Mr & Mrs D Bolland

Garlands Residential Care Home Limited

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 27 April 2016 and was unannounced. We carried out a second inspection day on 29 April 2016 and this visit was announced. The service was previously inspected on 24 October 2014 and was not meeting the requirements in relation to the maintenance of the premises, meeting the requirements of the Mental Capacity Act 2005, cleanliness, record keeping and monitoring the quality of service provision. We found some improvements had been made at this inspection to meet the relevant requirements but the service was not yet meeting all the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Garlands Residential Care Home provides personal care for up to 20 older people, some of whom are living with dementia. On the day of our inspection there were 18 people living in the home most of who were living with advanced dementia. Accommodation is in single and double bedrooms.

There was a registered manager in place who had been registered. 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.

Staff had received training in how to keep people safe. All the staff we spoke with demonstrated they understood how to ensure people were safeguarded against abuse and they knew the procedure to follow to report any safeguarding incidents.

Risk in some areas was well recorded such as for nutrition and skin integrity. Risks around the use of assistive equipment such as use of the stairlift, wheelchairs, and bathing equipment was not recorded to ensure identified risks were reduced to the lowest possible level to keep people safe.

We found examples of poor practice with the storage and administration of some medicines particularly those which were not administered through the monitored dosage system. This breached Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 around safe care and treatment.

Staff had received training to enable them to develop knowledge and skills to develop in their caring role. They also received regular supervision.

People were provided with nutritious meals and frequent drinks which meant people's nutritional and hydration needs were met, although this was not always recorded in detail in people's care records. However, the service was in the process of making improvements in this area of recording and the local authority had provided additional training on record keeping in general.

The service sought the assistance of health and social care professionals to ensure people were provided with appropriate and effective solutions to any health and social care issues.

The environment and decor in some areas was in need of refreshing and updating to be suitable for people living with dementia and/or physical disability. The home was to undergo a building programme to extend the facilities which will upgrade the environment to be more suited to people with a physical disability and those living with dementia and they are awaiting a start date from their chosen builder.

We found all the staff to be caring in their approach to the people who lived there and treated people with dignity and respect. We observed staff to be kind and compassionate throughout our inspection.

The service was not providing meaningful activities for all the people living there and there was little activity for those people who were difficult to engage to ensure their mental wellbeing. We found this was a breach in Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 around person centred care.

The management team were visible in the service and ensured there was cover in the absence of the registered manager who was not present on the first day of inspection. They knew the people who lived there well. They were passionate about the home and staff said they felt supported and listened to by the management team and told us they could make suggestions for change to improve the service.

Systems to assess and monitor the quality of the service were not robust enough to ensure the standards of care were effectively audited to drive up the quality of the service and although the home was proactive in following suggestions for improvements, they did not have a system in place to monitor and measure the service against good practice guidelines and regulations.

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

Staff we spoke with demonstrated a good understanding of how to ensure people were safeguarded against abuse and they knew the procedure to follow to report any incidents

Medicines were not always administered in line with nationally recognised good practice and we found this breached the regulation in relation to medicines.

Risk assessments were detailed to reduce some risks but not all risks had been identified with risk reduction plans in place to ensure risks were reduced to an acceptable level.

Is the service effective?

Requires Improvement

The service was not always effective

Staff had received an induction and training to ensure they had the knowledge and skills to perform in their role. They also received supervision but had not yet received an annual appraisal to identify development needs.

Deprivation of Liberty Safeguards (DoLS) applications had been made appropriately to comply with the Mental Capacity Act 2005.

The environment was not conducive to meeting the needs of people with complex moving and handling needs and was not 'dementia friendly' but the registered provider had plans in place to improve the environment to meet the needs of he people living at Garlands.

Is the service caring?

Good

The service was caring

We found staff to be caring and compassionate towards people using the service and they knew how to ensure privacy, dignity and confidentiality were protected at all times.

The home used both formal and informal advocacy services to ensure people at the service had a voice in decisions being made about them.

The home was working towards Gold Standard Framework (GSF) accreditation for End of Life Care. We found people had a record of 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) order in place in their care files to ensure this information was communicated when relevant.

Is the service responsive?

Requires Improvement

The service was not always responsive.

We found the service had commenced to personalise care records to include people's life histories to ensure staff knew the stories behind the people living there who were no longer able to communicate their past lives.

