HICA

Tamarix Lodge - Care Home

Inspection report

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Ratings

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

Overall summary

Tamarix Lodge is a care home that provides accommodation and personal care for up to 37 older people, including those with a dementia related condition. On the day of the inspection there were 29 people living at the home permanently.

This inspection was unannounced and took place on 6 October 2014. There was a registered manager in post at the time of this inspection and they had been in post since January 2014. A registered manager is a person who is registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

The last inspection took place on 26 November 2013. At that inspection we found the service was meeting all the essential standards that we assessed.

During our inspection we spoke to the registered manager, deputy manager and the area manager. We

Summary of findings

interviewed four care staff and two domestic staff. We spoke with five people who were using the service and five relatives. We also spoke with a visiting healthcare professional.

We found that people who used the service were not fully protected from the risks of infection. There was a significant and unpleasant odour in the main corridor area and the corridor carpets and two bedroom carpets were heavily stained. This meant the quality monitoring processes were not effective as they had not ensured that people were provided with a clean environment in which to live.

Although some people chatted and socialised in the lounge areas, there was no activity programme in the home and on the day of the inspection we saw that many people spent their time in their bedrooms. This meant that people who were not able to occupy themselves received limited social stimulation. People who lived at the home, visitors and staff were concerned about the lack of social stimulation.

People told us that they felt safe living at the home. We found that staff had a good knowledge of how to keep people safe from harm and that there were enough staff to meet people's needs. Staff had been employed following robust recruitment and selection processes.

People's nutritional needs had been assessed and they told us they were satisfied with the meals provided by the home. People were provided with a range of nutritious snacks, as well as hot and cold food and drinks, during our inspection.

We observed good interactions between people who lived at the home and staff on the day of the inspection. People told us staff were caring and this was supported by relatives and the health care professional who we spoke with.

Staff received a range of training opportunities and told us they were supported so they could deliver effective care; this included staff supervision, appraisals and staff meetings.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 in relation to protecting people by maintaining the home to a clean and hygienic standard, protecting people from inappropriate or unsafe care and treatment (a lack of activities) and not monitoring the quality of the service well enough. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Some aspects of this service were not safe.

People who lived in the home were placed at risk because some areas of the home were not cleaned to a hygienic standard.

People told us they felt safe. Systems were in place to make sure that managers and staff learnt from events such as accidents and incidents, complaints, concerns, whistleblowing and investigations. This reduced the risk to people and helped the service to continually improve.

Staff were recruited following robust policies and procedures and there were sufficient numbers of staff to support the people who lived at the home.

Staff we spoke with displayed a good understanding of the different types of abuse and were able to explain the action they would take if they observed an incident of abuse or became aware of an abusive situation.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had undertaken training on topics that provided them with the knowledge and skills they needed to support the people who lived at the home. However, the review and reassessment of people with anxious and distressed behaviours did not always fully explore all alternative options of care and treatment before people were given notice to leave the service.

People reported the food was good. They said they had a good choice of

quality food. We saw people were provided with appropriate assistance and support and staff understood people's nutritional needs. People reported that care was effective and they received appropriate healthcare support.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards. We found the location to be meeting the requirements of the Deprivation of Liberty Safeguards (DoLS).

Is the service caring?

Good

The service was caring.

People were supported by kind and attentive staff. We saw that care workers showed patience and gave encouragement when supporting people. People told us that staff explained procedures and treatment to them and respected their decisions about care. Healthcare professionals told us the staff interactions with people who lived at the home were positive.

We saw that people's privacy and dignity was respected by staff and this was confirmed by the people who we spoke with.

Summary of findings

People were included in making decisions about their care whenever this was possible and we saw that they were consulted about their day to day needs.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There was no activity programme in the home so people who were not able to occupy themselves received limited social stimulation.

There was a complaints procedure in place and forms were readily available for people to complete should they wish to make a complaint. People and relatives said that they could make a complaint if they wanted to, but they were not always satisfied with the way in which their complaints were handled. During our inspection we found that action had been taken to address people's concerns, but the home's approach could have been more open and effective.

People's care plans recorded information about their preferences and wishes for care and these were known by staff.

Is the service well-led?

Requires Improvement

Some aspects of the service were not always well led.

