Bupa Care Homes (CFHCare) Limited

Wombwell Hall Care Home

Inspection report

Wombwell Gardens
Northfleet
Kent
DA11 8BL

Tel: 01474569699

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20 October 2016
21 October 2016

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected Wombwell Hall Nursing Home on 19, 20 and 21 October 2016. The inspection was unannounced. Wombwell Hall Nursing Home is a residential care home providing nursing support and accommodation for up to 120 older people. At the time of our inspection there were 116 people living at the service. Wombwell Hall Nursing Home is split into 4 units each being able to accommodate up to 30 people. Each unit had its own food service area, communal area, dining area, medicine room and staff room. There was also an additional building which contained a kitchen, laundrette, manager's office, meeting room and staff rooms.

There was a registered manager in post who was registered with the CQC. 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.

At our last inspection on 14 July 2014, we found 7 breaches of the Health and social Care Act 2008 (Regulated Activities). These breaches were in relation to not being fully compliant with the Mental Capacity Act 2005 (MCA), not enough staff on duty, medicines not being stored or administered safely, poor infection control practice, people receiving treatment during lunch service, people being left in wheelchairs for long periods of time and poor quality auditing systems. The provider sent us an action plan stating that they would address all of these concerns by June 2015.

At this inspection, we found that the provider had taken action on all these areas and was fully meeting the regulations where breaches were found.

People were protected against abuse and harm. The provider had effective policies and procedures that gave staff guidance on how to report abuse. The registered manager had robust systems in place to record and investigate any concerns. Staff were trained to identify the different types of abuse and knew who to report to if they had any concerns.

Medicines were stored securely and administered safely. Staff had received training on medicines handling and administration, and checks had been undertaken to ensure staff were competent to administer medicines safely. However, we found that some people's medicine records had not been updated and that some required further details. We have made a recommendation about this in our report.

The provider had ensured that the home was well maintained. Up to date safety checks had been carried out on electrical and gas installations. Equipment, such as hoists, were being checked and serviced. However, we found a back up syringe driver that had not been serviced since 2014.

The service appeared clean and tidy and there were cleaning rotas in place to ensure that all areas were cleaned. The provider had ensured that the premises were safe for use and had up to date safety certificates.

There were sufficient staff to provide care to people throughout the day and night. The registered manager used a dependency tool to identify the amount of hours required to provide support. When staff were recruited they were subject to checks to ensure they were safe to work in the care sector.

People's needs had been assessed and detailed care plans had been developed. Care plans had appropriate risk assessments that were specific to people's needs.

The principles of the Mental Capacity Act 2005 (MCA) were adhered to. People were being assessed appropriately and best interests meetings took place to identify the least restrictive methods of keeping people safe. Staff had training on MCA and had good knowledge. The provider had recently introduced new MCA forms that ensured that records were being completed appropriately.

The CQC is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Appropriate applications to restrict people's freedom had been submitted and the least restrictive options were considered as per the Mental Capacity Act 2005.

People were supported to have a healthy and nutritious diet. Staff could identify when people required further support with eating and appropriate referrals were made to health professionals and staff were seen to be following the guidance provided.

People told us they were happy with the care staff and the support they provided. Staff communicated with people in ways that were understood when giving support. Staff and the manager had got to know people well. Staff could build positive relationships with people to fully understand their needs.

People and their relatives told us they were involved in the planning of their care. Records also confirmed people's involvement. Care plans and risk assessments were being reviewed on a monthly basis by staff and at any time when it was required.

Staff respected people's privacy and dignity at all the times. The provider had ensured that people's personal information was stored securely and access only given to those that needed it. People had freedom of choice at the service. People could decorate their rooms to their own tastes and choose if they wished to participate in any activity. Staff respected people's decisions.

People at the service had access to a range of activities that were personalised to their needs. People told us they were happy with the activities on offer but would like to go on more visits outside of the home.

The provider had ensured that there were effective processes in place to fully investigate any complaints. Outcomes of the investigations were communicated to relevant people.