Not all bedrooms were personalised and some were quite stark and lacking in personal effects.

The service was not providing meaningful activities for those people who were difficult to engage. We found this was a breach in the regulation around person centred care.

Is the service well-led?

Requires Improvement

The service was not always well led

The management team including the registered providers and the registered manager were well liked by the staff who told us they felt supported and listened to and could make suggestions to improve the service.

Systems to assess and monitor the quality of the service were not robust enough to ensure the standards of care were effectively audited to drive up the quality of the service provided.

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 27 April 2016 and was unannounced. We undertook a second day of inspection on 29 April 2016 and this was announced.

The membership of the inspection team consisted of an adult social care inspector and a Specialist Adviser with expertise in dementia care and the management of medicines.

Before our inspection, we reviewed all the information we held about the home. The registered provided had been asked to complete 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 contacted Healthwatch to see if they had undertaken a recent 'Enter and View' visit. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. They told us they had not undertaken a recent visit and they had not received any recent information relating to the service. We also contacted the local authority contracts department to gather recent information about this service to inform the inspection process.

We used a number of different methods to help us understand the experiences of people who lived in the home. We observed the lunch and teatime meal experience in the communal dining area. We also observed people in the communal lounges during the day. We spoke with the registered provider, the registered manager, the senior carer, three care staff and the cook. We spoke with six people living at the service during the inspection and five of their relatives after the inspection. We spoke with a member of the community mental health team in between the two inspections, and the local authority moving and handling advisor.

We also spoke with a relevant person's representative who was visiting one person who had a Deprivation of Liberty Safeguards in place, on our second day of inspection.

We reviewed the records in relation to the seven people who had authorisations in place for Deprivation of Liberty Safeguards and three care records and daily logs. We looked at all the records in relation to the maintenance of the service and the audits to determine the monitoring of the quality at the home.

Requires Improvement

Is the service safe?

Our findings

People who could voice their opinions told us they felt safe living at Garlands Residential Care Home. One person said "The staff are lovely and work very hard to look after me properly" and another person told us "Yes I feel very safe, there is always someone about and I am never on my own". Relatives told us they felt their relations were safe although one person told us they had raised concerns about one person who lived there whose behaviour challenged others and although this person had not challenged their relative, they were concerned this might happen. They told us they had been reassured there concerns had been acted upon.

We asked staff about their understanding of safeguarding. All the staff we spoke with demonstrated they understood how to ensure people were safeguarded against abuse and they knew the procedure to follow to report any incidents. One member of staff we spoke with told us if they suspected any type of abuse was happening they would "Always report this to my senior." And they would have no hesitation in whistleblowing if they saw anything of concern. They gave us an example of recent safeguarding incidents where there had been altercations between two people with behaviour that challenged others. They told us how they had responded to these incidents to ensure the safety of the people at the service. They also described the signs of abuse such as "the person withdrawing, quiet, not eating, bruises and unexplained marks."

Staff told us there were enough staff to care for people but every day was different describing some days as peaceful and others as extremely busy as people's needs varied on a day to day basis. The registered provider told us they had an apprentice carer in post during the week to provide additional support and staff told us this had made a difference. The registered manager told us they were not using a dependency tool to work out staffing levels but told us they had the right number of staff to meet the needs of the people at the home.

People's care plans included risk assessments for skin integrity, mobility, falls, nutrition and health needs. The home used recognised assessment tools for looking at areas such as nutrition and tissue integrity. We saw where risks had been found, risk reduction strategies had been identified. For example, one person had been assessed as being at high risk of harm through falling. We saw the person had recorded 22 falls in a four month period just over a year ago. The manager had referred the person to a falls clinic where an assessment had been undertaken by a physiotherapist. The assessment resulted in a care plan designed to mitigate the risk. The care plan was reviewed by care staff and the Care Home Liaison Team (CHLT). We saw a recent letter from the CHLT demonstrating the actions of care staff had been effective and the person was now discharged from the CHLT. This demonstrated good multi-disciplinary risk management care planning had been effectively delivered.

We found risk assessments did not include the use of assistive equipment such as wheelchairs or the stairlift used to access the first floor to ensure all risks were identified and minimised. On the review of one person's care plans we found they had an unwitnessed fall from a wheelchair. There was no risk assessment or risk reduction plan in place for the use of the wheelchair, which the senior care staff agreed to action

immediately. We found the home had not completed risk assessments for people using the stairlift to enable the risks associated with the use to be identified and reduced. The registered manager agreed to implement this immediately to ensure all risks were minimised and to ensure staff had clear guidelines to follow to enable them to support people using the stairlift safely.

