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Oakwood House Residential and Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Oakwood House Residential and Nursing Home provides accommodation and personal and nursing care for up to 24 people, some living with dementia and/or other mental health conditions.

There were 24 people living in the service when we inspected on 6 and 8 September 2016. This was an unannounced inspection.

There was a registered manager in post. 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.

We have recommended that the service develops a system to calculate the numbers of staff required to meet people's needs and seek guidance from a reputable source on staffing levels which takes into account the needs of people and the layout of the building.

Improvements were needed in the training provided to ensure that staff were provided with the information they needed regarding the specific and complex needs that people living in the service had.

The recruitment of staff was done to make sure that they were suitable to work in the service and people were safe.

There were procedures and processes in place to ensure the safety of the people who used the service. Risk assessments provided guidance to staff on how risks to people were minimised. There were appropriate arrangements in place to ensure people's medicines were stored and administered safely.

The service was up to date with the Mental Capacity Act (MCA) 20015 and Deprivation of Liberty Safeguards (DoLS). People's nutritional needs were assessed and met. People were supported to see, when needed, health and social care professionals to make sure they received appropriate care and treatment.

Staff had good relationships with people who used the service. Staff respected people's privacy and dignity and interacted with people in a caring, respectful and professional manner. People and/or their representatives were involved in making decisions about their care and support.

People were provided with personalised care and support which was planned to meet their individual needs. People were provided with the opportunity to participate in activities which interested them. A complaints procedure was in place. People's concerns and complaints were listened to, addressed in a timely manner and used to improve the service.

Where the service needed to improve in some areas, the provider was aware of these and committed to

delivering safe care to people. There was an open and empowering culture in the service. People were asked for their views about the service and they were valued and listened to.

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 consistently safe.

Improvements were needed in how the staffing arrangements are assessed and deployed. The systems for the safe recruitment of staff were robust.

There were systems in place to minimise risks to people and to keep them safe.

People were provided with their medicines when they needed them and in a safe manner.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Improvements were needed in how staff were trained and supported to meet the complex and diverse needs of the people who used the service.

The Deprivation of Liberty Safeguards (DoLS) were understood and referrals were made appropriately.

People's nutritional needs were assessed and professional advice and support was obtained for people when needed.

People were supported to maintain good health and had access to appropriate services which ensured they received ongoing healthcare support.

Is the service caring?

Good

The service was caring.

People were treated with respect and their privacy, independence and dignity was promoted and respected.

People and their relatives were involved in making decisions about their care and these were respected.

Is the service responsive?

Good

The service was responsive.

People's wellbeing and social inclusion was assessed, planned and delivered to ensure their individual needs were being met.

People's concerns and complaints were investigated, responded to and used to improve the quality of the service.

Is the service well-led?

Good

The service was well-led.

The service had a quality assurance in place.

The service provided an open culture. People were asked for their views about the service and their comments were listened to and acted upon.

Where the service needed to improve in some areas, the provider was aware of these and committed to delivering safe care to people.

Oakwood House Residential and Nursing Home

Detailed findings

Background to this inspection

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

This unannounced inspection took place on 6 and 8 September 2016 and undertaken by two inspectors on the first day and one inspector on the second day.

We reviewed information we had received about the service such as notifications. This is information about important events which the provider is required to send us by law. We also looked at information sent to us from other stakeholders, for example the local authority and members of the public.

We spoke with seven people who used the service and three relatives. We observed the care and support provided to people and the interaction between staff and people throughout our inspection.

We looked at records in relation to six people's care. We spoke with the registered manager and 12 members of staff including nursing, care, administration, activities, domestic, gardening and catering staff. We looked at records relating to the management of the service, staff recruitment and training, and systems for monitoring the quality of the service.

Requires Improvement

Is the service safe?

Our findings

People's comments varied regarding the staffing levels in the service. One person told us that staff provided them with the support they needed but said, "They are hard worked." Another person said, "I think there is enough [staff]." One relative said, "They are always very busy. I think there was some issues, but they are sorting it."

Staff we spoke with commented on if there were enough staff to meet people's needs. One staff member said, "There is usually enough staff to cover, but if someone becomes anxious and needs extra support, can be harder." Another told us, "Yes staffing is ok. Weekends can be harder as management are not about." Another staff member said, "There's enough staff 90% of the time, sometimes it is busy."

