Finchworth Limited

Dinsdale Lodge Care Home

Inspection report

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Ratings

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

Overall summary

The inspection took place on 23 June 2015 and 15 July 2015, both visits were unannounced. Following our last inspection of Dinsdale Lodge Care Home in December 2014 we found the registered provider had breached four regulations. During this inspection we found the provider had made progress with the assurances given in their action plan. We found the registered provider was now meeting these regulations.

Medicines were managed safely and people received their prescribed medicines on time. Recruitment checks were in place to ensure prospective new staff were suitable to work with vulnerable adults. A final referral to the Disclosure and Barring Service (DBS) had not been made. We have since had confirmation from the registered manager that this has now been done. Where there were doubts about a person's capacity to make decisions, an assessment had been undertaken to determine whether a Deprivation of Liberty Safeguards application to the local authority was required. We found that 12 out of 13 people had a DoLS authorisation in place. Staff had completed training on the Mental Capacity Act 2005 (MCA) and now had a better understanding of MCA. We viewed training records which confirmed staff had completed the training courses specified in the registered provider's action plan.

Summary of findings

Dinsdale Lodge Care Home is registered to provide nursing or personal care for up to 28 people. At the time of our inspection there were 13 people living at the home, some of whom were living with dementia.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they felt safe living in the home. One person said, "The staff are very good and helpful." Another person said, "Listen, there is nothing I want, staff are nice and pleasant, I go out regularly and the food is good." People told us they were very happy with the care they received and with their key worker. One person said, "It could not be better. Staff are great and like a bit chat." Another person told us, "The staff will help straight away, nothing is a trouble." Another person said, "Yes I have a keyworker but I really don't need one. I can chat to all staff."

Some areas of the home were not secure, potentially impacting on the safety of people using the service. For example, some areas that should be secure were not. We also found some areas, such as sluice rooms were not clean. We raised our concerns about these issues during the inspection. Cleaning audits were basic and indicated these areas hadn't been cleaned for a month. The registered provider took action straightaway to deal with these concerns. Communal areas and people's rooms were clean.

Staff members had a good understanding of safeguarding and whistle blowing. They knew how to report concerns. Detailed risk assessments were in place to help manage potential risks. We saw evidence of action taken to keep individual people safe, such as referrals to health professional for advice and guidance. We noted the provider had other more generic health and safety risk assessments in place.

There were enough staff to see to people's needs. 'Call bells' were answered in a timely manner. We saw plenty of staff on duty and found people did not have to wait to receive the care and support they needed. The registered manager reviewed staffing levels monthly.

Accidents and incidents were analysed to identify any particular trends and patterns. The registered provider had emergency procedures in place to ensure people continued to receive care following an emergency. Regular checks were carried out to check the premises were safe for people to use.

Staff asked people for permission before delivering any care and respected people's decisions.

People were supported to have enough to eat and drink. Staff provided the support people needed, which ranged from prompts through to practical assistance with eating and drinking. People were supported to meet their healthcare needs. Where required staff had made referrals to health professionals for advice and guidance. This included dietitians and speech and language therapists. People said staff contacted their GP when they were unwell.

People were treated with dignity and respect. We observed staff knocked on people's doors before entering their room. During our observations we saw people received regular positive interaction from staff. Staff checked that all people were alright and if they needed any assistance. Staff were kind and considerate and supported people in a calm and relaxed manner. Drinks were readily available at all times in the lounge for people to help themselves. At other times during the day of our inspection we saw good interaction between people and staff.

Staff encouraged people to be independent. Some people accessed their local community independently. One person said, "I am a local chap so I like to go out and see people I know. One of the staff takes me to the market every week and I see old friends". Other people chose how to spend their time in the home. For example, playing games, watching TV or taking part in a quiz.

People had up to date person centred care plans which included details about the care preferences. Care plans covered a range of areas including daily living, personal hygiene, medicines, nutrition, mobility, communication and activities. Staff were required to read people's care plans.

People were able to choose whether to take part in activities both inside and outside of the home. Activities included bingo, playing cards, taking part in quizzes, cinema trips or out shopping. Some people attended a

Summary of findings

local luncheon club. When time allowed staff sat and chatted with people. People told us they were taken out on outings both in groups and individually. One person told us, "I go on my own to play bowls which I enjoy." We saw people using adapted computers to access the internet or to watch movies.