As part of our inspection process we checked to see that medicines were ordered, stored and administered safely. The home used a monitored dosage system provided by a pharmacist. They were in the process of changing to a new provider which would include training and competency checks with the new pharmacy organisation.

Some prescription medicines contain drugs controlled under the misuse of drugs legislation. These medicines are called controlled medicines. At the time of our inspection a number of people were receiving controlled medicines. We inspected the contents of the controlled medicine's cabinet and controlled medicines register and found all drugs accurately recorded and accounted for. We saw the drug refrigerator and controlled drugs cupboard provided appropriate storage for the amount and type of items in use. Drug refrigerator and storage temperatures were checked and recorded daily to ensure that medicines were being stored at the required temperatures.

Medicines were administered to people by care staff. We were told people were assessed as to their capability to self-medicate which was evidenced in people's care records. We looked at people's medicine administration records (MAR) and reviewed records for the receipt, administration and disposal of medicines and conducted a sample audit of medicines to account for them. Allergies or known drug reactions were clearly annotated on each person's medicine records. We observed care staff administering medicines and saw oral medicines were administered correctly and in an unhurried and sensitive manner.

We saw from records some people could exhibit challenging behaviours. We looked at prescription sheets to ascertain the frequency of use of antipsychotic medication to manage behavioural issues. Through discussion with senior care staff, the review of the MAR sheets and our observation throughout the day we were assured non-pharmacological interventions were the preferred method of addressing challenging behaviours.

We found the administration of medicines was not underpinned by a robust policy and there was an absence of guidance and policy statements to ensure people received their medicines in a consistently safe way. We found prescribed creams and lotions were not effectively recorded and were on occasions incorrectly stored. The outcome of our audit of boxed medicines showed the provider was not always able to account for medicines either because of maladministration or poor documentation.

We conducted a random sample audit of eight medicines supplied in boxes. On two occasions we found discrepancies in stock levels. For example, one person was prescribed an 'as necessary' (PRN) medicine. The dose was to take one or two tablets up to four times a day. Whilst care staff were signing for each administration they were not always recording whether one or two tablets had been administered. Therefore we were not able to reconcile current stock levels. On another occasion the MAR showed one medicine had been signed as being administered when our count of medicines confirmed it had not been.

Our inspection of the medicines fridge showed some medicines were incorrectly stored. The fridge contained both opened and unopened prescribed bottle of the same medicine in liquid form, yet the labelling showed open bottles should not be stored in a fridge. We saw prescribed creams were not recorded as being administered as required by the prescriber. For example , two people were prescribed

creams, yet the MAR sheet provided no evidence they was being applied. The MAR sheet file contained body map sheets to denote where creams should be applied but these were not being used.

We witnessed the administration of PRN medicines without the availability of protocols. For example, one person was prescribed a medicine with the instruction to administer the medicine up to three times a day to a maximum dose on each occasion. Our discussion with the member of staff administering medicines showed the frequency and administered dose was left to the carer's discretion. On another occasion we saw a person was prescribed a specific medicine to be administered as required up to four times a day. Again no guidance was available to ensure the medicine could be administered consistently or with a safe period of time between each dose. We found the lack of information recorded as a result of PRN administration would not enable prescribing clinicians the ability to audit the effectiveness of their prescribing. Our discussions with the owners gave us assurance this shortfall would be addressed following discussion with the supplying pharmacists.

During the administration of medicines we were told one person may need to be administered their medicines covertly. Our subsequent review of this person's care records showed no legal or clinical guidance in place to support the giving of medicines without the person's knowledge. However, on discussion with the registered provider and registered manager, they immediately contacted the GP and there was an agreement that medicines would not be given covertly until the process had been initiated.

We saw some prescribed analgesics to be administered on a regular basis were being treated as PRN medicines. For example one person was prescribed an analgesic four times a day yet we witnessed the medicine being offered as a PRN medicine and past MAR sheet entries suggested this was normal practice. The care worker assured us they would ask the GP to review the prescription.

