Garlands Residential Care Home Limited

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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

Summary of findings

Overall summary

This inspection took place on 27 September and 2 October 2017 and was unannounced on the first day and announced on the second day. The service was previously inspected on 26 and 29 April 2016 and was at that time not meeting the regulations related to safe management of medicines and person-centred care. We found some improvements had been made at this inspection to meet the relevant requirements but the service was not meeting other requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Garlands Residential Care Home, known as Garlands to the people who live there, their relatives and staff, provides personal care for up to 20 older people, some of whom are living with dementia. Accommodation is in single and double bedrooms. On the day of our inspection there were 17 people living in the home.

The service did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission (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 current manager of the home had commenced their application to register with CQC but their application had not been finalised at the time of this inspection. The nominated individual was also applying to register as joint registered manager.

Robust emergency plans were not in place in the event of a fire because fire drills had not been regularly completed to reduce risks to people, and staff gave us inconsistent information about action they should take in the event of a fire.

We found improvements needed to be made to the registered provider's system of water temperature checks to ensure people were not at risk of scalding, as recommended by the Health and Safety Executive.

People told us they felt safe. Staff had a good understanding of how to safeguard adults from abuse and who to contact if they suspected any abuse.

Risks assessments were individual to people's needs and minimised risk whilst promoting people's independence.

Effective recruitment and selection processes were in place. Two staff members had recently commenced employment without a reference from their most recent employer; however alternative checks and safeguards had been put in place until references were received.

We found improvements had been made in the management of medicines, although some minor discrepancies were found during our inspection.

Staff told us they felt supported. Records showed they had received an induction and role specific training;

however we saw staff supervision was minimal. This meant staff were not always supported to fulfil their role effectively.

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, although some best interest processes had not been evidenced; for example, when consenting to the bedroom door being locked during the day. We made a recommendation about good practice where people may lack mental capacity to consent to certain decisions.

People told us they enjoyed their meals. People's nutritional needs were met and they had access to a range of health professionals to maintain their health and well-being.

The home had begun a building programme to extend the facilities and upgrade the environment to be more suitable for people with a physical disability. The environment had been adapted to be more suitable for people living with dementia, although the décor in some areas was in need of refreshing.

Staff were caring and supported people in a way that maintained their dignity, privacy and diverse needs. Relatives told us staff were caring and we observed staff interacting with people in a caring, friendly manner. Observation of the staff showed that they knew people well and could anticipate their needs.

Individual needs were assessed and met through the development of detailed personalised care plans. People's needs were reviewed as soon as their situation changed.

An activity coordinator had been employed at the service, which meant improvements had been made in the provision of activities.

Systems were in place to ensure complaints were encouraged, explored and responded to in good time and people told us staff were always approachable.

The registered provider and manager were available in the home to provide support and had an overview of the service. There were gaps in the auditing and overview of the service, which meant some of the issues we found had not been identified or addressed.

The manager and registered provider knew the needs of people who used the service and people and staff were positive about their input in to the service. People told us they liked the family atmosphere of the home.

The manager had taken some action to improve the quality of the service during the months prior to this inspection.

People who used the service and their relatives were asked for their views about the service and these were acted on.

We found breaches of the health and social Care Act (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the 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 always safe.

Fire drills were not regularly completed and the system of water temperature checks needed to be improved to reduce the risk of harm.

Sufficient staff were deployed to meet the assessed needs of people using the service.

Systems were in place to make sure people received their medicines safely.

Is the service effective?

Requires Improvement

The service was not always effective.

People's mental capacity was considered when decisions needed to me made, although some best interest processes had not been recorded.

Staff were trained to support people who used the service, but were not always supported by management supervision.

People were supported to eat and drink, and to maintain a balanced diet.

People had access to external health professionals as the need arose.

Is the service caring?

Good

The service was caring.

People told us and we saw staff were kind and caring.

Staff were respectful in their approach and were able to tell us how they maintained people's privacy and dignity.

People were supported to make choices and decisions about their daily lives.

Is the service responsive?

Good

The service was responsive.

People's care plans contained sufficient and relevant information for staff to provide person-centred care.