The registered provider had a complaints policy and procedure. There had been no recent complaints made about the service. People and family members had the opportunity to attend regular meetings. One person told us, "Yes meetings are held regularly and we had one last week. We discuss what we would like to do."

Staff told us the registered manager was supportive and approachable. People told us they regularly meet with the manager as well as the nurse. Staff told us they felt able to give their views about the service within regular team meetings. We observed there was a nice calm atmosphere in the home. One staff member commented there was a, "Good atmosphere, the residents get good care." Another staff member said the atmosphere was, "Good, everybody gets on."

There was a system of quality assurance checks in place including checks on fire safety, health and safety, supervision, complaints, staffing levels and care plans. We saw quality assurance checks had identified areas for improvement. The registered provider carried out external quality checks of the service. Since our last inspection the three monthly safeguarding analysis had been further developed to consider DoLS.

The registered provider regularly sought people's and family member's feedback about the quality of care delivered at the home. Feedback from the most recent survey was positive.

However, it was too early to assess whether these quality checks will be successful in delivering long term sustained improvement in the quality and safety of people's care.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not always safe. People told us they felt safe living in the home. The registered provider had effective recruitment checks in place. We found that medicines were managed safely. There were enough staff to see to people's needs.

Some areas of the home were not secure and some were not clean. The registered provider took action straightaway to deal with these concerns. Communal areas and people's rooms were clean.

Staff members had a good understanding of safeguarding and whistle blowing. They knew how to report concerns. Detailed risk assessments were in place to help manage potential risks.

Accidents and incidents were analysed regularly. There were emergency procedures to ensure people continued to receive care following an emergency. Regular health and safety checks were carried out to check the premises were safe for people to use.

Is the service effective?

Requires improvement

The service was not always effective. Where required, Deprivation of Liberty Safeguards (DoLS) applications to the local authority had been made. Staff now had a better understanding of the Mental Capacity Act 2005 (MCA). We viewed training records which confirmed staff had completed the training they needed.

Staff asked people for permission before delivering any care and respected people's decisions.

People were supported to have enough to eat and drink. They were also supported to meet their healthcare needs. Referrals had been made to health professionals for advice and guidance. People said staff contacted their GP when they were unwell.

Improvements were required to make the home suitable to meet the needs of people living with dementia.

Is the service caring?

Good

The service was caring. People told us they were very happy with the care they received and with their key worker.

People were treated with dignity and respect. We observed staff were kind and considerate and supported people in a calm and relaxed manner. We saw people received regular positive interaction from staff.

People were able to choose to take part in activities both inside and outside of the home. Staff encouraged people to be independent.

Summary of findings

Is the service responsive?

Good

The service was responsive. People had up to date person centred care plans which included details about their care preferences. Staff said they were required to read people's care plans.

People were able to choose whether to take part in activities both inside and outside of the home. When time allowed staff sat and chatted with people. People told us they were taken on outings both in groups and individually. We saw people using adapted computers to access the internet or to watch movies.

The registered provider had a complaints policy and procedure. There had been no recent complaints made about the service. People and family members had the opportunity to attend regular meetings.

Is the service well-led?

Requires improvement

The service was not always well led. Staff told us the registered manager was supportive and approachable. People told us they had regular contact with the manager as well as the clinical lead. There were regular team meetings.

There was a system of quality assurance checks in place. Since our last inspection the three monthly safeguarding analysis had been further developed to consider DoLS.

The registered provider regularly sought people's and family member's feedback about the quality of care delivered at the home. Feedback from the most recent survey was positive.

It was still too early to assess whether the quality assurance programme will be successful in delivering long term sustained improvement in the quality and safety of people's care. We had concerns that we identified further issues during this inspection that the registered provider had not previously been pro-active in dealing with.

Dinsdale Lodge Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 23 June 2015 and 15 July 2015 and both visits were unannounced.

The first visit was carried out by two adult social care inspectors, a pharmacist inspector and an expert by experience with experience of a care service for older people. 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 second visit was carried out by one adult social care inspector and a specialist advisor who was a qualified and experienced electrician.