A staff member told us that during the day there were two care staff on each of the three units as well as two nurses, who moved between all of the units. In addition to this one person had a one to one staff member. Records we reviewed and our observations confirmed this to be the case. However, on the first day we were told that there was a new staff member who was supernumerary because they were going through their induction and shadowing staff. This staff member was one of the two staff on duty. They were left alone in the unit they were working on for 30 minutes while the other staff member took their break. They said that they did not feel worried about this because a handset allowed them to summon support quickly if needed.

We observed that staff responded to requests for assistance promptly, and on the occasions when a call bell sounded, staff responded to these. Staff worked effectively as part of a team on all of the units and regularly updated each other. However, during the nurse's handover meeting, two members of staff were left on a unit who were both involved in supporting a person with their personal care needs. This meant that there were no staff in the communal area to support people. One person came into the lounge and sat on the arm of a chair where another person was sitting. The person on the chair tried to push this other person off the arm of the chair, saying that there was no room for this person to be on the arm of their chair. Although this situation did not escalate any further because the person moved, there was the potential risk of an incident occurring and staff were not available to support people.

Staff carried handsets so they could communicate with their colleagues promptly if support was required, or in the case of an emergency, in addition they could access the call bell system. This system ensured that resources were used effectively and people's safety was monitored. However, one staff member told us, "We need new ones; these are getting a bit rubbish now." We also saw one handset on a table next to a person in one of the communal areas. One staff member asked another why it was there and they were told that it needed charging, they then went to charge it. The registered manager told us that the handsets required new batteries and this was being addressed.

The registered manager told us about the staffing vacancies in the service and how they were actively recruiting to these roles. There was also a bank of nurses that they could call on when needed to reduce the need for agency nurses. In addition they said that they preferred to use existing care staff to cover shortfalls to provide people with a consistent service from staff who were known to them. The registered manager told

us how they and the care manager supported staff and worked on the floor when needed.

There were two activities staff who worked in the service. They were allocated 20 hours between them to provide activities for people who used the service. This meant that there was less than three hours each day allocated for meaningful activities with people. The activities staff told us that the care staff tried to do something, such as games with people in the evening. However, we saw that staff were busy supporting people with their care needs with limited time to provide time to participate in activities. On the first day of our inspection there were no activities provided to people because the two activities staff were on the rota to do other roles that day.

We asked the registered manager about how the provider assessed the staffing levels in the service and how the current numbers were decided on. They told us that if concerns arose they would look at the staffing on each of the units. There was no system in place which calculated the staffing numbers required in line with the numbers and dependency needs of people.

We recommend that the service develops a system to calculate the numbers of staff required to meet people's needs and seek guidance from a reputable source on staffing levels which takes into account the needs of people and the layout of the building.

Records showed that checks were made on new staff before they were employed by the service. These checks included if prospective staff members were of good character and suitable to work with the people who used the service. There was a system in place to check the nursing staff's fitness to practice and registration.

People told us that they were safe living in the service. One person said, "I am safe here." We saw staff ensuring people's safety. For example, when mobilising around the service, and intervening when people showed signs of anxiety. We saw a staff member checking temperature of hot drinks. One staff member told us, "We have to check the drink is not too hot, as people won't wait for it to cool down, so we make sure it is given at a safe temperature."

Staff had received safeguarding training and were able to identify different types of abuse and what action they needed to take if they suspected someone was being abused. One staff member said, "We are very aware of keeping people safe here. Many of the people we look after are vulnerable, and we have a duty to keep them safe, I would always raise concerns to the manager, or higher if needed." Another said, "I have raised concerns where people were at risk, and I was listened to."

We had received notifications from the service which identified that they had appropriately raised safeguarding referrals with the local authority safeguarding team, who are responsible for investigating safeguarding concerns. These included safeguarding incidents between people who used the service. Records and discussions with the registered manager showed that actions were taken to reduce the risks happening in the future, such as contacting other health professionals for guidance and support and seeking medicines reviews. Some people had been provided with gates to their bedrooms to prevent other people from going into them. This had been assessed and people had been asked for their views on this. Advice received from the safeguarding team had been acted upon to ensure people were protected. We discussed the safeguarding issues with the registered manager and they identified how the incidents had occurred which showed that they were analysed. This included a change in a person's medicines and changes to the units where people lived.