We found the above examples demonstrated a breach in Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed the recruitment records for three recent recruits. These demonstrated staff had completed application forms, and undergone an interview process and all pre-employment checks had been completed. A Disclosure and Barring Service (DBS) check had been completed before they started work at the home. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with vulnerable groups. However, although these checks had been completed, in one of the files we reviewed the member of staff had not given the dates of previous employment which meant there was no full employment history or details of any gaps in employment. We discussed the importance of ensuring all gaps in employment history were explored with the registered manager. They told us they checked this at interview but they could not provide the documented evidence to show gaps in employment history had been explored. They told us they would ensure this information was clearly recorded in the future.

The home had since our last inspection, employed a cleaner between 8am and 2pm five days a week. In between times and at weekends, the owner and staff undertook cleaning chores. We observed staff frequently mopping up spilled drinks during the day of our inspection. However, although the home surfaces were clean, there were areas which required a deeper clean and some areas were difficult to clean because of old, worn and peeling vinyl floor coverings. The registered provider told us they would be updating the premises once the builders were in place to complete the extension, and they were waiting on a start date for the builders. This and additional cleaning staff would enable the home to meet a higher standard of cleanliness.

We found other concerns regarding the control of infection during our inspection. For example, there were a

lack of toilet roll holders in both communal and en-suite toilets, which meant people had to hold the toilet roll to tear off the sheets. In the afternoon of our visit there were no toilet rolls in the communal toilets on the first floor. We also found the two communal bathrooms did not have paper towels in the paper towel dispensers. When we raised this with the registered providers, they told us the people living there regularly took these items from the communal areas, but they would look into toilet roll dispensers which would be hygienic and secure to ensure these facilities were always available and ensure paper towels were available.

Requires Improvement

Is the service effective?

Our findings

Relatives we spoke with told us in their view the staff at the service had the knowledge and skills to care for their relations. We asked staff how they had been supported to develop in their roles. They told us they had received an induction into the service. This included attending a two day external course and they had shadowed two to three shifts before being placed on the rota. All new staff either had or were completing the Care Certificate. The registered manager told us they took advantage of the local authority training for care staff when this was available. The registered provider had been using an external training provider for staff training but they were planning to do more training in-house as the registered provider had up to date qualifications as a train the trainer in some areas. The registered provider sent us their training matrix following our inspection which showed that staff were up to date with or had dates planned for essential training. They had received a significant amount of support from the Community Mental Health Team on how to manage people with behaviours that challenge and the registered manager was in the process of organising training in this area. Staff could tell us how they diffused difficult situations but as the home supported people with behaviours that challenged others, this was an area the home needed to focus on to ensure the staff had the knowledge and skills to support people to live safely and free from harm.

Staff told us they received supervision every 12 weeks. Regular supervision of staff is essential to ensure people at the service are provided with the highest standard of care and any gaps in knowledge and skills identified to ensure safe care delivery. Staff had yet to receive an annual appraisal from the registered manager to review their overall performance and to identify areas to develop going forwards. The registered manager told us they would be planned over the coming months.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

We saw evidence that six people were subject to DoLS and in two cases conditions had been attached to the authorisation. In one case the best interest assessor had seen the person had significant mobility issues and required the provider to offer the person a ground floor room as soon as possible. Whilst discussions with the owners indicated an offer had been made we found no evidence of this in the care plans. The owners assured us they would remain committed to offer a ground floor room when one became vacant and record this in the care plans. The registered provider told us a further two standard authorisations had been submitted to the supervisory body for authorisations and a further seven were sent at the time of our inspection which meant the service was compliant with the legislation.

We saw where issues around lasting powers of attorney required consideration in care planning this was clearly annotated in the care file. Care plans showed the provider was ensuring inclusive consent procedures were being enacted in determining people's care needs. However, we did see family members and the registered manager had signed consent forms for people who lacked capacity to consent, and although it is good practice to show the service had consulted with family members, this consent was not valid without the legal authority.

We spoke with care staff about how they ensured they supported people to make decisions in their everyday life in their best interests. One member of staff gave us an example of how they would ensure a person supported to dress would wear appropriate clothes for the weather by picking out the clothes from the person's wardrobes and offering the person a choice from these clothes. This showed they were supporting decision making which is one of the five principles of the Mental Capacity Act 2005.