We reviewed information we held about the home, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales. We also spoke with the local authority commissioners for the service.

We spoke with seven people who used the service and one family member. We also spoke with the registered manager, the clinical lead, one senior care assistant and three care assistants. We observed how staff interacted with people and looked at a range of care records. These included care records for four of the 13 people who used the service, seven people's medicines records and recruitment records for five staff.

During this inspection we carried out observations using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not communicate with us.

Requires improvement

Is the service safe?

Our findings

We reviewed the action plan the provider sent to us following our comprehensive inspection in December 2014. This gave assurances that the registered provider would improve the management of medicines administered to people using the service. The registered provider also gave assurances that recruitment checks would be completed before prospective new staff started their employment. The provider told us they would be compliant with the regulations by 23 April 2015.

We found the assurances the provider had given in the action plan had been met. Appropriate arrangements were in place for recording of medicines. We saw people's Medication Administration Record sheets (MARs) had photographs in place to assist with positive identification when administering medicines. Staff had signed medicines administration records for oral medicines correctly after people had been given their medicines. Records had been completed fully, indicating that people had received their medicines as prescribed. When people had not taken their medicines, for example if they refused or did not require them, then a clear reason was recorded. Staff carried out regular checks of medicines records to make sure they were completed properly.

Arrangements had been made to record the application of creams by care workers. However, the records showing the application of creams were sometimes missed. This meant that it was not always possible to tell whether creams were being used correctly. Staff told us they were still working on improving these records and ensuring they were always completed. We have made a recommendation about this.

Medicines kept at the home were stored safely. Appropriate checks had taken place on the storage, disposal and receipt of medication. This included daily checks carried out on the temperature of the rooms and refrigerators which stored medicines. Staff knew the required procedures for managing controlled drugs. We saw that controlled drugs were appropriately stored and signed for when they were administered.

We looked at how medicines were monitored and checked by management to make sure they were being handled properly and that systems were safe. A daily system of medicine checks was also in place. We found these checks helped to identify any issues quickly in order to learn and prevent the errors happening again.

We examined five staff recruitment records for recently recruited staff. We found each record held completed reference checks and a Disclosure and Barring Service (DBS) check, dated prior to their start date. DBS checks help employers make safer decisions and help to prevent unsuitable people from working with vulnerable adults. We noted that at least two references had been received, one of which was from the previous employer. In addition, we saw the provider had carried out a risk assessment following the disclosure of information on a DBS check.

People told us they felt safe living in the home. One person said, "The staff are very good and helpful." Another person said, "Listen, there is nothing I want, staff are nice and pleasant, I go out regularly and the food is good."

We found some areas of the home were not secure, potentially impacting on the safety of people using the service. We observed as we walked around a number of rooms were left unlocked. For example, the cleaning room door was held open by a large bottle containing a cleaning product. This meant steep stairs and the access to the boiler room were left open to people using the service. We observed the laundry room was also unlocked. We saw soiled laundry was lying on the floor. These rooms were adjacent to people's rooms and posed a safety hazard to people as they were easily accessible. We raised our concerns with the registered manager and clinical lead. We saw when we carried out our second visit to the home that these areas had been secured with a double lock system on the doors.

Some areas of the home were not clean. We found both sluice rooms were unlocked. In one sluice room we observed the sink was leaking onto the floor, the surface of the sink had a build-up of lime scale and dirt, and was full of urine bottles. We also found there was no hand cleaning products or paper towels available for staff to use. In the other sluice room we found the light did not work and the sink was filled with bags containing clinical waste. We saw in one shower room there were towels on the floor. There was also electrical wiring hanging from the ceiling, which was well out reach of people using the service. In another bathroom we also saw towels on the floor. There was also a large build-up of hair and debris in the plug area of the

Is the service safe?

basin. We brought our concerns to the attention of the registered manager and clinical lead. They advised us that they would deal with these concerns as a matter of urgency. Before the end of our inspection, the clinical lead showed us the areas had been cleaned and signage had been placed on doors reminding staff to keep doors locked. They advised that sluice rooms were never locked but they would consider the future use of keypads for access.

