The Orders Of St. John Care Trust

OSJCT The Cedars

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?	**Good**

Summary of findings

Overall summary

The Cedars provides accommodation and personal care for up to 49 older people. At the time of our inspection there were 38 people living in the home, 2 of whom were in hospital.
This inspection was unannounced. There was a registered manager in post when we inspected the service. 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. The manager was accessible and approachable. Staff, people who used the service and relatives felt able to speak with the manager and provided feedback on the service.
A previous safeguarding had been raised in relation to managing pressure care at the home. An independent tissue specialist nurse attended the inspection and explored this area in depth. The findings showed preventative measures had been put in place and action taken to protect people from pressure sores. We found staff to be very knowledgeable on pressure care and people had access to the correct equipment to help minimise the risk of pressure damage.
Recording was not always completed correctly. The recording in people's MAR's (medicine administration records) for supplement drinks and the rotation of medicine patches was not completed. This meant people were at risk of not receiving their prescribed medicines in line with the GP recommendations. Fluid charts in place to monitor people's liquid intake, had not been totalled correctly. This meant action that needed to be taken could be delayed as the monitoring system was not being used effectively to detect concerns. Care plan recording around people's mobility and dependency needs showed inconsistencies where the old paperwork had been left in the folders. The most relevant information was placed at the back making it hard to identify a person's current needs. This was a breach of the regulations.
People had a high number of falls. Whilst action around these falls had been taken we identified further precautions that needed addressing. The lighting in people's bedrooms was inadequate, posing a potential risk for people with visual impairments. Equipment such as hoists and wheelchairs were repeatedly left in narrow corridors or seating areas causing a hazard for people unsteady on their feet. This was a breach of the regulations.
Where there was challenging behaviour displayed from people, the home would work to find a more suitable placement that could meet this person's needs. Staff told us they were currently assisting one person who displayed aggressive behaviour. Three staff members would often attend this person and staff had not received appropriate training around safe method of restraint. This meant that this person and staff were potentially at risk from unsafe practices and a lack of knowledge. This was a breach of the regulation.
These breaches can be read about in more detail in the full version of the report and the action we have told the provider to take.
The service had a strong commitment to supporting people and their relatives at the end of their life. The management team were determined that people should remain in the home being cared for by the staff they knew unless the home could not provide the level of care someone might need at end of life.
People told us they felt safe living at The Cedars and they were well cared for. The provider had systems in place to manage risk and protect people from abuse. Staff had a good understanding of safeguarding and whistle-blowing procedures. They also knew how to report concerns and had confidence in the manager

that these would be fully investigated to ensure people were protected.
The home was piloting the new care certificate induction. New starters told us their induction prepared them well for their role and they were able to shadow experienced team members and get to know the people they would support. The manager spoke about how the induction should increase staff retention as they can offer more individual support in the area a new employee needs it.
People and relatives were very complimentary about the caring nature of staff. Staff were knowledgeable about people's needs and people's privacy and dignity was always respected. Staff explained the importance of supporting people to make choices about their daily lives. People told us they were involved in decisions about their care and systems were in place to monitor and review people's changing needs.
The manager had implemented many changes within the home and people and their relatives spoke highly of the positive direction the home was taking under the managers lead. Staff felt confident and comfortable in approaching the manager and had faith concerns raised would be actioned.

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.

Medicines that were administered by the home were not always recorded correctly.
People were potentially at risk of falling from inadequate room lighting and equipment left in unsuitable communal areas.
Staff were confident in recognising safeguarding concerns and potential abuse and were aware of their responsibilities in protecting people.
Previous concerns around pressure care had been managed well by the home. People could be confident from the good knowledge and care shown by staff around pressure care.

Is the service effective?

Requires Improvement

The service was not always effective.

Fluid charts to monitor people's intake were not completed correctly. This meant they were not effective in detecting early concerns so action could be taken.
Staff had not received appropriate training in safe methods of restraint and potentially were putting themselves and others in vulnerable positions.
Staff demonstrated good awareness of people's mental capacity and the action to take if they believed someone was lacking capacity.

Is the service caring?

Good

The service was caring.