Although there were systems to assess the quality of the service provided in the home we found that these were not effective. The systems used had not ensured that people were not always protected against risks about infection control and inappropriate care and treatment in regard to a lack of activities.

Staff told us that the organisation promoted a positive culture. Staff were able to discuss concerns with the managers and there were regular staff meetings so that people could talk about any work issues. This meant that staff were able to provide feedback to the managers and their knowledge and experience was recognised and taken into account.

Tamarix Lodge - Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 6 October 2014 and was unannounced. The inspection team consisted of an inspector and a second inspector.

We sent the registered provider a provider information return (PIR) that required completion and return to CQC before the inspection. This was completed and returned with the given timescales. The information within the PIR enabled us to contact health and social care professionals prior to the inspection to gain their views about the service.

Before the inspection we reviewed the information we held about the service. We also spoke to the local authority commissioning team who provided us with information about recent contract monitoring visits and safeguarding investigations.

During our inspection we spoke to the registered manager, deputy manager and the area manager. We interviewed four care staff and two domestic staff. We spoke with five people who were using the service and five relatives. We also spoke with a visiting healthcare professional.

We spent time observing the interaction between people, relatives and staff in the communal areas and during mealtimes. We looked at all areas of the home, including bedrooms (with people's permission), office accommodation and the garden. We also spent time looking at records, which included the care records for three people who lived at the home, three staff records and records relating to the management of the home.

Is the service safe?

Our findings

People who lived in the home were not safe because they were not protected against the risk of infection.

We found problems with the cleanliness and hygiene of some parts of the home. There was a significant and unpleasant odour in the main corridor near to some of the bedrooms and the corridor carpets were heavily stained. Two bedroom carpets also had stained carpets.

As part of our inspection process we had contacted commissioners and health and social care teams who visited the service to ask about their views of the service. We received information that indicated that they had noted concerns about odours in the home during their visits to the service. One person said, "There is a strong odour of urine in areas and this has become worse over the last year."

We discussed the odours in the corridor area and the stains on the corridor and bedroom carpets with the registered manager. They told us the domestic staff cleaned the communal and corridor areas each month with a carpet cleaning machine. We saw records that showed the carpets had been cleaned regularly by the domestic staff, but we found that this had not alleviated the problem.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Everyone who we spoke with said they felt safe living in the home. One person told us "I feel totally safe and I am lucky to be living here" and another person said "I am confident about my safety. I couldn't be better looked after if I had a carer at home."

The provider had appropriate policies and procedures in place to help safeguard vulnerable adults (SOVA). Two members of staff said these were in the 'shift office' and easily accessible to staff and our observation confirmed this. Safeguarding incidents had been correctly reported to the Care Quality Commission and the Local Authority. The provider took appropriate action with regard to safeguarding incidents. Full records were not available to us during the inspection as two safeguarding records were with the Regional Manager who was investigating the incidents. This demonstrated to us that the provider took safeguarding incidents seriously and ensured they were fully acted upon to keep people safe.

We spoke with six staff about their understanding of SOVA. Staff were able to clearly describe how they would escalate concerns both internally through their organisation or externally should they identify possible abuse. Staff said they were confident the registered manager would take any allegations seriously and would investigate. Two care staff told us that they had completed SOVA training in the last year and this was confirmed by their training records. The training records we saw showed that the majority of staff were up-to-date with safeguarding training, and any gaps in this training had already been highlighted by the registered manager and training dates booked.

Care plans included suitable risk assessments that recorded how identified risks should be managed by staff. These had been updated on a regular basis to ensure that the information available to staff was correct. When people displayed particular behaviours that needed to be managed by staff in a specific way to ensure the person's safety or well-being, this information was recorded in their care plan. Six staff told us that restraint was not used within the service. The staff were able to describe what they would do if an individual demonstrated distressed or anxious behaviours. Staff said "We would use distraction techniques to calm the person down or we would walk away for a time and try again at a later date."

The registered manager monitored and assessed accidents within the service ensure people were kept safe and any health and safety risks were identified and actioned as needed. We looked at the accident records completed by the staff. There were 16 recorded over the past 12 months, but none had required notification to the Commission as they were minor or had no apparent injuries. The staff used 72 hour accident short term care plans to monitor any minor injuries.

