to a Rugby Club for a 'vintage afternoon tea'. The service had celebrated special events such as the Queen's birthday, and the National Care Home Open Day with a 'walk in the country' theme. Staff were planning Halloween, Guy Fawkes and Christmas celebrations. One person told us, "There is always something going on."

People's feedback was sought and acted on. They were invited to attend residents meetings to give their feedback and participate in all decisions concerning the environment in which they lived. Records of these meetings were kept and analysed to identify how people's experience could be improved. Several yearly satisfaction surveys were carried out, relevant to maintenance, activities and overall satisfaction about all aspects of the service. A twice yearly food survey was carried out. As a result of people's feedback, watercolour painting and flower arranging had been introduced; seasonal menus had included special requests, and the registered manager was researching ways to keep food hotter while in transit from the kitchen to the dining room.

People and relatives were aware of how to make a complaint. Relevant information was on display in the communal areas and in the 'residents guide'. They were reminded of this at residents meetings. Four complaints had been received and had been appropriately addressed by the registered manager to a satisfactory outcome.

Good

Is the service well-led?

Our findings

People were complimentary about the way the home was run. They told us, "The manager comes into our rooms every morning to check things are OK", "The manager knows every single one of us and she cares." One resident told us they were appreciative of the registered manager's involvement. They told us, "The manager keeps up to date with all our families and knows all about weddings and new births; she sometimes knows more than I do about my own children and grandchildren." A relative described the registered manager as, "kind, totally approachable and very efficient."

Management responsibilities were clearly defined. The registered manager was supported by a deputy manager, a team leader, an administrator and senior care workers on each staff shifts. Staff were positive about the support they received from the registered manager and appreciated their style of leadership. They described the manager as, "approachable", "understanding" and "a good manager." Staff reported that they could approach any member of the management team with concerns and that they were confident that they would be supported. They told us, "We can go into the office at any time to discuss anything and are always welcomed; there is an open door policy here".

There was a system in place to monitor the quality of the service and drive improvements. Monthly management meetings were attended by the provider and the registered manager, where topics such as people's care, staffing issues, occupancy and repairs were discussed. As a result of the last meeting, new windows had been replaced; a new post of team leader had been created. The registered manager, deputy manager and senior care workers met monthly to discuss staff general routine and the daily checks that were carried out by staff, such as the Medicines Administration Records (MARS). As there was a daily checking system in place, no medicines errors had been made nor recorded in the last twelve months. A general staff meeting was held once a year and a meeting with heads of departments were held when needed. As a result of a recent heads of department meeting, new kitchen equipment had been purchased; cleaning schedules had been adjusted to include care staff at weekends; and a new computerised system had been installed.

The registered manager encouraged the staff to be involved with the running of the service, gathering their feedback at supervision, at staff meetings and collecting staff comments from a dedicated suggestion box. However they did not carry out a staff satisfaction survey and when we discussed this with the registered manager, they said this will be introduced shortly. A member of staff told us, "We get involved, maybe not through formal meetings, but we communicate well with management and they listen to us."

The registered manager and deputy manager carried out daily walk-rounds of the premises, taking time to talk with people and observe staff practice. Additionally, the provider visited the service on a weekly basis and carried out audits of care documentation to ensure care people's care files were appropriately completed. This system complemented regular audits that were carried out which included premises maintenance, care and medicines documentation, infection control, accidents and incidents, maintenance, complaints and satisfaction surveys. When an audit had identified a shortfall, the registered manager monitored the remedial action plan until completion. As a result of a premises audit, the service close circuit

camera system and monitors had been updated to enhance the security of the premises.

However, although the provider and registered manager had implemented an auditing system and were monitoring the quality of the service, they had not identified the lack of a fire risk assessment nor the need to have a robust system in place to assess people's mental capacity when necessary. We have requested action to be taken and discussed this with the registered manager who told us that improvements will be made.

The registered manager involved people with the running of the service. The minutes of 'Residents Committee meetings' and satisfaction surveys results were scrutinised to identify how the service could improve. As a result of recent meetings and surveys, staff photographs had been included in the newsletter at people's request; more quizzes had been added to the activities program; fish and chips had been added to the menus. A relative told us, "I was asked how often I would like to be involved and I said a lot, so I am consulted every time there is a change in my mum's care plan, she has agreed to this, I feel we work as a team with the management."

The registered manager kept an improvement plan for the year ahead that included the replacement of older mattresses; the purchase of new armchairs; an improvement of the service training matrix system; new staff appraisal and induction forms; an improving index system of the policies. Subsequent to our visit, the registered manager had updated the improvement plan to include the introduction of a system to correctly assess people's mental capacity when necessary and ensure staff were knowledgeable in this area; scheduled fire risk assessments; and a re-evaluation of the service's recruitment process.

The registered manager ensured the service maintained links with the local community. The service had held a 'Bake-off' coffee morning to raise funds for a charity and this was scheduled to be a regular occurrence. Warren Drive had opened its doors to people's families and the community at this event, during the National Care Home Open Day and at their party events. The registered manager had plans to link with other local care homes managers to exchange ideas about management practices and learn from each other.

We spoke with the registered manager about their philosophy of care. They told us, "We want to create a family environment where residents feel part of a family unit with staff, where their care is second to none and where they are helped to live a fulfilling and enjoyable life." From our observations and the feedback we collected, staff followed this philosophy in practice.

The registered manager was open and transparent. They consistently notified the Care Quality Commission of any significant events that affected people or the service. The service's policies and operating procedures were appropriate for the type of service and clearly summarised, to help staff when they needed to refer to them. They were in the process of being reviewed to ensure they were kept up to date with legislation and fully accessible to staff for guidance. Records were kept securely and confidentially. They were archived and disposed as per legal requirements.

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	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered manager and staff were not knowledgeable of the relevant processes to follow in regard to assessing people's mental capacity. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Need for consent (3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured that all environmental and fire risks to the safety of service users were identified and mitigated. This is a breach of Regulation 12 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment (2) (a) (b)(d).