People had access to activities in line with their tastes and interests.

People told us they knew how to complain and told us staff were always approachable.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The registered provider's quality assurance systems had not identified and addressed some of the concerns we found.

People and staff were positive about the family who ran the home. They said they were visible within the service and knew people's needs very well.

The culture was positive, person-centred, open and inclusive.

Garlands Residential Care Home Limited

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 29 September and 2 October 2017 and was unannounced on the first day and announced on the second day. The inspection was conducted by one adult social care inspector and an expert by experience on the first day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their expertise was in mental health and older people. One adult social care inspector conducted the second day of the inspection.

Prior to our inspection we reviewed all the information we held about the service. This included information from notifications received from the registered provider, and feedback from the local authority safeguarding team and commissioners. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used this information to help plan the inspection.

Some people who used the service communicated non-verbally and as we were not familiar with their way of communicating we used a number of different methods to help us understand people's experiences. We spent time with them observing the support people received. We spoke with four people who used the service and three of their relatives. We spoke with two care staff, two senior care staff, the deputy manager, one cook, the activity coordinator, the manager and the registered provider. We looked in the bedrooms of six people who used the service with permission.

During our inspection we spent time looking at four people's care and support records. We also looked at four records relating to staff recruitment, three training records, incident records, maintenance records, and

a selection of audits.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe at Garlands and the relatives we spoke with told us they felt confident their family member was safe. One person said, "I have a buzzer, but I have never used it." Another person said, "I am happy with staffing, there are always plenty about." A third person said, "Yes I do feel safe."

One relative commented, "The doors are always locked, and there is a safe area at the back for them all to use. It is all fenced off." Another relative said, "I have no concerns over safety." And a third relative told us, "They do wear protective clothing and gloves when dealing with residents."

Emergency plans were not in place in the event of a fire because fire drills had not been regularly completed to reduce risks to people. The last recorded fire drill was in 2015. The manager was aware of what to do in the event of a fire; however staff we spoke with gave us conflicting information about the procedure to follow. This meant the registered provider did not have emergency procedures in place to prevent the risk of harm to people in the event of a fire.

Following our inspection the manager sent us evidence staff had been made aware of the procedure to follow in the event of a fire and the schedule of regular evacuations planned.

Checks had been completed on fire safety equipment, emergency lights and the fire alarm. People had a detailed personal emergency evacuation plan (PEEP) in place. PEEPs are a record of how each person should be supported if the building needs to be evacuated.

We found the water in one of the hand basins in a communal toilet felt very hot, despite having a thermostatic mixing valve (TMV) installed. The registered provider found the TMV was faulty and rectified this immediately. However, records showed water temperatures were only checked once a year, in relation to the prevention of legionella, and the temperature of water from shower heads was not recorded prior to supporting people to shower. We found there were gaps in the recording of bath temperatures on 15 and 10 days in September and August 2017. This is important because Health and Safety Executive guidance states, "If hot water used for showering or bathing is above 44 °C, there is increased risk of serious injury or fatality."

This meant a suitable system of water temperature checks was not in place to mitigate the risk of scalding to vulnerable people.

The above issues were a breach of regulation 12 (1) and (2) (a), (b) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All other hot water outlets checked were within a safe range. The registered provider told us they would now check water temperatures monthly as part of their health and safety audit and ensure water temperatures were always checked and recorded prior to supporting people to shower or bath.

At our last inspection in April 2016 the registered provider was not meeting the regulations related to the safe management of medicines. At this inspection we found improvements had been made. The manager told us senior staff at the home completed training in safe administration of medicines and we saw certificates to confirm this. We saw staff competence in giving medicines had been assessed and plans were in place to continue to assess this regularly. This meant people received their medicines from people who had the appropriate knowledge and skills.

People's medicines were stored safely in a secure medicines trolley which was locked away in a secure medicines room when not in use. We found all of the medicines we checked could be accurately reconciled with the amounts recorded as received and administered with the exception of two counting errors, which a senior care worker on duty said they would follow up. This meant people were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.