People were involved in making decisions about the support they received.
People and family members we spoke with gave us very positive feedback about their care workers and told us they were caring.
People said they were treated with dignity and respect. Staff told us how they aimed to provide care in a respectful way whilst promoting people's independence.

Is the service responsive?

Requires Improvement

The service was mostly responsive.

People did not have enough to do to occupy them. The service was recruiting for the activities post at the time of our inspection. Relatives and staff told us it was having a negative impact on people.
Record keeping was not completed correctly. This meant monitoring systems were less effective and care plans contained inconsistent information.
There was a robust system in place to manage complaints and comments. People felt able to make a complaint and were confident any complaints would be listened to and acted upon.
People and their relatives were supported to make their views known about their care and support. People were involved in planning and reviewing their care and kept informed of changes.

Is the service well-led?

Good

The service was well led.

The registered manager provided strong leadership, demonstrating values, which were person focused. The manager demonstrated commitment in identifying areas for change and improving on the service that people received.
Staff were motivated, caring and positive about the support they received from the manager. Staff had opportunities to express their views in what they described as an "open culture".
The registered manager had developed organised systems in relation to the management of the home. Quality assurance checks were in place and used to further improve the service.

OSJCT The Cedars

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.

The inspection took place on the 5, 6 and 8 January 2016 and was unannounced. The inspection team consisted of one inspector and a specialist tissue viability nurse. We took a specialist nurse on this inspection to assess whether the provider had taken action to address previous concerns in relation to pressure care. This service was last inspected on 18 September 2013 and had no concerns.

We reviewed the provider information return (PIR) prior to this inspection. 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.

Before the inspection we checked the information that we held about the service and the service provider. This included previous inspection reports and statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send us by law. We used all this information to decide which areas to focus on during our inspection.

During our inspection we spoke with nine people living at the home, six relatives, fourteen staff members, one visiting health professional, two external health professionals, the registered manager, operations manager and a quality compliance manager.

We reviewed records related to people's care and other records related to the management of the home. These included the care records for nine people, medicine administration records (MAR) and a selection of the services other records relating to the management of the home.

We observed care and support in the communal areas during the day and spoke with people in their bedrooms. We spent time observing the lunchtime experience people had and the day to day running of the

home.

Requires Improvement

Is the service safe?

Our findings

We assessed the high number of falls that people were having in the home. One person had fallen seven times since October 2015. Another person had recently fallen three times in the same day. The manager had taken some preventative action to reduce the number of falls people were experiencing, for example a member of staff had been put in place to oversee the lounge at all times.
One member of staff was the falls lead for the home and staff spoke confidently about managing people's falls. One staff told us "If I found someone who had fallen, I would check them but not move them and immediately press the emergency bell". Another staff member said "People have risk assessments in place if they are prone to falling, and sensor mats are put in place".

During our inspection we observed the management team walking the corridor to identify places to put extra seating and create resting stops, for a person who was falling a lot in that particular area. The main meal had also been moved to the evening instead of at lunch and this was seen to correlate with a reduction in falls as people were not so sleepy in the afternoon after a big meal and more alert in their mobility. People who had experienced reoccurring falls had been referred to the GP and for x-rays to establish any underlying health conditions that may be contributing.

We observed the lighting in people's bedrooms was insufficient, especially if a person had sight difficulties. Staff also told us the lighting was not fit for purpose. We raised this with the management team and were informed that low energy bulbs were used in people's rooms and that this would be looked at.

During our inspection we saw that equipment was repeatedly left in unsuitable places. This included narrow corridors and seating areas. On day one of our inspection we saw one hoist had been left in an upstairs corridor, and another in a downstairs corridor. In the afternoon there was a hoist left in an upstairs seating area. This meant that for people who were already unsteady on their feet, they were then placed at further risk by potential trip hazards. On the second day we observed a wheelchair left in a downstairs corridor and in an upstairs sitting area a hoist, wheelchair and a weight chair had been abandoned in this small space. This area had recently undergone decoration to create a nice space for people, but the equipment left there prevented anyone from using this space. We discussed these findings with the manager who informed us staff should all be aware not to leave mobility equipment in these places.