We asked to see cleaning rotas and audits. The registered manager showed us a tick box checklist. We noted the checklist was blank against the sluice rooms for the period of a month. The clinical lead told us it was a task night staff should have carried out. They said following our findings they would introduce a new audit immediately. The registered manager told us the domestic had only been in post a few days. We observed them cleaning in their own clothes. However, the domestic told us her uniform had been ordered.

We saw all staff members had received training in safeguarding vulnerable adults or were booked on training courses. Staff we spoke with had a good understanding of safeguarding and knew how to report concerns. We asked the registered manager if there had been any safeguarding concerns raised. They told us they had raised two safeguarding concerns in the last year. We saw in the safeguarding records two safeguarding referrals had made to the local authority. However we noted that a final referral to the DBS, in respect of a former employee, had not been made. We advised the registered manager of the correct process. They told us they would forward on the referral. We have since had confirmation that this has now been done.

Where potential risks had been identified a risk assessment had been carried out. These included the risk of falling, mobility, communication and medication. The risk assessments we viewed were detailed. They contained the information required to inform staff of the exact process to follow to minimise the risk to people. For example, we noted one person had a choking risk assessment. It indicated the potential issues as 'difficulty in swallowing and may start to cough.' The assessment detailed the action required to keep the person safe, such as 'monitor at mealtimes' and 'if continues refer to SALT (speech and language therapy).' We saw these had been regularly reviewed to make sure they remained up to date. We noted the provider had other more generic health and safety risk assessments in place. These included the risk associated with using the stairs, burns and scalds and falling from a window.

There were enough staff to see to people's needs. We observed 'call bells' were answered in a timely manner. We saw there was plenty of staff on duty. We noted people did not have to wait for the support or care they required. We viewed staffing rotas and saw these were planned in advance. The registered manager showed us the dependency tool used to calculate the number of staff required. The registered manager reviewed staffing levels monthly. They calculated the number of staff required against people's dependencies and needs. They told us following advice from the last inspection, they now take in to consideration the increase in people's needs throughout different times of the day.

We viewed the accident and incident records. We saw appropriate information was recorded, including types of incidents and the times they occurred. We asked the registered manager if any analysis was carried out to identify any trends or contributory factors which may require investigation. They advised us an analysis of the information was carried out every three months.

We reviewed the emergency procedures in place, including personal emergency evacuation plans (PEEPS) for people. We saw these detailed the action required in the event of an emergency and were accessible to staff. The registered provider had a business continuity plan. This detailed the actions to be taken following emergencies that would stop the delivery of the service. For example, the loss of electricity or a water leak. This meant people would continue to receive care following an emergency. We looked at records relating to the safety and upkeep of the premises. Records we viewed in relation to gas safety, equipment checks, electrical appliances and water safety showed regular checks had been undertaken.

Following concerns raised to us about the electrical safety in the home, we reviewed electrical safety during this inspection. The electrical installation condition report completed in February 2014 described the condition of the installation as 'satisfactory.' We viewed the electrical installation and made some recommendations to improve safety at the home. The registered provider took note of these recommendations. They told us they would be added to the schedule of works for the home. During our

Requires improvement

Is the service safe?

first visit we noted that following an inspection of the fire detection system on 20 May 2014, a number of dangerous or potentially dangerous conditions had been identified. These mostly related to the addition of extra smoke detectors around the home. The registered provider told us these detectors had not been installed as they disagreed with the findings from the inspection. However, when we visited for our second day the registered provider had arranged for a different company to re-inspect. We found that all recommendations had been carried out and the system was satisfactory. The registered provider had also installed additional emergency lighting. We recommended to the registered provider that they may wish to consider extra smoke detectors and emergency lighting, which they arranged to install the following day.

We found some communal areas were not homely. For example, a number of wheelchairs were being stored in the dining room and moving and handling equipment stored in a communal lounge. Although, these were stored away from people using the service they made the environment appear cluttered and unattractive. The outside of the building required work such as re-painting. Building works and materials were evident. However, there were no signs of work on-going. The property manager told us work had now ceased and approval was being sought from the local authority to clear the site. We saw there was a smoking room accessed by going outside from the dining room to a small conservatory extension. However, this was very basic with flagstones for flooring, a couple of seats and a wall heater which we were told did not work. The ashtray was also full to overflowing.