Staff maintained records for medicines which were not taken and the reasons why, for example, if the person had refused to take it, or had dropped tablets on the floor. We saw a stock check was completed weekly.

Some prescription medicines contain drugs that are controlled under the misuse of drugs legislation. These medicines are called controlled medicines. We inspected the controlled medicines register and found all medicines were accurately recorded.

Creams and ointments were dated upon opening and found to be in date. Body maps were in place to guide staff as to where to administer creams, with the exception of one person who had recently moved to the home. Staff we spoke with were aware of where this person's topical cream should be applied. Eye drops were dated upon opening and found to be in date.

Medicines care plans contained information about people's medicines and how each person liked to take them, including individual 'when required' medication protocols for the person. One person was without a 'when required' protocol for Paracetamol and one person did not have one for Laxido. The manager told us they were sure these had been completed, but would address this. Staff we spoke with were aware of how and when these medicines should be administered. Having a 'when required' protocol in place provides guidelines for staff to ensure these medicines are administered in a safe and consistent manner.

Senior staff completed medicines audits which included areas such as checking the completeness of Medicine Administration Records (MARs), the use of protocols for 'when required' medicines and topical creams. Records showed action was taken when issues arose. We saw a memo was sent to staff in August 2017 regarding recent audit findings in order to improve staff practice. This demonstrated the home had medicines governance systems in place.

Staff we spoke with were clear about their responsibilities to ensure people were protected from abuse and they understood the procedures to follow to report any concerns or allegations. Staff knew the whistleblowing procedure and said they would be confident to report any bad practice in order to ensure people's rights were protected. One staff member said, "If I was concerned about staff practice I would go to (name of manager and owner). If I was concerned about managers, I would go to safeguarding (the local authority)." We saw information around the building about reporting abuse and whistleblowing.

Records showed safeguarding incidents had been dealt with appropriately when they arose and safeguarding authorities and Care Quality Commission (CQC) had been notified. This showed the registered

provider was aware of their responsibility in relation to safeguarding the people they cared for.

Systems were in place to manage and reduce risks to people. In people's care records we saw comprehensive risk assessments to mitigate risk in areas including physical activity, falls, safe use of the stair lift and bath hoist, physical health and hygiene. We saw these assessments were reviewed regularly, signed, and up to date. The members of staff we spoke with understood people's individual abilities and how to ensure risks were minimised whilst promoting people's independence. This showed the registered provider had taken action to deliver safe care and reduce risks to people.

Staff told us they recorded and reported all incidents and people's individual care records were updated as necessary. We saw in the incident and accident log that incidents and accidents had been recorded and an incident report had been completed for each one. Staff were aware of any escalating concerns and took appropriate action.

People and staff told us there were enough staff on duty. We saw appropriate staffing levels on the days of our inspection which meant people's needs were met and people received sufficient support. The provider had their own bank of staff to cover for absence and asked familiar staff to do extra shifts in the event of sickness, as well as using occasional agency staff. This meant people were normally supported and cared for by staff who knew them well.

We looked at four staff recruitment files. Two out of the four most recently employed staff lacked a reference from their most recent employer due to the employer no longer operating; however the manager showed us they were still pursuing the references via the former employer's head office in order to obtain confirmation of the dates the two staff members worked there. They said the staff members never worked alone and showed us all other vetting had been completed before they commenced employment, including two further references and a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups. Following our inspection the manager forwarded the references, which had been received by email. This showed staff had been checked to make sure they were suitable and safe to work with people.

People who used the service, staff and visitors were protected against the risks of unsafe or unsuitable premises. We saw evidence of service and inspection records for gas installation, electrical wiring and portable appliance testing. Equipment such as a stair lift had been serviced and certified as safe for use. A series of risk assessments were in place relating to health and safety.

The steps down to the staff office, which was located in the cellar, had a gate with a latch to prevent people using them. We discussed the risk that a person may open the latch and potentially be injured. The registered provider agreed to consider a more secure gate, until the new office was completed. People had access to a secure paved garden area with seating. The area contained a broken table. We discussed the risk of falls this may present to people who independently used a nearby part of the paved area. The registered provider removed the table straight away.