Care records included risk assessments which provided staff with guidance on how the risks to people were

minimised. This included risk associated with using mobility equipment, falls and pressure ulcers. The risk assessments were regularly reviewed and updated. When people's needs had changed and risks had increased the risk assessments were also updated. Where people were at risk of developing pressure ulcers records showed that there were systems in place to reduce and monitor these risks. This included the use of pressure relieving equipment and repositioning.

Risks to people injuring themselves or others were limited because equipment, including hoists and fire safety equipment, had been serviced and regularly checked so they were fit for purpose and safe to use. A staff member told us that the staff responsible for checking the safety of hoists did this regularly and if any issues were identified these were taken out of action to ensure people's safety. Records seen showed that there had been a time when not all of the hoists in the service were working and so had to be shared across the home. This had now been addressed and the registered manager told us that they were also in the process of obtaining a further two, which would minimise further risks of the hoists not being available. There was guidance in the service to tell people, visitors and staff how they should evacuate the service if there was a fire. There had recently been new paving laid in the garden to allow people to mobilise around it more safely.

People told us that they were satisfied with the arrangements for their medicines administration. One person said how they were prescribed with pain relief medicines and they were provided with these when they needed them, "I just have to ask and they [staff] ask me if I need them."

Staff responsible for administering medicines were provided with training to do so safely. The medicines policy and procedure had been signed by the nursing staff responsible for administering medicines, to show they had read and understood the document.

We saw that medicines were managed safely and were provided to people in a polite and safe manner by staff. We saw a staff member give one person their medicines, which were to be taken before breakfast, they spoke with the person about having their breakfast after these and that their medicines to be administered after food would be provided following their meal.

Medicines administration records were appropriately completed which identified staff had signed to show that people had been given their medicines at the right time. Where people were prescribed medicines to be taken as required (PRN) there were protocols in place to guide staff when these should be administered. People's care records included information when people required their medicines at specific times and the importance of this, for example for people living with Parkinson's disease. A nurse told us that if people received their medicines later than planned the times of their next medicines were adjusted to ensure people were provided with their medicines safely.

People's medicines were kept safely but available to people when they were needed. Regular audits checks on medicines were completed which ensured that any shortfalls were promptly identified and addressed. For example, a log of incidents identified that there had been an error with medicines and further training was provided for the staff member involved. Where there were omissions in the medicines records we saw that the management team had left post it notes on these with the name of the nurse on duty directing them to sign the records. The registered manager told us that they had also checked the medicines stock to ensure that people had received them before the post it notes were left. There were gaps in records which identified when people had been provided with their prescribed creams. We spoke with the registered manager about this and they told us that they had advised staff about the importance of completing them and this was an ongoing improvement. This showed that the systems in place identified discrepancies and these were addressed.

Requires Improvement

Is the service effective?

Our findings

People told us that the staff had the skills to meet their needs. One person's relative told us that people living in the service had complex needs and commented on how the staff met their needs, "They do it well," and, "The carers are superb."

Training records showed that staff had received training in subjects such as moving and handling, data protection, Mental Capacity Act 2015 (MCA), Deprivation of Liberty Safeguards (DoLS), first aid, equality and diversity, and safeguarding. The registered manager told us that the nursing staff were provided with training, such as verification of death, venepuncture, Parkinson's disease and palliative care, some of which was accessed from community services. The training plan showed that training including first aid, record keeping, dignity, diabetes, infection control, effective communication, equality and diversity, MCA and DoLS had been planned. These planned courses were to both provide training for new staff and update learning for staff.

There was a dedicated training officer employed by the organisation to provide training to all of their staff. The registered manager told us that the training officer had been in post for a year. They said that this staff member was working to ensure that all staff had received their mandatory training, including moving and handling and safeguarding, and then would be planning bespoke training in people's specific needs and in areas such as dignity and respect and end of life. Staff had not been provided with training in subjects such as supporting people with behaviours that challenge, and mental health conditions.