We observed the lunchtime and tea time experience at the home. People were offered choice at the table and we saw one person brought three different meals before they settled on what they would like to eat. People were heard to compliment the food and told us they were enjoying the meals. The service used a recognised assessment tool to assess people's nutritional requirements. As a result of the assessment we saw people were weighed at regular intervals and appropriate action taken to support people who had been found to be at risk of malnutrition. We spoke with the cook to determine their understanding of people's dietary needs and found they had a list of each person's dietary needs and preferences The cook told us they fortified foods for each person to ensure they had a high calorie diet.

Records showed arrangements were in place to ensure people's health needs were met and appropriate referrals made to other health and social care services. We saw evidence staff had worked with various agencies and made sure people accessed other services in cases of emergency, or when people's needs had changed. This had included GP's, hospital consultants, psychiatrists, community mental health nurses, social workers, moving and handling advisors, advocates, opticians and dentists.

The building was a converted Victorian house, with bedrooms on the ground and first floor. There were 15 bedrooms with five twin rooms and 10 single rooms. The environment was not ideal for people with complex moving and handling needs as access between floors was by the use of a stairlift and there was restricted access to bathing and showering facilities and there was no accessible toilet on the ground floor. There was one person living at the home who required hoisting for transfers, and whose abilities had deteriorated whilst living there and advice had been sought on how to improve access to facilities for this person, although the issue had not been resolved at the time of our inspection. However, the registered provider was in the process of engaging builders to create an extension to the home, which should improve access for those with physical restrictions and the provision of a through floor lift, had been included in these plans.

We found that although the majority of people living there had dementia, the environment was not 'dementia friendly'. For example, bedroom, toilet and bathrooms door signage did not use pictures or words of a suitable size. The doors and surrounding walls were painted in the same colour making orientation hard for people with recognition difficulties. One of the lounges had a highly patterned carpet and lighting which produced areas of light and shade. There was little consideration given to providing sufficient space between chairs to enable carers to help people with their needs. The outdoor space was cluttered with wooden pallets, but the registered provider told us they had sourced these materials to create raised bed and area where people living at the service could utilise as a safe, outdoor area. The registered provider recognised the need to create a dementia friendly environment and understood how this could be achieved.

They had purchased dementia friendly signage but had not yet put these into use.

Good

Is the service caring?

Our findings

People were complimentary about the staff who they described as "Really good and worth every penny they are paid". Another person told us, "Staff put themselves out to help me and make me comfortable". Our observations found staff to be kind and considerate in delivering care to individual people. We saw people's wishes regarding their carers was recorded and respected. For example, one person wished to be cared for by female staff. We spoke with the person who said, "Yes it's the girls who look after me". This showed the provider was respecting people's personal wishes. Relatives of people living there told us all the staff were caring and kind to their relatives. One relative told us "I can see [Name] is really settled and really, really happy. They would tell me if they were not happy." Another relative told us how the staff at the home had accompanied their relation to their wedding, which demonstrated to them how they went the extra mile.

We observed staff interaction with people throughout the day. The care staff were gentle, patient and respectful. 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. Very soon afterwards we saw the person was calm and happily sat relaxing. One member of staff told us how they encouraged a person who was resistive to care to be assisted with personal care tasks on the morning of our inspection. They told us how they encouraged this person by singing with them and by the end of the process this person was smiling and singing along.

Staff told us they always ensured privacy and dignity was maintained. One member of staff told us "They would ensure a person was covered with a towel when undertaking personal care, they would ensure the bedroom door was shut." They also told us they would be respectful and would "always ask someone if they wanted to use the toilet discreetly and not shout it across the room".

We asked care staff how they supported people to remain independent in their daily lives. One care worker told us "I prompt people to have a wash and then let them do it themselves. I support people to sort their laundry and fold clothes away". This demonstrated staff understood the importance of supporting people to undertake activities to maintain their independence and also to give the person opportunities to engage in meaningful everyday activities.

We found the registered manager and the senior care worker had a good understanding of the need to use advocacy services for those people who were without family and friends to help them make decisions about their care. We spoke with a visiting relevant person's representative from an advocacy service who had been appointed by the DoLS supervisory body to advocate on the person's behalf. They told us they had no concerns following their meeting and the staff had provided information about how they supported the person and information in their car files had been clear and informative.