Staff were not always consistently updating people's records. Some people's care plans had gaps in their records. Staff could tell us why there were gaps but this information was not being recorded. We have made a recommendation about this in our report.

The registered manager was approachable and supportive and took an active role in the day to day running of the service. Staff were able to discuss concerns with them at any time and know they would be addressed appropriately. The registered manager was open, transparent and responded positively to any concerns or suggestions made about the service. The provider carried out surveys to identify shortfalls within the service.

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 were stored and administered safely. However, we found that records of people's 'when required' medicines were not always accurate.

The provider had ensured that the service was well maintained carrying out appropriate safety checks and servicing. However, we found that a backup syringe driver had not been recently serviced.

People were protected against abuse by staff who had the knowledge and confidence to identify safeguarding concerns.

The provider had ensured that there were sufficient numbers of staff in place to safely provide care and support to people.

Is the service effective?

Good

The service was effective.

The principles of the Mental Capacity Act 2005 (MCA) were applied in practice.

The provider had ensured that appropriate applications were made regarding Deprivation of Liberty Safeguards.

Staff received training that gave them the skills and knowledge required to provide care and support to people.

People had access to a range of food options that was nutritious and met their needs. People were supported to maintain their diets when required.

Is the service caring?

Good

The service was caring.

People spoke very positively about staff. People and relatives

told us they were happy with the service they were receiving.

Staff had good knowledge of the people they supported. Staff communicated in ways that were understood by the people they supported.

People's privacy and dignity was respected by staff.

Is the service responsive?

Good

The service was responsive.

People were encouraged to make their own choices at the service. Staff would respect people's choice.

People at the service had access to a wide range of activities. People told us they were happy with the choice on offer. However, people did tell us they would like more opportunities to go on outings.

The manager investigated complaints and the provider had ensured that people were aware of the complaints procedure.

Is the service well-led?

Good

The service was well-led.

The registered manager ensured there were good links with the community through working with local schools and arranging summer fetes.

The registered manager carried out audits of the service to identify any shortfalls within the service. The manager acted on the outcomes of the audits positively.

People, friends and staff were encouraged to give feedback through surveys and meetings. The manager listened and acted on these appropriately.

People's records were not being consistently updated by staff.

Wombwell Hall 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 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 19, 20 and 21 of October 2016 and was unannounced. The inspection team consisted of three inspectors and a pharmacist. At our last inspection on 14 July 2014 the service was rated as requires improvement. We issued seven requirement notices in relation to breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Prior to the inspection, we gathered and reviewed information we held about the service. This included notifications from the service and information shared with us by the local authority. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We spoke to 13 people who lived at the service, three relatives, seven care staff, five nurses, two activities coordinators, an NVQ assessor, deputy manager, registered manager and regional director. We looked at people's bedrooms, with permission, and all facilities at the service. We made observations of staff interactions and the general cleanliness and safety of the home. We observed people with higher support needs in a communal area to help us see how their needs were met. We looked at 14 care plans, three staff files, staff training records and quality assurance documentation.

Requires Improvement

Is the service safe?

Our findings

People we spoke to at Wombwell Hall told us they felt safe. One person told us, I feel very safe here." Another person told us, "Of course I am safe here." Relatives we spoke to told us they felt that their loved ones were safe living at Wombwell Hall.

At our previous inspection on 14 July 2014, the provider was in breach of regulation 17 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2010. We found that medicines were not stored securely or administered safely. At this inspection improvements had been made.