The provider had safe and effective processes in place to look after people's personal allowances. Individual records of all transactions were kept, with receipts. Printouts were available to families or people who used the service on request.

We looked at the service's policies and procedures and found that they had a business continuity plan in place for emergency situations and major incidents such as flooding, fire or outbreak of an infectious disease. The plan identified

Is the service safe?

the arrangements made to access other health or social care services or support in a time of crisis, which would ensure people were kept safe, warm and have their care, treatment and support needs met.

People were protected from unsafe or unsuitable equipment because the provider had ensured the equipment used in the service was serviced and maintained and service certificates were available for inspection. Our review of the maintenance documentation showed that service contract agreements were in place to ensure equipment that was fixed to the premises was tested and fit for purpose; this included systems such as fire, electrics, nurse call, lighting, lifts, water and gas.

Staffing numbers were based on meeting people's individual needs, such as their level of dependency and whether they needed the support of one or two staff for mobilising. We looked at the last four weeks rotas from 15 September to 12 October 2014 and discussed the staffing levels with the registered manager and staff on duty. There were a number of vacant posts that were actively being recruited to, including six care staff positions on day shifts, one activity person and one servery position. Cover for these posts was being provided by the permanent staff and over the last month the staff had managed to cover most of these shifts. However, the provider may wish to review the contingency arrangements so that staffing levels can be continually maintained.

We observed that there was a visible staff presence throughout the home and staff were attentive to people's needs with call bells being answered quickly. This indicated that there was sufficient staff on duty to meet people's care needs. Staff told us that there was usually a low turnover of staff and that the majority had worked in the service for two years or more. Four care staff told us that they were managing to give people appropriate care and support based on the current staffing levels but were concerned that these would not increase even if the number of people who used the service did. Two domestic staff said "There is only usually one member of staff on each day. We can get the basics done but it is difficult to do more in-depth cleaning." Our observation of the service found it to be clean and tidy.

Senior care staff were working 16 hour shifts from 07:00 to 23:00 although shifts were planned so they got 11 hours rest between shifts. The registered manager said this was staff choice. We asked about the quality of care and staff stress levels and the registered manager reiterated that they had not received any complaints about this and it was staff's own choice to work the long hours. Five people who used the service and four relatives confirmed to us that they had no complaints about the staffing levels and their care and support. Staff also raised no concerns with us about the length of their shifts.

We looked at three staff recruitment records. All of those viewed included an application form, two references and a police check. This indicated that the provider did not allow people to commence work until they had checked that they were suitable to work with vulnerable people.

The provider had systems in place to provide people with their medicines in a safe and effective manner. People who spoke with us said "We get our medication on time and when we need it. The staff will call the GP when we feel unwell". The senior staff informed us that they had received training on the handling of medicines. This was confirmed by our checks of the staff training plan and staff training files.

We looked at the medicine administration records (MAR) for people who used the service. We found these were accurate and up to date, with staff signatures in place for the medicines they had administered. Checks of the medicine stock levels showed these tallied with the records.

We checked the stock levels of the controlled drugs (CD's) kept in the service and looked at the record keeping in the controlled drug register. These medicines have a high risk of being misused so are strictly monitored and checked on a regular basis. The CD stock levels and register balanced and two staff had signed each time a controlled drug was administered to a person who used the service. We found that the controlled drugs were stored correctly and disposed of safely.

Medicines that required refrigeration were stored appropriately. We saw that staff recorded the fridge temperature and the medication room temperature each day. This ensured that medicines were stored at the recommended temperatures and therefore remained effective and fit for purpose.

We found there was a system in place for the return of unwanted medicines to the pharmacy with records kept. The member of staff showed us where medicines were

stored whilst waiting for the pharmacy to collect them. We saw the returns book which staff completed for unwanted medicines and this was then signed by the pharmacy representative when they collected the returns.

Is the service effective?

Our findings

The service provided care and support for older people and those with dementia conditions. We had received information prior to our inspection that one family had concerns about staff not having the confidence to manage people with behaviours that challenged the service. Discussion with the registered manager indicated that two people with dementia had been given notice to leave the home in the last six months due to the service not being able to meet their needs. This was confirmed by information we received from the commissioning team at the local authority.