The home was working towards Gold Standard Framework (GSF) accreditation for End of Life Care and the registered manager was a clinical associate with the GSF, although no one at the service was requiring end of lift support. We found some people had a 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) order in place which had been completed by relevant clinicians. Staff we spoke with had an accurate

knowledge of which people had DNACPR arrangements in place.

Requires Improvement

Is the service responsive?

Our findings

We asked staff how they provided personalised care. One member of staff told us "I go on what I've learnt from people. How the resident likes things to be done. And what the family member have said to us." It was clear from our observations that staff knew people well and were knowledgeable about the things that were important to them in their lives and their individual personalities and preferences.

Care plans included an assessment which was carried out on admission to the home. We saw life histories were recorded which showed staff that people had lived a rich life before they were diagnosed with dementia. Assessments indicated relatives had been included in the initial care planning process. Documents relating to care planning were clearly written and logically filed to be accessible for care staff. All elements of care were subject to a monthly review. We did find that on some occasions, there were small gaps in monitoring records, which we brought to the attention of the registered manager who told us they were working on person centred up to date record keeping with staff who had also recently had training from the local authority in record keeping to improve their practice.

We found some of the bedrooms we inspected had been personalised with photographs and personal possessions but other rooms contained very basic furniture with no personal effects. Many bedrooms did not have bedside tables or bedside lamps and we asked the registered provider the reason for this. They told us people had a tendency to break these but they ensured safety for people getting up in the night by leaving the toilet light on during the night . They told us they would re-look at possible alternatives which did not deprive people of the ability to control their own environment.

The home did not employ an activities coordinator but we were told they were in the process of recruiting one. They told us they currently used outside entertainers to come to the home and they had positive feedback regarding a recent singer. They also held a chair based exercise class and Zoolab visited with animals for people living there to touch and hold for therapeutic benefit. However, we saw little meaningful occupation during the day for some of the people living there. We saw the apprentice care worker playing dominoes and a member of staff holding a quiz with people who were able to engage. However, we also observed some people displaying symptoms that involved loss of ability and enjoyment in life. We saw some people did not easily interact with others preferring to sit alone, many people said very little, some lacked motivation, whilst others constantly paced around the home. For these people, the home needs to seek advice on how best to ensure their lives have meaning and fulfilment and we recommend the service utilises nationally recognised guidance and advice from the Community Mental Health Team to ensure they meet the mental wellbeing of people living at the home on a daily basis.

On the two days of inspecting one person spent the day in their room through choice but there was nothing for this person to do and they remained isolated. Our observations found this person either sat on the edge of their bed or asleep during the day. They told us they preferred to be in their room as it was too noisy in the communal areas which confirmed this was their choice. However, there was no recorded evidence to suggest attempts had been made to find activities for this person to do in their bedroom.

During our inspection we observed staff took advantage of times of low activity to engage with people in the communal areas. However discussion with staff and our reviews of care plans showed more could be done to understand the rituals and behaviours of some people. We also heard from care staff some people were experiencing disturbed sleep but we did not see evidence in people's care plans to show how this was being managed. For example, we saw one person asleep in a chair for most of the time we were inspecting the home. We saw whilst drinks were frequently offered to people this person was less interested in waking to eat and drink. These people's care plans did not direct staff to ensure people who slept for much of the day was not having a detrimental effect on their nutrition as a result of missed meals and drinks.

Relatives we spoke with also told us they had observed there was very little going on at the service in relation to activities. One relative said " They don't seem to do anything. There was a Christmas party and a celebration for someone's birthday, but my relative spends most of the time asleep." We found not enough had been done to ensure care was person-centred in relation to activities that brought meaning to the lives of people who could not take part in group activities and therefore the service was in breach of Regulation 9 of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The people we were able to communicate with told us they had no complaints about the service but knew who they should complain to. Relatives told us they knew who to complain to if they had any issues and all the relatives told us if they had any concerns they felt able to raise these issues with the management team. We asked staff how they would respond to a complaint from a person using the service or their relative. Staff told us they received very few complaints. They gave us a recent example of lost handkerchiefs. They told us what they did about this which showed that although they were not recording informal complaints, they were acting on them to ensure the issues were resolved to the satisfaction of the complainant. There were no formal complaints recorded.

Requires Improvement

Is the service well-led?