Medicines were stored securely and were within their expiry dates. Medicines were stored at the correct temperature, including those requiring refrigeration. Arrangements for ordering and receiving people's medicines from both the GP and pharmacy were suitable. GPs ensured appropriate monitoring of people's medicines was undertaken. There were suitable arrangements in place for people to take their medicines with them when they left the home. Controlled drugs (medicines which are more liable to misuse and therefore need close monitoring) were stored securely and registers to record their handling were accurately completed. Waste medicines were disposed of correctly. Although there were no waste disposal kits available for controlled drugs, by the end of the inspection staff were arranging these to be delivered to the home. Staff had received training on medicines handling and administration and checks had been undertaken to ensure staff were competent to administer medicines safely. A total of eight MARs were reviewed (Medicines Administration Records); these contained no administration gaps. Handwritten MARs had been double signed to reduce the chance of errors. Additional records showed that creams and transdermal patches had been applied correctly. Staff had access to information to support them to administer medicines to people on a "when required" basis. However, some people did not have this information in place for all their medicines. Medicines administration times were recorded as "breakfast, lunch, tea and bed" on MARs. However, it was not always possible to tell from MARs what time medicines (such as "when required" medicines) were administered, if they had been given outside the "regular" slots. This could be a problem should people need a certain time gap between repeated doses of a medicine. Without this record it was not possible to tell exactly when people last had their medicines and therefore when it was safe to administer the next dose.

We recommend that information is available to support staff to administer people's 'when required' medicines and that there is an accurate record available.

People at the service were protected against potential abuse. The provider had an effective system in place to recognise, record, investigate and track safeguarding incidents. Staff received training on safeguarding and were knowledgeable on how to spot the different types of abuse and who they can report it to. One member of staff told us, "Safeguarding is to protect people from all kinds of abuse. If I had any concerns I know I could go to my senior, the manager, area manager, the local authority or the care quality commission." Another member of staff told us, "I know my manager would do something if there was abuse going on." The registered manager had records of all previous safeguarding concerns. These records included any correspondence from other parties, notes from any conversations that were had and any

evidence required to carry out an investigation. The registered manager investigated any concerns reported by staff and would inform the local authority if required to do so. The provider had a clear and up to date safeguarding policy.

People had risk assessments in their care plans that were individually designed to minimise risk. Each of the care plans we looked at had risk assessments for falls, swallowing and moving and handling. Staff were observed assisting people to transfer and move around the units, and this was done in a safe way. People had risk assessments that were specific to their needs. For example, one care plan identified the risk of a person not being able to use a call bell and others had risk assessments on the use of bedrails. The risk assessments highlighted the risks to staff and gave guidance on how these could be reduced. To manage the risks around epilepsy staff were given guidance on how to reduce the risk by being able to identify the types of seizures and how to support the person before, during and after a seizure. We asked staff about their understanding of risk management and keeping people safe whilst not restricting freedom. One staff member told us, "We don't stop someone doing things for themselves. We let them go where they like in the home. It's up to them". Sufficient suitable equipment such as hoists and wheelchairs were available for staff to use. The premises were purpose built and the layout was such that it did not present significant difficulties in evacuating people in the event of an emergency.

The provider had ensured that the environment was safe for people. There were up to date safety certificates for gas appliances, electrical installations, portable appliances, lift and hoist maintenance. The registered manager completed general risk assessments that included slips and trips. Regulatory risk assessments were completed to reduce hazards around manual handling, Control of Substances Hazardous to Health (COSHH) and the use of ladders. The registered manager also completed specific risk assessments that included exposure to discarded needles and syringes. Each risk assessment identified the risk and what actions were required of staff to reduce the risk. The service had up to date safety certificates for gas and electrical installation and appliances. The home stored a syringe driver (portable pump which delivers medicines over a sustained period of time) to support people who needed medicines for end of life care. This had not been serviced since 2014; the manufacturer recommends services are undertaken annually. However, we did not see evidence that the syringe driver had been in use. We reported this to the management team who informed us that the syringe drive kept on site has not been used but is there as back up. The service used syringe drivers that were supplied and maintained by a local hospice. The management team assured us that a service will be undertaken for the device. Following inspection we were told by the provider that the service had been booked with the manufacturer.

Records showed that there were arrangements in place to keep people safe in an emergency. The policies and procedures identified the service contingency plans to guide staff as to how they should react in an emergency; for example, if there was a fire, flood or loss of electricity at the service. Each person had an environmental risk assessment that gave staff guidance on what support in required for an evacuation. For example, one risk assessment told us that a person requires the assistance of two carers and the use of the hoist. Each unit had its own fire risk assessment in place and their own testing of fire equipment that included fire extinguishers, alarms and lighting.