An extension was in the process of being completed to add extra rooms to the home, including a larger dining area and lounge, a through floor lift, additional en-suite bedrooms and office space. The registered provider told us during building works the health and safety of people using the service, staff and visitors was a priority and they would complete building health and safety walk round checks to ensure any risks were assessed and reduced.

Requires Improvement

Is the service effective?

Our findings

Relatives told us they were confident the staff team could meet their family member's needs. One relative said, "Staff seem to know what they are doing. Most of them are experienced."

Staff we spoke with told us they felt appropriately supported by managers and had occasional supervision and staff meetings. Regular supervision of staff is essential to ensure people are provided with the highest standard of care. We looked at four staff supervision records and found minimal supervision had been completed. The registered provider's policy stated supervision should be held four times a year for full time staff. In one record we found supervision had been completed in May 2017 and February 2016, a gap of 15 months and for the second record we sampled in June 2017 and September 2016, a gap of nine months. This showed staff did not always receive regular management supervision to monitor their performance and development needs.

This was a breach of regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager showed us they had completed staff supervision and appraisal recently and planned to use a supervision matrix to ensure staff supervision was more regular in the future.

Staff were provided with training to ensure they were able to meet people's needs effectively. We saw evidence in staff files that new staff completed an induction programme when they commenced employment at the service. This included two days of initial induction training and then shadowing a more experienced staff member for three shifts or more, before they were counted in the staffing numbers. The shadowing focused on getting to know people's individual needs and preferences. This demonstrated new employees were supported in their role. We saw three new staff members had completed an appraisal with the manager after their induction to ensure their development needs were met.

We looked at the training records for four staff and saw training included infection prevention and control, emergency first aid, food hygiene, moving and handling, equality and inclusion, the Mental Capacity Act and Deprivation of Liberty Safeguards, safeguarding adults, and breakaway techniques. Staff told us and we saw they were supported to complete nationally recognised qualifications at level two and three and some staff had also completed additional training in palliative care and pressure ulcer prevention. We saw from the training matrix almost all training was up to date and further training was planned onto the rota. Some staff had not completed recent refresher courses in dementia awareness and the manager told us they were planning this in the near future. This demonstrated people were supported by suitably qualified staff with the knowledge and skills to fulfil their role.

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

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

Staff at the service had completed training and had an understanding of the MCA. One staff member said, "If someone refuses their medication we would keep going back to offer, but if they keep refusing we would contact the GP about covert. If they lacked capacity you would have to have a best interest meeting to make sure it's the right decision."

We asked the manager about the MCA and DoLS and they were able to describe to us the procedure they would follow to ensure people's rights were protected. Nine people were either subject to DoLS authorisations with no conditions or were awaiting assessment. Eight further people were considered to have the mental capacity to decide to live at the home.

We found for one person there was evidence of good practice in the assessment of mental capacity for important decisions, such as the use of a door alarm. There was evidence a relative had lasting power of attorney to make decisions around care and welfare, as well as an advanced decision the person had made on one particular issue.

Care records we sampled contained mental capacity assessments and best interest decisions which had been completed in relation to decisions such as coming to live at the home and the administration of medicines. We found where mental capacity assessments had been completed for some people, no best interest discussion had been recorded to show the person's representative had been consulted and the decision that was made on the person's behalf was the least restrictive and in their best interests.

We found there was some inconsistent information regarding one person's capacity and ability to consent to certain decisions. The communication section of the person's care plan stated 'Can be disorientated.' And their mental health section stated, "Confused," with no reason given. The person had recently signed their consent to their bedroom being locked when they were not in it, however their consent to the administration of medicines form was signed by the manager only. A mental capacity assessment had not been completed for each decision to evidence whether the person did or did not have the capacity to consent to the decisions. This meant the manager may not have gained valid consent and no best interest process was recorded where the person may have lacked mental capacity. The manager told us they would arrange to record best interest discussion with people's representatives as soon as possible and we asked them to send us evidence of this.

We recommend the registered provider consults best practice in this area to ensure mental capacity assessments and best interest processes are always recorded when decisions need to be made on behalf of people who lack capacity.