The service's brochure stated, "We care for people with physical and sensory disabilities; a variety of complex mental health needs; Dementia; Multiple Sclerosis; and other long term complex conditions," and that they provided care for, "…people with advanced Dementia including Alzheimer's, behavioural challenges or mental health needs." There was no evidence in place to show that staff had been provided with the training relating to the conditions and needs of the people using the service as identified in their own brochure, other than some staff had received training in dementia. The registered manager told us that the previous provider had this training on their programme. However, this was two years ago and new staff had started working in the service. It is the current provider's responsibility to ensure that staff are provided with the training they need to meet people's assessed needs.

There was a procedure in place for restraint, which stated, "If decisions to use restraint are taken, it must be the least restrictive option and undertaken for the shortest variable length of time," and, "The amount, type and time period of the restraint is proportionate to the likelihood and seriousness of the potential harm." In addition to this the safeguarding policy stated, "A staff member who witnesses a situation in which a service user is in actual or imminent danger must stop what is happening without further damage to anyone involved including themselves, either by immediately intervening personally or by summoning help." However, staff had not been provided with training in restraint or how to support people with behaviours that may be challenging. This meant that they had not been provided with the knowledge they needed to restrain people safely, if needed, and ensure that people were supported effectively in these situations.

The restraint procedure also stated, "Training on restraint as part of our programme of Dementia training. Homes with specific resident needs will have tailored training programmes." Records identified that not all staff had been provided with training in dementia and there was currently no tailored training programme to ensure staff are appropriately skilled to meet people's needs.

Staff spoken with said they felt confident using 'breakaway' techniques, one told us, "I feel confident if faced with aggression, but if someone really wants to hurt you they will." The registered manager told us that they delivered personal safety training which incorporated guidance such as how staff could remove themselves from situations which may cause them harm (breakaway techniques) and effective communication. However, despite the registered manager's experience and previous training they were unable to demonstrate that their knowledge was up to date in relation to 'breakaway' techniques. This meant that people and staff were at risk as they could not be assured that the techniques being taught were in line with current best practice.

Despite the lack of training, staff we spoke with knew about the people they cared for and care records identified how to support individuals. However, the provider had not ensured that all staff were trained in people's diverse needs to ensure that they were met effectively or that the potential risks to people's safety were minimised by the provision of effective training.

In addition to this we had received a high number of notifications from the service regarding challenging incidents between people using the service, whilst these had been managed, the provider had not ensured staff received formal training in supporting people with behaviours that may challenge which would benefit both the people using the service and staff.

Staff told us that they were supported in their role. Records showed that staff were provided with one to one supervision and staff meetings. These provided staff with a forum to discuss the ways that they worked, receive feedback on their work practice and used to identify ways to improve the service provided to people. However, these were not always provided as identified in the provider's own guidance, for example, 'four one to one supervision meetings each year.'

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were provided with an induction when they started working in the service, this included in house information, such as fire safety, and shadow shifts with more experienced staff. Probationary reports showed that new staff had been provided with the opportunity to receive feedback on their practice, identify any training needs and discuss any issues. This was confirmed by a staff member who said, "I have been here 6 months, and have already had 3 supervision sessions." Formal training for the induction was arranged in line with the planned training programme. The registered manager told us that during the induction period staff worked on the care certificate. This is an identified set of standards that health and social care workers adhere to in their work. One new staff member told us, "The induction has been very good so far. I haven't worked in care before but all my training is booked, and I have been observing more experienced carers." Another staff member said, "I had an excellent induction. I have learnt more here than in previous care homes I have worked in. The training is good."

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

possible.

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

The registered manager understood when applications should be made and the requirements relating to MCA and DoLS. They told us how they had made applications to ensure that any restrictions were lawful. These were kept under review where required. Staff were provided with training in MCA and DoLS. The minutes from a staff meeting in August 2016 showed that MCA and DoLS were discussed to ensure staff had an understanding of the requirements.

People told us that the staff asked for their consent before providing any care. We saw that staff sought people's consent before they provided any support or care, such as if they wanted to participate in activities, if they needed assistance with their meals and where they wanted to spend their time in the service. We heard a nurse asking a person if they could take their pulse, when the person had given their consent, the nurse said, "Thank you very much."