We recommend the service considers the current guidance on managing medicines and takes action to update their practice accordingly.

Requires improvement

Is the service effective?

Our findings

We reviewed the action plan the provider sent to us following our comprehensive inspection in December 2014. This gave assurances that the registered provider would provide staff with the training they required. The registered provider also gave assurances that Deprivation of Liberty Safeguards (DoLS) authorisations would be requested for all people requiring authorisation. The provider told us they would be compliant with the regulations by 23 April 2015.

We found the assurances the provider had given in the action plan had been met. The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA), including the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. MCA is a law that protects and supports people who do not have the ability to make their own decisions and to ensure decisions are made in their 'best interests.' It also ensures unlawful restrictions are not placed on people in care homes and hospitals.

Since our last inspection the registered provider had made progress with complying with the MCA. Where there were doubts about a person's capacity to make decisions, an assessment had been undertaken to determine whether a DoLS application to the local authority was required. We found that 12 out of 13 people had a DoLS authorisation in place. The registered manager had re-applied for a DoLS authorisation for one person, who had been in hospital for more than four weeks, as their previous authorisation had lapsed. From viewing people's care records we saw examples of 'best interest' decisions made on behalf of people. For example, a best interest decision had been made in respect of one person's admission to Dinsdale Lodge. This had been made with the involvement of an IMCA (Independent Mental Capacity Advocate).

Staff had completed training on MCA and now had a better understanding of how MCA applied to people they cared for. They described how MCA applied to people when they lacked capacity. They said in these situations a, "Best interest decision would be made involving an IMCA if they don't have family." One person had regular monthly visits from an IMCA. Staff also described how they supported people who lacked capacity to make day to day decisions using their knowledge of people's likes and dislikes. We saw that each person had a specific decision making care plan. These provided general information about how to support people with decision making. However, these required further development to ensure they were person-centred with specific strategies identified for individual people.

Staff told us they always asked people for permission before delivering any care. They said they would respect people's decisions. We observed throughout the day of our inspection that people were asked first before receiving support.

We viewed training records which confirmed staff had completed the training courses specified in the registered provider's action plan. This included training relating to safeguarding, MCA, and moving and handling. Although, staff had now completed relevant training courses since our last inspection, action was still required to ensure future training requirements are completed in a timely manner.

People were supported to have enough to eat and drink. We observed over the lunch time to help us to understand people's lunch time experience. We saw that six out of 13 people ate their lunch in the dining room. Tables were nicely set ready for people to sit down. However, we did observe some crumbs on the floor from a previous meal time. We saw that a picture menu was displayed on the wall to help people make choices about what they wanted to eat. We saw the cook took lunch orders during the morning. However, people were still given a choice at their table. Meals were well presented and hot. People were offered the choice of a hot drink or juice. There were plenty of staff available to help with lunch and to provide the assistance people needed. Staff interacted with people throughout lunch. We heard one staff member ask a person whether they were enjoying their lunch. The person replied, "Yes it is very nice and the gravy is nice and thick. It reminds me of my mother's gravy." We saw that drinks were provided mid-morning and again in the afternoon with biscuits. Staff described how they supported people with eating and drinking. They told us some people were independent, whilst other people required prompts or practical support. For instance, staff said for one person they placed food into their hands and they could then eat independently.

People were supported to meet their healthcare needs. From viewing care records we saw people had regular input from various health professionals when required. This included speech and language therapists and dietitians.

Requires improvement

Is the service effective?

Where required, staff had made a referral to the relevant professional. For example, where a person had lost weight or was experiencing swallowing difficulties. We found people had been assessed and advice and guidance given to help keep the person safe. People told us staff contacted their GP when they were unwell. Family members confirmed staff contacted them to keep them informed if the GP had been called.