This was a breach of Regulation 15 (1) (b) Premises and equipment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People benefited from having knowledgeable staff who understood their safeguarding responsibilities. People told us "I feel safe here, we are well looked after" , "I feel very safe, if I had worries would speak to the girls", "I have lived here a while, it's lovely I feel very safe" and "I have lived here a long time, I like living here, I feel safe". Relatives were also reassured that their loved ones were kept safe commenting "[x] is safe, safer here than at home, they do everything", "My relative is very safe, I have only seen things that make me feel very comfortable" and " I feel my relative is safe".

Staff spoke confidently in knowing how to detect potential signs of abuse for people that are unable to communicate it. One staff member told us "I look at their behaviour for signs, such as being withdrawn". Staff had completed safeguarding training and commented "If I had concerns I would take them to a higher level, I'm confident to do that", "We report all concerns and if not satisfied with the outcome I would take it higher" and "I have had safeguarding training, and I feel confident to report anything".

There had been a previous safeguarding concern raised around pressure care within the home. An independent tissue viability clinical nurse was part of the inspection to specifically look at the concerns in this area. The home was seen to have worked hard putting preventative measures in place, and had acted on the guidance from external professionals. This included buying new 'high risk' mattresses for everyone in the home, not just those most at risk. During the inspection we case tracked the people most at risk of pressure care and saw they were always sat on their own pressure ulcer prevention cushions.

Every person at risk of developing a pressure ulcer had a repositioning wheel in place, which prompted carers to reposition that individual in two to four hourly intervals. The home was using SSKIN (Surface, skin, keep moving, incontinence) gold standard and NICE 2014 prevention of pressure ulcer guidelines to inform their knowledge. One care leader and one experienced carer had become pressure care leads for the home, and had devised a folder for staff with pressure ulcer protocols on prevention, treatment, and reporting. We saw tissue viability support plans in place which identified if someone was high risk, and the plan accurately reflected the care needed to meet these needs.

Staff demonstrated good knowledge around pressure care identifying who was at risk, who currently had a pressure sore and the grade of it. People had their skin checked daily and staff were confident in the process of identifying any early signs of tissue damage. One staff member told us "If I see anything I immediately take the pressure off that area, complete a body map, alert the lead in charge, and they alert the GP or district nurses". One person said "The carers are very good and check my skin every day". A pressure ulcer monitoring form was in place which documented every new pressure ulcer acquired at the home, or inherited from another organisation, and was sent to head office monthly.

People, their relatives and staff told us they felt more staff were needed. The general consensus was there were adequate staff for people to be kept safe, but not enough to afford the extra time that people needed. One person told us "Sometimes they are short staffed, and in a rush as there are so many people here". Another person commented "It's very short staffed, they are overstretched with work". Relatives also spoke about staffing levels saying "Staff work so hard, they do their best", "At one time they didn't have enough staff to assist people to the toilet but that's improved" and "In an ideal world there would be more staff, there's not enough time for things to be done unrushed, the manager has worked on reducing agency".

Staff told us they do feel the pressure among the team with comments including "There's not enough staff, we sometimes feel rushed", "There's not enough time to support people, I feel I'm in and out, and spend more time on paperwork than with residents", "Staffing levels a challenge, we are all too busy, one relative told me, you are so busy I don't know how you do it" and "Staffing levels have not reflected peoples changing needs, it's becoming more nursing, with more people needing two carers"

We spoke to the manager about the staffing levels and this had recently been addressed and continues to be monitored. The manager told us that they calculated staffing using a dependency tool to assess people's level of need and the required level of staff needed to keep people safe. The home had worked on reducing the number of agency hours, and building up regular staff levels.
The management team told us that they had observed care on the floor last month, and saw that people were not getting up in a timely manner, and carers appeared to be rushed, so they had recruited an extra

staff member for mornings. In response to this change one staff commented "having that extra staff member has been fantastic, kudos to the manager, they listen to us and come up with a way to make things better". A relative told us "It's getting better; they had lots of agency staff at one point but its cutting down".