Our findings

Staff all told us how much they enjoyed working at the service. One member of staff told us "It's more challenging than anywhere else I've worked before but I really enjoy it". They told us they felt able to make suggestions to both the senior carer and the registered manager to make improvements at the service and they would take these suggestions on board. They told us the registered providers were at the service every day and at weekends and they were very visible in the service. One member of senior staff said "We are a family run home. I do genuinely believe we care. The service users are not just a number to us. They are part of our own family. That's how we expect staff to treat them."

The registered manager had only been registered for three months at the time of our inspection and had been managing the service for a few months prior to this. They had been working with the registered provider (the owners) to implement changes at the service and there had been a high turnover of staff which meant the focus was on ensuring staff had the knowledge and skills to provide a safe and caring service at the home. We found the registered provider was passionate about the service they provided and wanted to provide a "good service." They were willing to put in place suggestions for improvement but we found the leadership was not proactive in continuously striving to improve. They had not looked at recent national guidance in relation to updating some of the practices at the home particularly around medicines management and mental well-being. We asked the registered manager whether they had audited the service against the fundamental standards of care so the service could assess whether quality assurance and governance systems were effective, and used to drive continuous improvement. They told us they had not yet monitored the service against the standards as they had prioritised getting the staffing right in the first instance.

At our last inspection we found there was no robust quality assurance and governance system in place to drive continuous improvement. Although improvements had been made, we found there were still shortfalls in this area. For example, we saw audits for care plans, and housekeeping issues had been completed which had identified issues, but there were no dates for actions to be completed. The registered manager told us they had not looked at the housekeeping audit completed by the owner and registered provider, which demonstrated they had not yet go a rounded view of this element of service delivery to drive up quality. We found equipment was regularly serviced and the audits for these and the electrical and fire equipment testing were all up to date and clear. The service also notified us in accordance to the requirement of their regulations and these notifications were timely and appropriate.

At our previous inspection we found policies and environment risk assessments used within the home were out of date; At this inspection we found improvements had been made and the owner had commissioned a company to re-write all the policies and procedures which were now accessible to all staff. Staff were required to sign to agree they had read the new policies and procedures but not all staff had completed the process by the time of this inspection. The registered provider told us they had offered staff paid time to read the policies to ensure this task would be completed in the near future. We saw the registered provider had also placed the latest Medicines & Healthcare products Regulatory Agency (MHRA) safety notices on the board for staff to read. This meant staff had access to up to date legislation about

safety matters affecting the home or their role in caring for people.

The registered manager described the culture at the service as positive and open. They told us staff had the right mix of skills and new staff had brought a high level of experience of care to the home. They told us their vision for the service was for "Everyone to be happy, residents to be stimulated and given the best outcomes." They told us they encouraged good practice amongst staff by leading by example and showing the staff how to do things correctly. They told us they attended the local registered manager meetings, attended local authority training and kept their own skills up to date. The registered provider and registered manager were unaware of nationally recognised guidance around the management of medicines in care homes and mental wellbeing and they were directed to these by the inspection team to inform their practices. They told us they followed the Gold Standard Framework for good practice around end of life care and the registered manager was accredited in this area, although there was no one at the end of life at the service.

We saw the results of quality assurance questionnaires sent to residents, relatives and health and social care professionals in May 2015, most of which had resulted in positive feedback about the home although no comments had been recorded on the publicly available document, which we were given and was kept in the entrance for people to read. However, as a result of comments that had been made through the questionnaire, the service had changed the optician and chiropodist, which showed they were listening to the views of the people offering feedback. The registered manager had also recently instigated family, residents and staff meetings and the first meeting had been held on 14 April 2016. We were shown the aims and objectives of the meeting and the minutes of the latest meeting which had been attended by five relatives and two residents in addition to the registered manager and the owners. This demonstrated the service was putting systems in place to ensure they took the views of people and their relatives into account when planning improvements at the home.

Staff meetings are an important part of the registered provider's responsibility in monitoring the service and coming to an informed view as to the standard of care and support for people using the service. We saw minutes of meetings held with the registered provider, the registered manager and kitchen staff. We also saw minutes of meetings with night staff, senior staff and care staff. These minutes showed detailed discussions had been held to drive improvements at 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 service was regularly monitored by the local authority and worked with them around training to improve practice at the service. The service met their regulatory requirements by notifying us in line with their registration.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care There was a lack of meaningful activities for the people living at the service, particularly for those people who were difficult to engage with.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always managed in line with good practice.