One person said, "The food is lovely. I will be as fat as a pig before I leave here." Other comments included, "I am now putting weight on as I'm having regular meals", "There is always enough to eat and drink", "There is a choice, and it is always hot", and, "Yes it is nice food. I don't want a lot."

One relative told us, "Sometimes the food doesn't look good but there is always a choice, even if it's not on the menu." Another relative said, "I haven't seen much fruit available, but they can get drinks anytime." A third relative said, "[My relative] eats their food. It's a hearty meal. [My relative] likes the puddings."

Meals were planned around the tastes and preferences of people who used the service. Menus were on display with a choice of two meals and two desserts. We heard staff offering people a choice of meal and drink and we saw they received the meal and drink of their choosing.

We saw staff supported and encouraged people to eat and drink. Interactions between staff and people were friendly and supportive. One person waited in the dining room for their meal for over ten minutes, whilst other people were being supported.

The cook had a list in the kitchen with people's special dietary requirements and tastes. We saw the individual dietary requirements of people were catered for, for example, some people needed low sugar diets and some people required food to be fortified.

Meals were recorded in people's daily records. This included a record of food consumed, including where food intake was declined, and details of the food eaten. There were some minor gaps in recording for one person, which the manager told us they would address with staff. We saw some people helped themselves to a drink, and snacks and drinks were offered to people throughout the day. People were weighed weekly to keep an overview of any changes in their weight. The manager kept an audit of people's weight to look for any patterns or changes and contacted the GP if action was required. This showed the service ensured people's nutritional needs were monitored and action taken if required.

One person said, "The GP comes to see me here. Have not had my eyes checked for a while." Another person said, "I am going to the dentist tomorrow." Records showed people had access to external health professionals as the need arose. Staff said people attended healthcare appointments and we saw from people's care records a range of health professionals were involved. This had included GP's, psychiatrists, community nurses, chiropodists, dentists, speech and language therapists, physiotherapists, and the falls team. This showed people who used the service received additional support when required to meet their care and treatment needs.

People's individual needs were met by the adaptation, design and decoration of the service. We saw the home was homely and comfortably furnished and there were pictures and photographs in the communal areas. The majority of the home was in good decorative condition, although some areas were in need of updating, such as the entrance hall doors, which were scuffed. The registered provider showed us the program of updating and decoration they had completed and planned.

Bedroom doors were numbered along with a photograph of the person if they wished, to aid orientation. The registered provider had begun to improve the environment to support people to live well with dementia. They showed us they had painted one person's bedroom door to look like an external door, with a letter box. They told us the feedback about this had been positive and they intended to offer the same option to other people living with dementia to help them identify their own bedrooms. In communal areas doors and surrounding walls were painted in contrasting colours, making orientation easier for people with recognition difficulties. This meant the design and layout of the building was conducive to providing a homely but safe and practical environment for people who used the service.

Good

Is the service caring?

Our findings

People and relatives told us the staff were caring. One person said, "I'm happy and content, well looked after." Another person said, "Staff are very approachable." A third person said, "I don't need any help washing, but they do check-up." A fourth told us, "They are very nice. They leave me to sleep." And a fifth person we spoke with replied, "The staff are lovely. Very nice."

We asked relatives if they thought staff were caring. One relative said, "Wonderful. They are very good with residents." Another relative commented, "People (staff) care, they're a lovely lot. No worries about them doing the right thing for them (people)." A third relative told us, "Staff are friendly."

People who used the service told us they liked the staff and we saw there were warm and positive relationships between people. Staff we spoke with enjoyed working at Garlands and supporting people who used the service. One staff member said, "I love it. I get on with everyone. The residents are lovely." Another staff member said, "I enjoy it. You feel like you are helping residents to enjoy their life."

Staff we spoke with had a good knowledge of people's individual needs, their preferences and their personalities. They used this knowledge to engage people in meaningful ways, for example, with conversations about activities or by playing music they knew the person liked. We saw people laughing, smiling and dancing with staff.