At the time of our inspection the home had five people with a chest infection. The manager had taken preventative steps to minimise the risk which had included asking relatives to refrain from visiting the home unless absolutely necessary. We observed antibacterial gel in all the toilets and bathrooms and staff were seen offering freshener wipes to people before they ate their meals. The housekeeper informed us they attend handover each day to learn if anyone is at risk of infection and aid communication between the different staff teams.

We observed the lunchtime medicine round and saw the appropriate procedures were being followed in administering people's medicines. The staff member administered to one person at a time, locking the medicine trolley each time, and explained to the person what their medicine was for and stayed with them while they took it. Where medicine errors had occurred these had been raised with the head of care who investigated and took appropriate action in reassessing a person's competencies, holding reflective meetings or in more serious cases following disciplinary procedures.

Requires Improvement

Is the service effective?

Our findings

Where people had a diagnosis of dementia this was mostly early onset dementia and that this was being supported by the home. Where people's needs had increased beyond the home's capabilities an alternative placement was considered. We saw in one person's care plan at times they exhibited behaviours that were challenging to manage. We observed the training matrix for the home and saw that staff had not received training in appropriate restraint and safe hold training. Staff we spoke with told us they were having to hold one person due to the aggressive behaviour displayed and sometimes three members of staff would have to be present during care.

We spoke to the manager who confirmed staff had not received this training as it was unusual to have that level of challenging needs in the home, and this person was waiting on an assessment for a new placement. We discussed that even in the short term this person was being put in a vulnerable position by staff who had not received the appropriate training, and the staff themselves were at risk of potentially hurting someone through inappropriate holding and lack of knowledge. One staff member told us "There is a need to make sure that clients coming here are right for the home as other people get neglected for the more challenging needs".

This was a breach of Regulation 12 (2) (c) Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff had a good knowledge and understanding of mental capacity and could confidently identify those people who had a DoLS (Deprivation of liberty and safeguards) in place. The Mental Capacity Act 2005 (MCA) provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. The Deprivation of Liberty Safeguards (DoLS) are part of the Act. The DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. They aim to make sure that people in care homes are looked after in a way that does not inappropriately restrict or deprive them of their freedom. Staff comments included "We assume everyone has capacity until proven otherwise and even then you still have respect for what they say", "If a person doesn't have capacity to make decisions, we have best interests meetings and they have a DoLS in place" and "We have training on dementia and mental capacity, we were given booklets on mental capacity and we carry them on us". The manager and head of care had provided additional training around capacity to the staff in which they tailored it to people in the home and what it meant for them.

We saw in people's care plans where required a mental capacity checklist had been completed and evidence best interest meetings had taken place. There was best interests care summaries in place stating which areas of care a person needed help with. For example for one person it stated there were difficulties around communication, and the person found it easier when choices were given in shorter sentences. Where it was considered necessary a DoLS application had been applied for. One relative told us "The home helped with a DoLS for [x]and went through the process and paperwork with me".

We observed during our inspections that although choices of drink were available at lunch time they were not placed in people's reach. One table was given a jug of orange drink and another table had a blackcurrant drink. This meant people's drink option depended on the table they sat at instead of both choices being available on every table.

People were supported to have a meal of their choice by organised and attentive staff. Sample plates were made up and taken to people at the table so they could make a choice based on the sight and smell of the food. The manager told us they plan to order a hot trolley so this same experience can be given to people who remain in their rooms for meals.

The dining tables were laid nicely and people appeared to enjoy the relaxed environment during the mealtime. Staff assisted people if they required it and checked that everyone was ok and had enough to eat. We saw that nobody was waiting long before their meal was served and there was good communication between staff in ensuring people in rooms had their meal in a timely manner.

Around the home we observed snacks available in all sitting areas and people had jugs of drink available in their rooms. A tea trolley went round regularly to people in their bedrooms. People commented on the food saying "The food is very nice, there is a choice, they know what I like", "Lunch is very nice" and "I eat in the dining room, the food is alright, you get plenty and there is lots of choice". One relative told us "I join my relative for lunch, the food is ok, there is enough to eat and drink". Staff mentioned it would be nice to see more fresh fruit available for people and one commented "there is not enough homemade food". We passed these comments onto the manager.