We found improvements were required to the environment to effectively meet the needs of people living with dementia. The registered manager told us 12 out of 13 people were living with dementia. We found some minimal adaptations had been made to the home, such as specific dementia signage to help people's orientation. However, most of the walls in the home were bare and lacked interest to engage or stimulate people. We saw there were no rummage items to help with people's sensory needs. We also saw no evidence from our observations, from speaking with people and staff or from viewing care records that meaningful activities, specifically catered for people living with dementia, were available for people to take part in. We noted a recent health watch report focusing on dementia had concluded the décor and environment within the home were not suitable for people living with dementia. The clinical lead described some ideas they had to improve the environment. We found though the registered provider did not have a specific dementia strategy or action plan detailing any future improvements plans.

We recommend the service considers current guidance on caring for people living with dementia and takes action to update their practice accordingly.

Good

Is the service caring?

Our findings

People told us they were very happy with the care they received. One person said, "It could not be better. Staff are great and like a bit chat." Another person told us, "The staff will help straight away, nothing is a trouble." People had named key workers to lead on their care. We saw that people had the name of their key worker on their door. People told us they knew who their key worker was. One person said, "Yes I have a keyworker but I really don't need one. I can chat to all staff."

People were treated with dignity and respect. We observed staff knocked on people's doors before entering their room. We saw two staff members tidying out a person's wardrobe. Staff told us, "We asked if it was OK to do it and were told just to get on with it." Staff we spoke with also described how they aimed to support people whilst maintaining their privacy and dignity. They said they would always allow people their choices, check people wanted support and keep people covered as much as possible when supporting them with personal care. We noted the registered provider had recently introduced a 'person centred policy' which described the approach to involving people in care planning, developing and accessing care with compassion, and treating people with dignity and respect.

We carried out a specific observation in the communal lounge using SOFI. Throughout the 40 minutes of our observation we saw people received regular positive interaction from staff. One person who was watching a movie on the computer asked a staff member if they could turn off a light as they were finding it difficult to see the screen. We saw the staff member responded quickly and turned off a light. Another staff member spent time chatting with the person about the movie. Staff checked that all people were alright and asked if they would like a drink. Some people replied that they would like a drink and staff provided this straightaway. Drinks were readily available at all times in the lounge for people to help themselves. One staff member asked a person if they would like to help them to do a jigsaw to which the person agreed. The staff member was calm and relaxed. They gave the person the time they needed to perform each task. The staff member patiently explained to the person what each piece was whilst at the same time prompting the person to eat a biscuit and drink some squash. After completing the jigsaw the staff member suggested the person could read the newspaper, which the person agreed to do. The staff member then proceeded to move a small table towards the person to make it easier for them to read the newspaper.

At other times during the day of our inspection we saw good interaction between people and staff. Staff sat and talked with people or played games. Staff were present in the lounge most of the time to check people were safe. There was also a window in the nurses office which looked onto the lounge, so people could be observed most of the time. We observed staff checking very regularly on people in their own rooms.

Staff encouraged people to be independent. We saw two people had chosen to access the local community independently. One person said, "I am a local chap so I like to go out and see people I know. One of the staff takes me to the market every week and I see old friends." Other people chose how to spend their time in the home. For example, playing games, watching TV or taking part in a quiz.

Good

Is the service responsive?

Our findings

Staff had access to up to date information about how people should be supported and cared for. Care records contained a document called 'This is me.' This provided staff with important information they needed to know about people and specific things staff needed to do to enhance their well-being. For example, for one person this was for staff to use specific toiletries when supporting the person with personal care and specific dietary requirements.

We looked at four people's care plans. We saw these contained personalised information about the person and their preferences. For example, a short 'pen picture' about the person, which included details of the person's next of kin, key worker and their GP. All care plans were comprehensive including people's preferences and priorities. For example, within communication it stated, '[Person's name] is able to write down his thoughts and wishes….staff must be vigilant of [person's name] body language.' Care plans covered a range of areas including daily living, personal hygiene, medicines, nutrition, mobility, communication and activities. All records we viewed were current and up to date.

Staff were required to update themselves about people's current needs and support requirements. One staff member told us, "[Staff member's name] encourages staff to read people's care plans, it's about getting to know the person." They also stated, "If [person's name] has had a bad night we get to know through daily handovers." In this way staff were knowledgeable about the people they cared for and had an understanding of their needs.