We observed staff intervening in a positive and sensitive manner when a person became verbally aggressive. Staff intervened and gently guided the person away from the source of their agitation. Staff used appropriate touch and spoke kindly to the person offering them a cup of tea and spending time with them. One person was searching in their pocket for a handkerchief and the manager noticed this and went to fetch one for them.

People were supported to make choices and decisions about their daily lives. One person said, "I choose what I want to wear myself." People told us they had a choice of meals, what time to get up or go to bed, clothing, activities, or when to have a bath or shower. People's diverse needs were respected and care plans recorded the gender of carer they preferred to support them, as well as their religious and cultural needs.

Staff used speech, gestures, and facial expressions to support people to make choices according to their communication needs. Staff told us they showed people a choice of clothing or food to support them to make every day decisions if a person's verbal communication was limited. One staff member said, "I write choices down for one person due to hearing loss."

People appeared well groomed and looked cared for, choosing clothing and accessories in keeping with their personal style.

We saw some people who used the service had their own bedroom door key in order to lock their room if they wished to do so. Staff knocked and asked permission before entering bedrooms. Staff told us they kept

people covered during personal care and ensured doors were closed. People's private information was respected and records were kept securely in a locked cupboard. A privacy statement was on the staff notice board entitled, "A resident's room is their home."

People's individual rooms were personalised to their taste with personal items, photographs, ornaments and bedding they had chosen. Personalising bedrooms helped staff to get to know a person and helped to create a sense of familiarity and make a person feel more comfortable.

People were encouraged to do things for themselves in their daily life. Care plans detailed what people could do for themselves and areas where they might need support. This showed us the home had an enabling ethos which tried to encourage and promote people's choice and independence.

Staff were aware of how to access advocacy services for people if the need arose and some people who used the service had independent mental capacity advocates. An advocate is a person who is able to speak on a person's behalf, when they may not be able to do so for themselves.

People and their representatives had been consulted regarding end of life plans and wishes and these were recorded. Our review of care plans evidenced there was a record of 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) decisions. This included an assessment of the person's capacity, communication with relatives, and the names and positions held of the healthcare professional completing the form.

Good

Is the service responsive?

Our findings

Through speaking with people who used the service and their relatives we felt confident people's views were taken into account in planning their care.

One relative said, "There is a key worker. I would recognise her if I saw her." Another relative said, "The home rings if anything is wrong straight away." A third relative told us, "I know there is a care plan but I don't deal with it. Another relative sees to this."

We found care plans were person-centred and explained how people liked to be supported. For example, entries in the care plans we looked at included, "Likes to have a cup of tea with plenty of milk", and preferred pet names, "Not darling." This helped care staff to know what was important to the people they cared for and helped them take account of this information when delivering care. This is important as some of the people who used the service had memory impairments and were not always able to communicate their preferences.

A detailed 'getting to know me' life history was included in the records we sampled and a, "love and well-being flower", which detailed important relationships and things that mattered to the person.

Care plans covered areas such as consent, orientation, personal care, eating and drinking, communication, mobility and falls, mouth care, social activities, medication, moving and handling, skin integrity and finances. People's needs were reviewed as soon as their situation changed. Reviews were held regularly and care plans were evaluated and updated monthly or when needs changed. These reviews helped monitor whether care plans were up to date and reflected people's current needs so any necessary actions could be identified at an early stage.

People's care plans contained direction for staff in how to provide safe care, for example, when supporting a person to transfer from a wheel chair to an easy chair. Care plans also contained information about how staff would care for people when they experienced behaviours that may challenge others, and the action staff should take in utilising de-escalation techniques. When we spoke with members of staff they were aware of this information. This showed the service responded to changes in the behaviour of people who used the service and put plans in place to reduce future risks.

Daily records contained information about each person's food intake, personal care, mood and social interactions.

Some people told us they were able to access activities in line with their tastes and interests. One person said, "Yes sometimes there are activities. I go into the lounge. I go into the garden sometimes. It's very nice outside if it's sunny." A second person told us, "I go shopping sometimes." A third person commented, "Activities? Nowt."

One relative said, "[My relative] joins in with communal activities." Another relative said, "I think there could

be a greater variety of social activities." A third relative told us, "Activities could be improved as there are long periods of time when there is nothing happening. They have people come in to sing to them."