New staff were supported to complete an induction programme before working on their own. The home had been piloting the new care certificate induction programme and staff who had received this spoke positively about the support it offered. Comments included "I had a good induction, I met everyone, and shadowed other staff", "my induction included lots of supervision" and "I had good support in induction, I shadowed lots and was given time to look at care plans". The manager told us they hope the new induction programme would increase staff retention saying "It offers that extra level of support to someone who might need it, so new staff aren't overwhelmed".

We saw that staff had received pressure ulcer training in November 2015 and twenty two staff had attended including the kitchen and housekeeping staff. The manager spoke about wanting to train all staff in different skills outside of their role, in order to create a multi-skilled team who could be versatile in any eventuality.

Staff told us supervisions were carried out regularly and enabled them to discuss any training needs or concerns they had. Staff comments included "The supervisions are useful, I get feedback", "Staff supervisions are useful, problems gets supported and sorted" and "We have regular supervisions, and are able to chat about things".

We saw that group supervisions also took place. A recent group theme had been around the relatively high number of raised awareness in staff to complete the falls checklist after every fall. Staff observation forms were in place to monitor standards of personal care delivered, ensuring privacy and dignity were maintained, and feedback gathered from people about the staff member. From these observations a feedback session took place and one had been used to inform a probationary review.

People's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals. One relative told us "The GP comes every Thursday, they are good at accessing healthcare, and the carers write in book if we want anything passed on to the

GP". Another relative said "When my [x] was unwell they made a snack box and put it by bed". We heard staff making telephone calls to seek health professional advice for some people and one staff member notified the district nurse team that a person's dressings had come off and needed reapplying.

The manager informed us that if someone had been in hospital for more than forty eight hours they are reassessed to ensure the home can continue to meet their needs. The manager said no discharges from hospital were accepted after 5pm due to this being unsettling for a person to arrive back late.

The general upkeep of the home needed some attention. We observed areas that needed repainting, some marks and dents on the walls and décor that needed updating. There were two maintenance staff in place that split the role. One staff told us "The general upkeep needs looking at and revamping". Another staff commented "the decoration needs updating, but that costs money, the manager has made some changes".

We noticed throughout our visit the different floors and corridors were referred to as 'up or down' or by the colour of the walls. The manager told us this was currently being reviewed. People had been asked what colour paint they would like along their corridor and suggestions for a name had been sought and recorded. The manager discussed how they were setting aside money from the budget for door numbers and names, and if possible for people to have real door knockers like they would on any front door.

Good

Is the service caring?

Our findings

Staff showed concern for people's wellbeing in a caring and meaningful way, and they responded to their needs quickly. Comments from people included "The staff are very friendly", "I'm happy here, its home from home", "staff are very kind" and "the carers are nice, I'm happy with them, they help me". The home was spacious and allowed people to spend time on their own if they wished outside of their bedroom. Many smaller seating areas had been created around the home and we observed people enjoying these restful spaces.

Staff spoke respectfully about the people they cared for and observed interactions demonstrated choices were offered to people. One staff member explained "Everyone has their own ways, and you have to learn them. This staff went on to give examples of things that were important to particular individuals. Another staff commented "It's a very friendly place; everyone is upbeat, as long as the residents are happy that's the main thing".

People's relatives praised the care in the home telling us "The care staff are great, they have all got a good sense of humour", "Staff are so dedicated to people who are at a difficult time of their lives", "When we walked through the door we knew it was the right place, [x] is happy" and "they have done an amazing job. My relative is so well cared for, they are so considerate".

There was a calm atmosphere throughout the home, people were relaxed and appeared comfortable in the company of the staff supporting them. Care staff were nominated as keyworkers for individual people which meant they were a point of contact to provide that extra support and care. One relative told us [x]has done things they haven't done for years with the help of this home and staff". An external health professional commented on the care saying "There are many experienced carers who I have observed treating residents with respect and recognising individual's differences".

People's privacy and dignity was respected by staff. People told us "The carers ask me what I like", "The staff are very friendly, they give you a choice" and "The staff always knock, even if they have left the room to get a pillow they always knock again". During our visit we observed staff knocking on people's doors before entering, and offering an explanation as to why they were there. Some people had chosen to have signs on their door that said please knock first.