Staff understood why it was important to seek people's consent. One staff member said, "I always ask the person first if they want to wash, or eat, or take part in an activity. It is there choice and we [staff] respect that." Another commented, "Consent is important. I always ask first before helping people with anything."

Care records identified people's capacity to make decisions and they were signed by the individual or representative to show that they had consented to their planned care and treatment. Best interest decisions were in place where this was necessary, for example, in relation to the positioning of a pain patch. Care records guided staff to ensure that they involved people in all decisions about their care.

People were supported to eat and drink sufficient amounts and maintain a balanced diet. People told us that they were provided with choices of food and drink and a healthy diet. One person said, "The food is very good here. I can have what I want." One person's relative told us how the person has a softer diet, "It seems very good." Another relative described the food as, "Excellent." One person told a staff member after their meal, "I have just had the most delicious meal."

The menu included two choices, including a vegetarian option, for each meal. The menu also stated that if people wanted an alternative, they could request one. The meals were served from a hot trolley; people chose what foods and the amounts they wanted on their plate. Staff showed people the choices on offer, which helped them to make their choices. Where one person took time to make a decision about the two main choices, staff offered that they could have both.

People were encouraged to eat independently and staff promoted independence where possible. Where people required assistance to eat, this was provided on a one to one basis allowing people to eat at their own pace. We also saw a person's relative visited at lunch time and assisted the person to eat their meal. Where staff identified that people may need assistance this was offered in a caring manner, for example, by cutting up their meal. People ate at their own pace and were not rushed by staff.

People were provided with choices of hot and cold drinks throughout the day. There were also cold drinks available for people in the communal areas and in their bedrooms, for people who spent their time there.

We saw one person making themselves a hot drink in one of the lounges, they told us, "I make a drink when I want one." A staff member was assisting a person with a drink, when they said they did not want any more the staff member said, "Are you sure?" The person then said that they wanted some more. This meant that there were drinks available for people to reduce the risks of dehydration. There were systems in place to monitor people who were at risk of dehydration and records of their fluid intake were kept.

Staff had a good understanding of people's dietary needs and abilities. Members of the catering staff were knowledgeable about people's specific dietary requirements and how people were supported to maintain a healthy diet.

People's records showed that people's dietary needs were assessed and met. There were weekly recordings of people's weights, monthly reviews of MUST [Malnutrition Universal Screening Tool] and a date scheduled for the next review. Where issues had been identified, such as weight loss and difficulty swallowing, guidance and support was sought from health professionals, including a dietician, and their advice was acted upon, for example, providing people with food and drinks to supplement their calorie intake.

People told us that they felt that their health needs were met and they had access to health professionals when needed. One person told us about their ongoing medical issue and that they had recently seen the doctor. One visiting health professional told us, "They call us in when needed. Never had any problems here."

People's health needs were met and where they required the support of healthcare professionals, this was provided. Records showed that people were supported to maintain good health, have access to healthcare services and receive ongoing healthcare support.

Good

Is the service caring?

Our findings

People spoken with said that the staff were caring and treated them with respect. One person said, "I like them, I think they care." Another person said, "No one has ever been unkind to me." Another commented, "The staff are lovely, it's nice here." One person's relative said the staff were, "Very nice, kind."

There was a relaxed and friendly atmosphere in the service and people and staff clearly shared positive relationships. Staff communicated with people in a caring and respectful manner. They communicated in an effective way by making eye contact with people and listening to what people said. All of the interactions between staff and people were positive. Appropriate use of touch was used and respectful interactions. During lunchtime we observed chatting between people and staff, with lots of laughter. One person said, "I wind the [staff member] up, [staff member] takes it well, we have a laugh". The staff spoke with people in a way which respected their perception of time which maintained their feelings of wellbeing, such as discussions about their parents and children.

Staff respected people's privacy by knocking on bedroom doors before entering. People's privacy was further respected by staff who communicated with people discretely, for example when they had asked for assistance with their continence. However, we saw that a folder which contained details of checks on people had been left out in one of the communal lounges. This included details about people's care such as repositioning charts and when people had their continence aids changed. This could have been easily accessed by people using the service and visitors. We spoke with the registered manager about this who told us that these should have been kept in a secure place and would speak with the staff.