At our last inspection in April 2016 the registered provider was not meeting the regulations related to person-centred care, because activities were not provided to meet the needs of all people living at the home, including those who may be living with dementia. The registered provider had employed an activity coordinator in May 2017, although they had been absent for a period of around a month shortly after this. We found activity levels had improved and people with limited ability for social interaction were now receiving more person-centred one to one interactions suitable for their needs.

On the first day of our inspection the activity coordinator held a quiz with some people in the lounge, as a planned clothes party had been cancelled by the clothes company. On the second day of our inspection the activity coordinator was doing a bean bag challenge with one person and later people joined in with painting in the dining room. We saw activities such as carpet bowls and table top games were used in communal areas and some people looked at books, read newspapers, watched TV, chatted and listened to music. The activity coordinator was trying out different activities to see what worked with people and spent time every day they were on duty interacting one to one with people in the home, as well as completing some small group activities. This meant staff supported people with their social needs.

Staff spoke with good insight into people's personal interests and we saw from activity records some people had taken part in activities both inside and outside the home. We saw from records some people had been on a canal trip and a further trip was planned later in the week of this inspection. Other activities had included a 'Zoo lab' visit, use of a scent box, quizzes, guessing games, musical entertainers, shopping for clothes and nail manicures.

Some people told us they did not want to do activities and were happy to read the paper and listen to music. Two people went out alone in to the community and we saw two people used the garden frequently during our inspection. One person enjoyed filling up the bird feeder in the garden and they were supported by staff with this.

A church service was offered at the home once a month. The activity coordinator was planning to engage with other denominations in the community to make links for people who lived at the home and provide spiritual support.

We found when the activity coordinator had not been on duty limited activities or social interaction was recorded. The registered provider said they would consider additional staffing when the activity coordinator was not available to ensure staff had the time to interact with people in meaningful ways.

People we spoke with told us staff were always approachable and they were able to raise any concerns. One relative said, "Any serious concerns are sorted immediately." Another relative said, "I have complained in writing to the manager about the laundry as even though name tags are on clothing things still go missing or are given to other residents." We saw there was an easy read complaints procedure on display. Staff we spoke with said if a person wished to make a complaint they would facilitate this. If it was a simple complaint they could resolve immediately, for example missing clothing, they would attempt to find the clothing and resolve the issue. We saw from a memo to staff in December 2016 two complaints regarding laundry had been received from relatives and the manager had taken action to resolve these. Compliments were also recorded and available for staff to read.

Requires Improvement

Is the service well-led?

Our findings

People and their relatives told us the home was well managed. One person said, "The owners are nice. They are very nice, very good. I don't know who the manager is. [My relative] knows."

One relative said, "The manager is always about and is easy to talk to. You do not need an appointment." Another relative said, "It's difficult to care for everyone's needs, but it is a family business and I like that as they are all involved." Other comments included, "We moved a relative here from another home where the building was beautiful but the care was atrocious, this is more like a family home than a care home", "I really think they should get the laundry sorted out", "We can speak on a casual basis with the manager rather than complete surveys", and, "Improve? I don't know really. Couldn't improve on care."

Staff we spoke with were positive about the manager and told us the home was well-led. One staff member said, "Yes I feel supported a lot. I am confident to talk to managers about anything. They are a lovely family." Another staff member told us, "It's a nice friendly atmosphere", and a third commented, "I think it's well-led. It's a lovely family home."

At the time of this inspection the service did not have a registered manager in post. The current manager had been previously registered as manager and had stepped down due to family commitments. A registered manager was then employed until September 2016. When this manager left the current manager stepped back in to manage the home and had begun the process of applying to register with the Care Quality Commission (CQC) again in September 2017. At the time of this inspection their application had not been finalised. The registered provider was also applying to register as joint registered manager of the home.

We found there were some gaps in the audits for medicines, recording of complaints and incidents overview, and some safety checks were not completed, which meant some of the issues we found had not been identified or addressed. For example a health and safety building walk round scheduled to be completed monthly had last been completed in November 2016. Fire drills had not been completed since October 2016.