Best practice guidance such as the Dementia standards developed by the National Institute for Health and Care Excellence (NICE) and the Social Care Institute for Excellence (SCIE) indicates that people with dementia who develop non-cognitive symptoms that cause them significant distress or who develop behaviour that challenges should be offered an assessment at an early opportunity to establish the likely factors that may generate, aggravate or improve such behaviour.

We found no evidence that this best practice guidance had been followed by the service. Information in the care files we looked at indicated that on one occasion alternative care options were not fully explored before the decision was made that the service could not meet the person's needs. Checks of three care files indicated that for one individual the staff and registered manager had failed to contact the person's GP or refer them to the community psychiatric team about their anxieties and distressed behaviours until after they had been given notice to leave the service. Treatment from their GP to reduce the person's anxieties was on-going at the time of our inspection. The area manager had met with the family to discuss their concerns about the move and a letter of apology was sent to them as they found the provider's usual procedures had not been followed.

We looked at induction and training records for three new members of staff to check whether they had undertaken training on topics that would give them the knowledge and skills they needed to care for people who lived at the home. We also spoke with staff about their experience of the induction training and on-going training sessions. Staff told us they had completed a block induction programme lasting a week prior to commencing in post. This covered all aspects of mandatory training such as SOVA, moving and handling, fire safety, infection prevention and control and health and safety. Following induction training, staff had completed refresher training on these topics. We saw evidence of the induction programme in the staff files we looked at. Staff also said they 'shadowed' experienced staff until they were confident about working unsupervised.

Other training undertaken by staff included first aid, food hygiene, care of the dying, pressure area care and use of a nutritional risk assessment tool known as MUST. We saw from the records that ancillary and care staff had completed training in SOVA, challenging behaviour, dementia care and the Mental Capacity Act 2005 (MCA). This ensured that all front line staff were able to provide appropriate support and intervention within their job role. Six staff confirmed to us that this training took place.

Records of staff supervisions showed that care staff were observed as part of their supervision in order to provide feedback about their practice. We looked at three staff supervision records. These showed that supervision meetings were held every six weeks. The six staff who spoke with us said they found this helpful as they were able to discuss their work and get feedback on their working practice.

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the Mental Capacity Act 2005 (MCA) legislation which is designed to ensure that any decisions are made in people's best interests. The registered manager understood the principles of DoLS and was aware of the recent supreme court judgement and its implications on compliance with the law. At the time of our inspection no one was subject to a DoLS application. Staff had completed training on Mental Capacity awareness during the last two years and we saw in care records the home had taken appropriate steps to ensure people's capacity was assessed to record their ability to make complex decisions. Literature about MCA, DoLS, advocacy and SOVA was readily available to staff, people who used the service and visitors as it was on display in the entrance hall of the service.

We discussed people's care with different members of staff. Staff demonstrated to us that they were aware of what care each person required to meet their needs. Staff were able to say which people had input from the district nurse or dietician; they also knew what health problems each

Is the service effective?

person had and what action was needed from them to support the person. We observed staff assisting people into and out of their armchairs, taking some individuals to the toilet and others to the dining room. We saw staff helping people to eat and drink and all interactions were positive. We saw that staff took time to converse with individuals and made the effort to sit with them and gave them opportunities to respond to these conversations.

Our observations showed that staff treated people with respect and dignity whilst assisting them to eat and drink. People were offered the choice of having a protective cover over their clothes whilst eating. If the person declined then the staff respected their wishes. For those people who needed full assistance from the staff with their dining experience the staff talked to them and explained what they were doing at all times. There was no menu on display, but staff explained well what menu choices were available when people asked.

Everyone we spoke with said they received sufficient drinks and meals that were appropriate to their needs. One person told us "I have problems with swallowing so I have liquidised meals. These are done in separate portions so it looks okay and tastes good." Another person said "I don't have a special diet and it is very good food that we receive. I fancied a jacket potato the other day and asked for one – staff said 'no problem'." Two visitors told us "I feel welcome here. You are always asked if you want a drink of tea or coffee" and "Mum enjoys the food and has put a bit of weight on which is great."