Staff we spoke to were knowledgeable about maintaining people's dignity highlighting the ways they protect it such as, covering people with a towel during personal care, asking permission first and closing curtains and doors. Staff told us "We let people choose, and ask them what they want", "take the time with people; it's their time with you" and "give people the knowledge that this is their home, not our workplace". Relatives also commented on how well staff promoted dignity saying "There is always dignity there, if someone is distressed a carer is always right there", "The way staff talk to people is good, you can't fault them, I have nothing but admiration" and "They bring back the dignity that goes missing at that time of life".

Staff told us that people were encouraged to be as independent as possible. One staff told us how they

encourage people to do daily tasks for themselves even if it is a small thing, "I tell residents, come on you can wash your face, we observe people and promote their independence, it's better to encourage people". Another staff told us "I know how people like their coffee and tea but I always ask, so they use their memory and make that choice". People also told us this was happening with comments including "Staff encourages me to dress myself" and "I always dust around my room myself".

People and their relatives were given support when making decisions about their preferences for end of life care. Where necessary, people and staff were supported by palliative care specialists and services and equipment were provided as and when needed. The home and the staff spoke considerately about wanting to keep people at the home if this was their wish. One staff told us "We give good end of life care, and support for the families". The new life history care plan that is currently being completed with families and people asks about any advance care decisions and preferences for care. There was also a section which establishes if any family members have power of attorney over making decisions around health and welfare for a person, so the home can ensure information is shared only with the people who have the right to assist in these choices.

Requires Improvement

Is the service responsive?

Our findings

People's medicines were not always recorded appropriately. We saw on the fluid chart that people who had been prescribed complan (nutritional supplement drink) did not have it recorded in their daily fluid. We cross referenced this with the supplement recording chart kept in people's MAR's (medicine administration record) and saw this had not been completed. We spoke to staff who told us it was not being recorded. This meant we did not know if people were receiving their daily prescribed supplements.

One person's MAR showed they had a medicine patch prescribed for pain relief. We saw a chart in place to record where the patch had last been placed so it could be put in a different area the following time. This was not being filled out which meant the patch could potentially be placed in the same position making it less effective for the person. We spoke to staff who said they were aware of the need to do this and were in practice changing the patch position but were not recording it. We raised this with the home and were told a monthly medication audit had been completed identifying uncompleted supplementary drinks and patch rotation charts. This was to be implemented in the next monthly medication change over, taking place the following week from this inspection date.

We saw that people had fluid charts in place where required. However these were not being completed appropriately. The chart stated the recommended amount of fluid each individual person required daily. The totals each day were not being collated to see if a person was receiving this amount. This meant staff were unaware of how far below the recommended amount people were, and actions to support this person would not be identified. We spoke to staff about this and they were unable to tell us what happens to this information or how it was monitoring people, staff informed us they 'just fill it in'.

We observed that people's care plans were being reviewed and updated regularly however when a person's needs changed the old information was still kept in the folders with the newest information recorded at the back. This meant the care plan contained conflicting information and made it hard to establish a person's most current needs. Instead of writing a new care plan the old care plans continued to be reviewed despite people's needs having changed dramatically. For example one person's mobility support plan stated they were independent but the reviews recorded they needed full support. Another person's care plan said they were a low risk for falls but the falls risk assessment tool rated this person as high risk. In a review completed on the same day it did not mention this person had moved to a high risk status. The information did not correlate and people could potentially have their needs overlooked with the inconsistent information contained in the care plans.

This was a breach of Regulation 17 (2) (c) Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Care, treatment and support plans were personalised. The examples seen were thorough and reflected people's needs and choices. An example of this was where one person's emotional wellbeing care plan stated they liked to help with some chores, and staff were to use these techniques to engage the person if they felt anxious. Staff demonstrated good understanding of the people they supported saying "We find out

about people from their care plan, but tastes do change so we always ask them and document any changes" and "People change over time and may like something they didn't before so I talk to them to find out, not just looking in care plans".