Staff talked about people in a caring and respectful way and they knew people well. One staff member said, "We know people well here, we know their ways and how they react to different things." We saw one staff member ask another to go to see a person as they were asking for them. The staff member told us that they made time for this because the person looked forward to seeing them. When they visited the person, they smiled and reached out their hand to the staff member. This interaction enhanced the person's wellbeing.

People said that their views were listened to and were taken into account when their care was planned and reviewed. We spoke with one person about their preferred times of getting up in the morning. They told us that this was respected and supported by staff and said, "I get up early most mornings." People moved about the building independently, many walked outside to the garden areas. People's bedrooms were personalised which reflected their choices and individuality.

Each care plan we reviewed had a 'This is me' booklet, which described how people liked to be cared for, best communication methods to use, and what made them anxious. This booklet was used when people moved between services, for example, a hospital admission, and provided new staff with knowledge of how people could be best cared for in an unfamiliar setting.

Records showed that people and their relatives, where appropriate, had been involved in planning their care and support. This included their likes and dislikes, preferences about how they wanted to be supported and

cared for. People's care records provided information about their history which provided staff with knowledge of the person.

Good

Is the service responsive?

Our findings

People told us that they felt that they were cared for and their needs were met. One person said, "I'm looked after here." They told us about their previous living arrangements and how they felt that the service was the best place for them to live. One person's relative said that they felt that the person's needs were met and that the service was, "Possibly the best in the country." Another person's relative described the care as, "Gold standard."

One person told us that they had a gate across their bedroom door which, "Someone used to come into my room, they don't anymore. I don't like them to touch my things." Discussions with the registered manager showed that if their belongings were moved this caused them distress. This showed that the staff responded to people's individual needs and comments.

Staff moved around the service to make sure that people were not left with any interaction for long periods of time. This resulted in people showing signs of wellbeing.

People's records held detailed assessments which were undertaken prior to them moving into the service. Discussions with the registered manager identified how the service had worked with people from moving into the service and how their wellbeing had improved. This was evidenced in records and photographs of people when they first moved into the service. This meant that people had received personalised support which had assisted them to improve their health and wellbeing.

Guidance in relation to effectively managing the specialist needs of people living with dementia were noted in people's care plans. For example, where people displayed behaviours which may challenge, there was guidance for staff on the best approach to use, and how to diffuse a situation. This guidance helped staff to understand the needs of the people they were caring for so they could support them in the most responsive way. One staff member said, "The care plans are good, lots of information. I read them twice a week to see if there are any changes."

People's life histories were not always completed fully. This could be an area for development, and would create an opportunity to tailor care for the individual needs of people more fully. Activities staff told us that they were currently working on this.

Care reviews were held which included consultation with people and their relatives, where appropriate. These provided people with a forum to share their views about their care and raise concerns. Relevant people were invited to attend reviews, including families and professionals. This meant that people's views were sought and their care records reflected the most up to date information about their needs and preferences.

Daily care records included information about people, such as the care they had been provided with and their wellbeing. Handover meetings were held at the changeover of staff. Each person was discussed, including how they were, if they had slept, their dietary needs, medicines, and general well-being.

People told us about the social events that they could participate in, both individual and group activities. One person said, "I can do things if I want to. I go to the shops to get things I want." Another person told us, "I would like more to do during the day." We observed a discussion between staff and people about the games of scrabble they had played and the fete the week before.

The activities staff told us how they spoke with people about what they wanted to do, and as well as having a planned activities programme, including entertainers, people had one to one activities which were meaningful and specific to their wishes. They told us about how they had started working with services in the community, such as a local shop who provided raffle prizes and a café. They were enthusiastic about their role, shared some good examples of activities they had done with people and how this was to be developed further. However, we found that because there were only 20 hours a week allocated for activities this limited the amount that they could do with people.

On the first day of our inspection there were no planned activities, apart from an individual who had visited the service and provided foot massage where people wanted this. The activities staff were working in other roles on that day. On the second day of our inspection we saw staff throwing a ball with people in the garden, people had also had ice cream. There was lots of chatting and laughter.