Entries in the care files we looked at indicated that people who were deemed to be at nutritional risk had been seen by dieticians or the speech and language therapy team (SALT) for assessment on their swallowing / eating problems. We saw that care staff kept a 'food diary', which was a record of the food and drinks consumed by people at breakfast, lunch, tea, suppertime and overnight. This helped staff ensure people who were deemed 'at risk' had received enough food and drink to meet their nutritional needs.

The provider told us in the provider information return (PIR) that when looking at the effectiveness of the home's environment they took into account good practice for Design in Dementia Care. They were aware that colour could be used to increase and reduce visibility and colour contrasts could help people's navigation and orientation skills. We saw plain carpets were used in the corridors and bedrooms, bedroom doors were painted in bright colours and toilet / bathroom doors had pictures on them. This enabled people to find their way to the different amenities and reduced their confusion and anxieties.

Is the service caring?

Our findings

People were supported by kind and attentive staff. We saw that care workers showed patience and gave encouragement when supporting people. One visitor told us that they visited the service daily and they were delighted with their relative's care. This person said "I made the right decision in bringing my relative into this service. The staff are caring –very much so. My relative definitely feels they care about them. I am really impressed with the staff and delighted with the care. The staff keep me informed about my relative and call in their GP or the district nurse when they need them. The staff are the right kind of people you want looking after your family."

People who used the service had their own care file, which identified their individual needs and abilities, choices, decisions, likes and dislikes. We spent some time observing daily life in the home and saw that people's wishes and choices were taken into consideration by the staff. This included decisions about what people wore, ate, who they spoke with and contact they had with others. People who spoke with us said "We are very satisfied with our care, the food is good and there are plenty of choices available" and "We get help from the staff when we need it, you only have to ask and they cannot do enough for you."

We spoke to people about the care and support they received from staff. People told us that staff explained procedures and treatment to them and respected their decisions about care. One person who used the service told us about their health problems and what effect this had on their life. They told us "I try my best to remain independent, but the staff are always there to offer me support should I need it." One relative who was visiting the service told us "We are kept up to date by the staff with anything to do with my parent's care and treatment. The staff are very good at letting me know if anything happens such as a fall or ill health".

We saw that people and staff had a good rapport with each other. Observations of people in the lounge, dining room and around the home indicated that individuals felt safe and relaxed in the service and were able to make their own choices about what to do, where to spend their time and enjoyed chatting to each other and staff. Two visitors told us "Our relative thinks her bedroom is her home and the service is a hotel. We are always made welcome when we come here and our relative gets lots of visitors." One person who used the service said "I have no concerns about living here. There are usually staff around when you need them and they let me know about things going on in the home. The staff would send for a doctor if I needed one and they always let my daughter know if anything is wrong."

We spoke with a visiting healthcare professional who told us "The staff interactions with people who live here are positive – they know the individuals and most staff can tell me how a person is feeling and how their health is. In the past staff have hoisted a person so that I could see to their care. I have confidence in the staff skills and knowledge."

We saw that privacy and dignity was maintained by staff and, where required, people were assisted from communal areas to be assisted with personal care. Staff were able to give us examples of how they promoted people's independence and maintained their confidentiality. One person who used the service told us "There is a wide range of ages in the staff. I personally prefer the more mature ones who are great, really caring. The staff are very good at protecting your privacy and dignity when giving care. They always cover you up with a towel and are very discreet. It could be embarrassing but they put you at ease and you can even have a laugh and a joke about things which makes you feel better."

Is the service responsive?

Our findings

We did not see any evidence of planned activities taking place during our visit. There was no information on display and we noted that the lounge areas lacked items for people to interact with such as magazines and reminiscence materials. We saw some people engaged in simple activities such as watching television, chatting in small groups or listening to the radio. Six staff told us "There is a lack of activities. On Saturday one person cried due to boredom and frustration as they had nothing to do. The staff do their best, but we have a lack of time to carry out activities. This has been the case since June 2014 when the activity person left."

We spoke with people and visitors about activities in the service. One person told us "I enjoy gardening and bowling. The home has entered two competitions with others in the community this year and we did really well. The gardening keeps me occupied, but on days like today when it is raining I cannot go outside. There are no other activities available so I am often bored and restless." Three relatives said "There have been no activities or entertainment for some time. It is sad to see so many people with nothing to do."