The registered manager told us the home employed an activities organiser. They ensured people had a range of activities to take part in, including maintaining links to the local community. We saw from viewing daily records a number of people were members of a luncheon club at a local hotel which they attended every Thursday. We saw people enjoyed activities such as playing bingo, playing cards, taking part in quizzes, cinema trips or out shopping. We also saw board games, dominoes, jigsaws and puzzles were visible around the home. We observed staff talking to people as they went about their work. When time allowed they sat and chatted with people.

People told us they were taken on outings both in groups and individually. Other people went out independently. One person told us, "I go on my own to play bowls which I enjoy." We saw people using adapted computers to access the internet or to watch movies. The activities organiser told us they had a monthly budget. This was boosted by other events held at the home, enabling entertainers to be booked. People told us a hairdresser visits every Tuesday afternoon.

Each person had an 'activities plan' which detailed their preferred activities. For one person these were visits from family, watching TV and having their hair done. The activity plan had a clearly identified goal. For example, for one person this was to ensure the person does not become bored by ensuring they had access to their TV and music. We saw activities people had taken part in were recorded in their care records.

The registered provider had a complaints policy and procedure. It outlined the complaints process including contact details for external organisation such as CQC and the Citizens Advice Bureau. The registered manager told us there had been no recent complaints made about the service. However, the provider had a system in place to log and investigate complaints.

People had opportunities to give their views about the home. We saw resident and visitor meetings were regularly held however we were told visitors rarely attended. One person told us, "Yes meetings are held regularly and we had one last week. We discuss what we would like to do."

Requires improvement

Is the service well-led?

Our findings

The home had a registered manager. Since our last inspection the manager's application to register with the Care Quality Commission had been approved. Staff told us the new manager was supportive and approachable. One staff member said, "If I have any problems I can go and see Cynthia [registered manager] or [nursing manager's name]. They are approachable." Another new staff member said they were, "Fully supported from everybody, the manager and nursing manager. All the staff are there to help you. Everybody made sure I was ok." People told us they had regular contact with the manager as well as the nurse.

Both staff members we spoke with confirmed there were regular team meetings. Previous meetings had been used to raise awareness of important issues. Staff told us they felt able to give their views within team meetings. One staff member said, "I feel confident giving my views in team meetings."

We observed there was a nice calm atmosphere in the home and staff related well to people. One staff member commented there was a, "Good atmosphere, the residents get good care." Another staff member said the atmosphere was, "Good, everybody gets on."

The registered provider had a system of quality assurance checks and audits in place. The approach to quality assurance was documented in the 'Quality Assurance Policy.' This included checks on a range of areas including fire safety, health and safety, supervision, complaints, staffing levels and care plans. We saw quality assurance checks had identified areas for improvement. For example, where care plans needed to be updated or record keeping improved. We found the registered provider carried out external quality checks of the service. We viewed recent examples of these checks which included further checks of record keeping, staff dress code, staff conduct and complaints. The most recent check had looked at staff interaction with people using the service, with visitors and between staff. The findings from this check were that interaction was 'good.' However, we found there was little evidence of lessons learned. For instance, the lessons learnt section of most the quality checks we viewed had been left blank.

We found it was still too early to assess whether the quality assurance programme will be successful in delivering long term sustained improvement in the quality and safety of people's care. Particularly, as we had concerns that we identified further issues during this inspection that the registered provider had not previously been pro-active in dealing with.

Since our last inspection the three monthly safeguarding analysis had been further developed to consider DoLS. This included a check on the number of DoLS applications made, how long authorisations had been granted for and when a re-application was due. The outcome of the latest analysis dated March 2015 was that all required DoLS authorisations were in place.

The registered provider regularly sought people's and family member's feedback about the quality of care delivered at the home. We viewed the feedback from the most recent surveys, this was provided by three people and six family members. They were asked about their overall experience, professionalism of staff, staff understanding of people's needs and communication. Feedback given was positive with three out of six family members stating the service was excellent or good. Specific comments made in the feedback included: 'Friendly, relaxed and re-assuring. A well run home'; 'Very friendly, staff are very helpful'; and, 'I have been well impressed with the home and looking after my brother.' We saw one person had requested in the feedback that they would prefer a bigger room. The registered provider had agreed to this request and the person had since moved rooms.