We saw the registered provider had a system in place for analysing accidents and incidents to look for themes; however this overview had not been completed since May 2017. We also found two incidents recorded on incident forms in people's care files that were not recorded on the incident log, which meant the overview would not be accurate and up to date. This demonstrated the registered provider was not always keeping an overview of the safety of the service.

We saw from a memo to staff in December 2016 two complaints regarding laundry had been received from relatives and the manager had taken action to resolve these by sending a memo to staff; however these were not recorded as complaints in the complaints file or log, in order to look for themes and document learning from complaints.

Records for one person who had recently transferred from another service included allergy information which was inconsistent on different records. The manager clarified this with the GP immediately following

our inspection.

We saw from records staff meetings had been sporadic since our last inspection in April 2016. One meeting with senior staff had been held in July 2017 and prior to that the last meeting was in May 2016. No day care staff meetings had been held since March 2016 and two night staff meetings had been held in August 2016 and March 2017. Staff meetings are an important part of the provider's responsibility in monitoring the service and coming to an informed view as to the standard of care for people.

This above concerns were a breach of regulation 17 (1) and (2) (a) (b) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because effective systems were not in place to assess, monitor and improve the quality and safety of the service.

Care plans were reviewed and audited regularly and were up to date. Audits of medicines were completed, although there was a three month gap in 2016. We saw some audits were completed in relation to premises and equipment, for example, wheelchair and building cleaning regimes were checked and maintenance audits were completed every few months. This showed staff compliance with the registered provider's procedures was monitored.

The management team were visible in the service and regularly worked with staff providing support to people who lived there, which meant they had an in-depth knowledge of the needs and preferences of the people they supported.

The manager said they operated an 'open door policy' and people were able to speak to them at any time. People we spoke with confirmed this. The senior care staff told us they felt supported by the registered provider, and were able to contact a manager at any time for support. They said they enjoyed working for the organisation and worked well as a team to support each other.

People who used the service and their representatives were asked for their views about the service and they were acted on. Residents' and relatives' meetings had been held twice a year and topics in July 2017 included feedback from the canal tip that people enjoyed and ideas for further activities, the summer fair and money raised for the residents fund, laundry issues, the last CQC report and dementia friendly environments. Any issues raised had been addressed by the manager. This meant people's views were taken into account and they were encouraged to provide feedback on the service provided. The service also produced a newsletter for residents and relatives to keep up to date with any developments.

The manager used memos to update staff approximately monthly on issues such as record keeping, laundry, medicines management, accident log completion and the documenting of people's personal care.

The manager told us they attended training, managers meetings and good practice events, and were currently completing a level five management qualification. They had been involved in a mouth care project with the local community health team to improve practice in care homes. We saw this good practice was now embedded within the service.

The manager was also involved in the development of a 'grab a pack' scheme, to ensure essential information was available when people were admitted to hospital in an emergency. The manager showed us the packs and discussed the meetings they had attended to promote the project. This meant the manager was open to new ideas and keen to promote the best outcomes for people who used the service. The manager had also signed up to an 'Experience manager" course and had a one to one mentor assigned to them in order to support their practice.

The registered provider told us they felt there was a call for a small homely home like theirs, with character and a family atmosphere. "We want to extend the lounge and add a quiet lounge and some bedrooms. Not too big. We want to keep people as independent as possible."

The registered provider and manager were available in the home to provide support and had an overview of the service. We found the service worked in partnership with health and social care professionals and there was no delay in involving partners to ensure the wellbeing of the people living there.

The manager understood their responsibilities with respect to the submission of statutory notifications to CQC. Notifications for all incidents which required submission to CQC had been made.

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 12 HSCA RA Regulations 2014 Safe care and treatment Emergency plans were not in place in the event of a fire because fire drills had not been regularly completed to reduce risks to people. A suitable system of water temperature checks was not In place to mitigate the risk of scalding burns to vulnerable people. (1) and (2) (a), (b) (d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective systems were not in place to assess, monitor and improve the quality and safety of the service. (1) and (2) (a) (b) (f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not always receive regular management supervision to monitor their performance and development needs. (2) (a)