One person who had dementia spent a large part of the day in their room. At times they walked out into the corridor and at one point sat with us in the office. Staff occasionally came to lead them back to their room and their interactions were kind and considerate, but there was no effort to engage the person in any kind of pastime.

The registered manager told us that the post of activity co-ordinator was being advertised. We were told by the area manager that the provider did have a budget for activities such as trips out and outside entertainers, but this had not been utilised. The day after our inspection we were informed that a programme of social events provided by outside entertainers had been put together and would be starting shortly.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at three care files. Each person had a 'care need' assessment completed before a placement was offered to them. This assessment had included other health and social care professionals and family members to ensure as much information was gathered as possible. Information from the initial assessment was then used to develop people's care plans, which identified their individual needs and abilities, choices, decisions and likes and dislikes. In addition to this information there were risk assessments to cover daily activities of life, and behaviour management plans where a risk to the person or others had been identified. The care plans and risk assessments identified when and where people suffered from distressed reactions and responses as part of their dementia condition.

Each of the care files we looked at contained a 'map of life' and 'all about me' information. The registered manager explained this was an on-going process to gather information collaboratively with individuals and / or their families. Having this kind of information assisted staff in understanding the person's needs, past history and experiences and in developing individual person centred care.

The care plans we looked at were person centred. We saw that staff reviewed the care plans on a monthly basis and the review notes indicated that this task was carried out with the person who used the service and their input and views formed part of the review. Three people we spoke with confirmed that they spoke with staff about their care and their wishes and choices were respected by the staff. However, four care staff told us they felt there was a lack of time to provide person centred care. The staff said "Care can be task orientated, but we try to make it personal by chatting to people as they get up or during their daily activities."

We asked people about their experiences of living in the home. One person said "I love it here. Staff will tell me if there is anything I should know about such as activities, appointments and meetings." Another person said "It is like one big family. The staff are lovely, I don't have to wait long at all if I have to use my buzzer for assistance. I like to have my breakfast in bed and then the staff will come and get me washed and dressed and I sometimes go down to the lounge to chat with my friends."

The service had a complaints policy and procedure in place and this was accessible to people who lived in the home, staff and visitors to the service. We asked for and received a summary of complaints people had made and the provider's response. A relative told us they had made a complaint to the registered manager, but their response was poor and the home's approach could have been more open and effective. Checks of the complaint records

Is the service responsive?

indicated that the area manager had arranged a meeting with the family to discuss their issues and a letter of apology had been sent to the family. Another person's complaint had been dealt with by the registered manager in a timely manner and was resolved quickly.

Is the service well-led?

Our findings

Although there were systems to assess the quality of the service provided in the home we found that these were not always effective. The systems had not ensured that people were protected against some key risks described in this report about infection control and receiving care and treatment that was inappropriate or unsafe. We found problems in relation to odour in one part of the home, and the lack of social activities and mental stimulation meant people's individual needs were not being met.

This was a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We sent the registered provider a provider information return (PIR) that required completion and return to CQC before the inspection. This was completed and returned with the given timescales. The information within the PIR enabled us to contact health and social care professionals prior to the inspection to gain their views about the service.

There was a registered manager in post who was supported by a deputy manager. The PIR stated that the registered manager met with other managers working for the provider, including area managers, on a regular basis. These meetings had external speakers, good practice discussions and were an opportunity to share practice issues for learning. This was confirmed by the registered manager and area manager on the day of the inspection.

Feedback from people who used the service, relatives and staff was obtained through the use of satisfaction questionnaires, meetings and one to one sessions. This information was usually analysed by the provider and where necessary action was taken to make changes or improvements to the service.

We looked at the March 2014 satisfaction questionnaires that had been returned to the registered manager. Relatives had commented that they were not aware of complaints procedure. The registered manager had acted on this and had gathered in the welcome packs and the complaints procedure had been added to this information pack.

The analysis of the resident's surveys showed that some people did not know what their care plan was, how to make a complaint or who their key worker was. Residents had also commented that they were happy with the food and would like to see bingo activities return to the service. An action plan had been produced to address these issues and during our inspection we found people were better informed.

There had been a survey response from 16 members of staff, one person said they would like more regular supervision but there were few other comments on the surveys.