We asked the activities staff if they had items in the service that people could use to stimulate their senses. They showed us a box of hand muffs with items attached that people could feel and handle but these were kept in the activities room so people did not have regular access to them. There were also aprons with similar items attached, which were in the laundry. They said that these would now be available in the service for people to use as they chose to. They told us that the aprons were in the laundry because they had been washed. On the second day of our inspection we saw people using the hand muffs. The staff also showed us a piece of equipment that they had made which was wooden and had switches, bolts and hooks on it. They said that this was for people who liked to handle items which related to their previous work or interests. There were also dressing up boxes which had been used for activities, but again these were in the activities room, the activities staff told us that they would ensure that the items were accessible for people.

The activities staff showed us photographs of activities that people had participated in, including both group and individual. These included trips out, meals out, and the annual Christmas cake competition.

People told us that they could have visitors when they wanted them. This reduced the risks of isolation. Where people required assistance to reduce the risks of them becoming lonely or isolated, this was reflected in their care records. We saw people enjoying visits with their relatives and one went out with their visitor. One person told us how they had been out with one of their relatives to visit their parent.

People told us that they knew how to make a complaint and that their concerns and complaints were addressed.

There was a complaints procedure in the service, which advised people and visitors how they could make a complaint and how this would be managed. Records of complaints showed that they were responded to and addressed. People's concerns and complaints were used to improve the service and reduce the risks of similar incidents happening. The registered manager told us that they spoke with people and relatives if there was a concern and tried to address this before the need for formal complaints.

Good

Is the service well-led?

Our findings

We had identified some areas in the service which needed improvement, such as window blinds not being complete and part of them lying on the window sill. In addition to this a person's relative had pointed out that the person's bedroom carpet needed to be cleaned. Records of audits and the registered manager's monitoring system showed that communication with the provider had taken place and there were plans to update the environment. This showed that the service had independently identified these shortfalls and were taking actions to address them. On the second day of our inspection the registered manager told us that they had been visited by a company to discuss the redecoration and refurbishment programme. They told us that they had spoken with them about seeking more robust furnishings to limit the risks of people damaging them or taking them apart. However, whilst the system in place had identified some shortfalls and actions taken to address them, the provider had not yet developed a robust system to identify the numbers of staff needed to support people safely and to ensure that the staff received the training they needed to meet people's needs safely and effectively.

Audits and checks were made in areas such as medicines, falls, infection control and care records. Incidents and accidents were analysed and checked for any trends and patterns and to allow for action to be taken to minimise future risks.

The registered manager understood their role and responsibilities and was committed to providing good quality care for the people who used the service. They told us that they felt supported in their role and they could contact the provider and their senior management team when needed.

There was an open culture in the service. People knew who the registered manager was and we saw them speaking with people and staff. The registered manager told us how they felt it was important to be seen in the service and available to speak with people, staff and visitors. People and their relatives who we spoke with were complimentary about the registered manager and their approach. One person pointed to the registered manager and said, "Very nice."

People and relatives were involved in developing the service and were provided with the opportunity to share their views. This included in satisfaction questionnaires and meetings. The summary of recent satisfaction questionnaires from May 2016, were generally good. One person had commented, "More activities would be nice." Discussions with the activities staff showed that they were seeking ways of improving the provision of activities. The minutes from a residents and relatives meeting in August 2016 showed that people were kept updated with events in the service, including staff recruitment and activities. Concerns had been raised about laundry and people not always receiving their own clothing. We saw that this had been discussed in a head of department meeting. The registered manager told us how they were taking action to change the way that clothing is labelled and all clothing which staff did not know who it belonged to was put on a rail for people and/or relatives to check. This showed people's comments were valued and used to improve the service.

Staff understood their roles and responsibilities in providing good quality and safe care to people. Staff were

provided with the opportunity to share their views about the service in meetings and in daily discussions. One staff member said, "Good managers, no pressure to not speak your mind here." Another told us, "I feel valued in my role." Another commented, "[Name of manager] supported me recently with a personal issue, which meant a lot." One other staff member said, "The service is well-led, we get the support we need generally." The registered manager told us that the staff who worked in the service were, "Amazing."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not provided with the training that they needed to meet people's complex and diverse needs. Regulation 18 (2) (a).