We looked at the daily records for people and saw staff wrote about people in a person centred way. For example one person was recorded as being 'in a lovely mood, very chatty and seemed to enjoy being in others company'. Another person had expressed concern over falling and staff recorded that they had took time to reassure the person so they knew they were safe. We saw that for people with a specific health condition, guidance had been put in place in their care plan for staff to effectively support them. For example we saw guidance for one person at risk of oedema (risk of swelling) and for another information on supporting a condition of diabetes.

At the time of our inspection there was not an activities co-ordinator in place. The manager told us they were currently recruiting for this position. We observed that the activity board displayed in the entrance hall detailed no activities for that week. Although people we observed appeared to be content, staff and relatives told us people did not have enough to do in the home. Relative comments included "They are sat there all day and [x] will say I'm fed up, they need some more activities". Another relative told us "There is no activities person at the moment, so not a lot of activities are going on". One person living in the home said "There's not a lot to do here but I don't do a lot".

Staff also raised their concerns with us about the lack of social interaction people were receiving commenting "People don't have enough to do and staff don't have time to help them", "As carers we try and put a movie on, or get magazines out but there's not enough activities, people are bored", "We need more help for the residents so they can talk to someone" and "people haven't got a lot to do at the moment, carers haven't got time but I can tell people want to do something". The manager informed us that while they continue to recruit for the post, they have put out some available hours for care staff to pick up in the role of providing activities in the home.

During our visit a volunteer was present assisting with lunch and chatting to people. We observed the home's pets, two Guinea pigs, which people seemed to enjoy watching. One person was able to have their pet bird with them in their bedroom. Staff told us that when the activities post has previously been filled a lot more was on offer for people. This has included trips out to places of interest, a mobile pantomime company that came in, visits from local school children and cake icing. The manager told us of the plans to transform a space downstairs into a bar and social area so people can enjoy pre dinner drinks.

Where appropriate the home encouraged people's relatives to be involved in the home and their loved one's care. This included inviting relatives to be part of care reviews. One relative told us "They do a review of [x] every month, they bring me in, and we talk about the care plan". Another relative said "I attend care reviews; they are good at sorting things out". For some relatives there was a communication book in place so families had the opportunity to record any messages in case they did not get time to speak directly to staff.

Relatives told us the home was very good at informing them of events that happened to their relative. Comments included "They always ring me about everything", "They ring and keep me informed", "There is good communication, they let me know the good and bad things" and "They are good at informing relatives, they phone straight away, they are very good at that".
People's concerns and complaints were encouraged, investigated and responded to in good time. People and their relatives informed us they were satisfied with their responses when they had raised a complaint or concern. One person told us "I had one issue here and was happy with how the manager handled it". Relative's comments included "I feel comfortable to raise concerns, they are dealt with and they keep me

informed" and "I feel confident to go to the manager about any concerns". When people came to live in the home they were provided with a handbook which contained a copy of the homes complaint procedure.

We reviewed the complaints log and saw examples of good candour. Acknowledgement letters were sent to people which offered an initial apology for any distress. A later letter we viewed then described the lessons learnt and offered a further meeting if a person was not happy with the outcome. Staff also felt confident in following the service's complaint procedure and informed us "If a resident made a complaint I would take it to management, but would see if there was something that could be done immediately" and "Residents make general concerns to us, if I can deal with it immediately I do, if not I report it to the manager, record it and take it to handover".

People's experience of care was monitored through regular resident and relatives meetings which gave people an opportunity to discuss ideas and learn about plans for the home. One relative commented "The manager is doing very well; we have relatives meetings and can say anything". One person living in the home said "We are asked what we think of the service when we have resident meetings; I have complained about the staff numbers but was told there was enough". We observed in the entrance hall a suggestion box so people could leave feedback anonymously at any time if they wished.

Employee feedback was being sought and the manager told us this will be done every six months and then collated and shared back to staff, with any necessary actions taken. Staff told us they always try and ask people if they are happy commenting "I like to think residents are happy, its friendly and homely, I love it here" and "We have a friendly happy atmosphere, feedback from people say it's a happy place, and it's like home".

Good

Is the service well-led?

Our findings

The service had an open culture that was person-centred, inclusive and empowering. The registered manager was very much at the heart of this and was a positive role model for the staff. The registered manager had taken time to build a supportive team and discussed how the home was in a much more stable place than it previously had been commenting "I enjoy seeing staff developing". During our inspection the registered manager was supported by an operations manager and a quality compliance manager from within the service. The home had a head of care who was a very visible presence for people, and staff and relatives spoke highly of the efficiency of the management team.