We asked people how well-led they thought the home was and if they knew who the registered manager was. Five people said they had a good relationship with the deputy manager, but had less interaction with the registered manager. Everyone was confident that if they had any problems these would be listened to and acted on as needed. One person said "The deputy manager is a capable person and always around the home. The registered manager is there if you need them, but I think they have a lot to do." We did see people and visitors going into and out of the registered manager's office during our inspection, which indicated there was an open door policy in place. The registered manager also walked around the home during the day and spent time talking with people and their relatives, which indicated that there were opportunities for people to speak to the registered manager on an individual basis.

Discussion with three visitors to the service indicated that they all attended the relative / resident meetings when held. One visitor said "I like to go to these as you get to find out what is happening in the home." We saw that these meetings were held throughout the year and the last minutes were dated September 2014. The registered manager had discussed what staff changes were taking place in the home and people / relatives had the opportunity to talk about what was important to them. For example, one person wished to learn how to use a computer and we were told how the registered manager was arranging computer access within the service for them.

Staff who spoke with us also said they had a good working relationship with the deputy manager, but had less daily contact with the registered manager. However, all the staff agreed they felt well supported in their roles and the registered manager would take any action needed when issues were brought to their attention.

We saw that staff had regular supervision meetings with a senior member of staff and that these meetings were used

Is the service well-led?

to discuss staff's performance and training needs; they had also been used to give positive feedback to staff. Our checks of the staff files showed that senior care staff completed staff supervision meetings and documented the minutes of the meetings on the supervision records. These were monitored by the area manager during their quality audits.

The service held regular staff meetings so that people could talk about any work issues and there were up to date policies and procedures regarding work practices that staff could easily access. Staff said there was a positive culture promoted by the registered manager and the deputy manager and that they were also given feedback at staff meetings in respect of any serious safeguarding investigations. We were able to confirm this by reviewing the meeting minutes and policies and procedures. We saw that the registered manager had held meetings each month from January to September 2014.

We saw that the provider was taking action to improve the environment for people with dementia. We saw three rooms had been provided with furniture designed for people with memory impairment. The wardrobes had see through doors so people would know they contained clothing and the drawer units had curved fronts making it easy for older people to open and close the drawers and also see that they contained clothing and other items. Some toilet seats had been replaced with brightly coloured ones, making it easier for people to see and use the facilities.

The registered manager had completed dementia mapping training and observed a selection of people on a monthly basis. Information gathered from the dementia mapping was used to amend and update people's care plans to ensure they received the care and interactions they needed to meet their dementia needs.

Quality audits were undertaken to check that the systems in place at the home were being followed by staff. The area manager carried out monthly audits of the systems and practice to assess the quality of the service, which were then used to make improvements. The last recorded audit was completed in September 2014 and covered areas such as finances, reportable incidents, recruitment, complaints, staffing, safeguarding, health and safety. We saw that the audits highlighted any shortfalls in the service, which were then followed up at the next audit.

We saw that accidents, falls, incidents and safeguarding concerns were recorded and analysed by the registered manager monthly, and again annually. We also saw that staff undertook internal audits on infection control, medicines and care plans. This was so any patterns or areas requiring improvement could be identified.

We checked a sample of maintenance certificates and these evidenced that the premises and equipment had been maintained in a safe condition. There was a fire risk assessment in place and there was a current safety certificate in place for the fire alarm system. In-house checks were carried out each week to ensure that the fire alarm system and emergency lighting were in full working order.

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 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control People who used the service were not protected against the risks associated with acquired infections because of inadequate maintenance of appropriate standards of cleanliness and hygiene in relation to the premises occupied for the purpose of carrying on the regulated activity. Regulation 12 (1) (2) (c) (I)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The registered person did not take proper steps to ensure that people were protected from the risks of receiving care and treatment that was inappropriate or unsafe, as the lack of social activities and mental stimulation meant people's individual needs were not being met. (Regulation 9 (1) (b) (i)).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers People were not protected against the risks of inappropriate or unsafe care and treatment because of ineffective operation of quality assurance systems to identify, assess and manage risks relating to the health, safety and welfare of people who used the service. Regulation 10 (1) (a) (b)