Staff told us the manager operated an open door policy and they felt comfortable in seeking out their manager for advice. Comments from staff included "The manager is very approachable, I would go to the manager in an instant", "The manager is friendly and supportive, and helps out on the floor or with personal care", "The manager is brilliant, they listen, and have an open door policy" and "The manager listens, and always finds time".

Relatives also felt confident in the manager's abilities and reassured by their approachable nature saying "The manager is approachable and says if I'm not here arrange to see me, they are very conscientious, and wants everyone to be happy", "It's an impressive set up and well managed, I was impressed from the first day I met the manager" and "The manager is approachable and considerate, very good at what they do". One health professional told us "The manager is very approachable and does appear to act upon our queries and concerns".

Staff told us they felt supported within their roles saying "I really enjoy working here, people are supportive" "The company have given me a lot of opportunities, I have been able to progress", "I feel supported in my role, the manager will go through things with you", "I feel supported, you need to trust who you work with" and "I feel part of a team here".

The registered manager had recognised the challenges of the home when taking up the post, and told us one of the key achievements had been in changing the culture which was very task focused and institutionalised. Staff, people and their relatives spoke warmly about the registered manager and the positive changes seen in the home from their influence. Staff told us "Things have improved since this manager has been in place, we have stable staff now and we have the continuity", "We are going the right way, it's more positive, it's a nice atmosphere" and "The home has come on leaps and bounds, we needed leadership badly".

Relatives could also identify the changes in conversations to us and felt reassured by the direction the home was taking. Comments included "The manager has made a lot of changes", "The manager has made positive changes, and brought colour to the place, their intentions are always good" and "They put into practice what they say". One relative told us they chose the home simply because the manager had told them there was no need for an appointment to view the home, but to just 'come and see it as it is, we have nothing to hide'.

The registered manager had made links with the local community and plans to continue developing this further through setting up a dementia support café. The local schools had visited and people in the home regularly attended coffee mornings at a social club across the road. The manager spoke passionately about finding out what people needed and has done a lot of personal research especially in the domain of dementia. This has included bringing the outside inside with an indoor garden seating area and a bus shelter with a sign and timetable was constructed in the garden to alleviate people's anxiety of asking about buses. Staff told me people spend time sitting and chatting in the shelter and it has become a focal point of the home.

The registered manager had notified CQC about significant events. We used this information to monitor the service and ensure they responded appropriately to keep people safe. The manager collated evidence within the home on aspects such as person centred care, safeguarding, staffing and complaints. From this an action plan would be formulated and reviewed regularly. The manager conducted an analysis of falls as this had been a frequent occurrence in the home and discussed with the head of care which people were high risk and the subsequent action to be taken.

Walk the floor audits were in place and these were being completed weekly. This looked at the staff members on shift that particular day, if people were being assisted up in a timely manner and if bedrooms were left tidy. The quality compliance team within the trust carry out a yearly audit and from this the home is eligible to receive accreditations in different areas. The manager informed us the home was currently striving for their dining experience accreditations as they recently scored high in this sector. We spoke to the manager about the lack of recording and inconsistency's in recorded information, and were told the care plans are currently being reviewed. The manager was going to address the team members responsible for auditing these areas and ensure that staff were aware of their responsibilities in recording and reporting. The manager would oversee actions in this area to ensure the service was effectively monitoring people's needs.

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 12 HSCA RA Regulations 2014 Safe care and treatment Staff were using a form of restraint on one person displaying challenging behaviour. Staff had not received the appropriate training or knowledge to manage this situation safely. Regulation 12 (2) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The home had a high risk of falls. Equipment was repeatedly left in unsuitable communal areas.The lighting in people's bedrooms was dim and unsuitable for purpose. These potentially posed further fall risks to people. Regulation 15 (1) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Record keeping was not correctly completed, meaning monitoring measures could not be actioned appropriately. This was identified in people's care plans, medicine records and on fluid intake charts. Regulation 17 (2) (c)