At our previous inspection on 14 July 2014, the provider was in breach of regulation 22 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2010. We found there were not enough staff on duty to ensure that people's individual needs were met. At this inspection improvements had been made.

There was sufficient staff to meet people's care needs, and effective processes in place to cover leave or unexpected absence. The manager told us, "We use a dependency tool to identify the amount of hours required to support people. There are currently 91 vacant nurse hours and we are advertising for this. We are

using our nursing bank staff during the recruitment period. We are also recruiting 10 new bank caring staff." The dependency tool used was specific to each person's needs. The dependency tool added 15% more hours to ensure there were enough staff to meet the needs of the people living at the service. We looked at the rota of individual units for four weeks leading up to our inspection. The rota revealed staffing levels were consistent across the time examined, with two registered nurses on duty during the day, five carers on duty in the morning and three in the evenings, in addition to the manager. There was one registered nurse and two care staff on night duty. There were also administrative, domestic, kitchen and maintenance staff on duty.

The provider followed safe recruitment practices that ensured that staff were safe to work in a care setting. We looked at the personnel files of three members of staff. The information provided included completed application forms, two references and photo identification to ensure that the member of staff were allowed to work in the United Kingdom. The records showed that checks had been made with the Disclosure and Barring Service to make sure people were suitable to work with vulnerable adults.

At our previous inspection on 14 July 2014, the provider was in breach of regulation 12 of the Health and social care act (Regulated Activities) Regulations 2010. We found the registered person did not have effective systems in place to protect people from the risks of acquiring a health care associated infection as appropriate standards of cleanliness and hygiene were not maintained. At this inspection improvements had been made.

The registered manager had ensured there were effective cleaning systems in place. There was a housekeeping cleaning plan that identified the amount of time it should take to complete each cleaning task. There was a housekeeping walk around twice a month on each unit and cleanliness was covered in the management's twice daily walk around. We looked around the home, spoke with staff and examined documentation regarding the cleanliness of the home and the quality of infection control. The home was clean and in a good state of maintenance; there were no unpleasant odours in the home. The provider employed a team of cleaners who had received training in infection control. We noted staff used personal protective equipment (PPE), such as gowns and gloves, when providing care. We also noted that all care staff had received infection control training. The staff we spoke with displayed a good knowledge of infection control. We were told the provider had recently introduced a system of infection control leads for each unit; that is a staff member with overall responsibility for ensuring high standards were maintained.

Good

Is the service effective?

Our findings

People and their relatives told us staff knew people well and provided them with the care they needed. One person told us, "The care staff here are very good at what they do." Another person told us, "The nurses certainly know what they are doing." One relative told us, "The staff are honest and caring. They know what they are doing".

At our previous inspection on 14 July 2014, the provider was in breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We found that mental capacity assessments had not been fully completed and had not been reviewed for more than three years. At this inspection improvements had been made.

Staff and management demonstrated understanding of the Mental Capacity Act 2005 (MCA) and DoLS. Staff had received training to support them to identify if someone may need an assessment. All the staff we spoke to could identify the main principles of MCA. All mental capacity assessments had been recently reviewed and were to be reviewed again with the introduction of a new form that is easier for staff to follow and complete. The management understood when a Deprivation of Liberty Safeguards referral was required. The CQC is required by law to monitor the operation of Deprivation of Liberty Safeguards, which applies to care homes. Appropriate applications to restrict people's freedom had been submitted and the least restrictive options were considered as per MCA. People can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). The registered manager told us, "There are 34 people with applications for DoLS and 4 have been granted." We did find that mental capacity assessments were being completed when not necessary for decisions that included breathing and circulation. The forms showed us later on that the decisions were regarding the use of medical intervention and that staff had followed appropriate steps to identify if a person had capacity. We reported this to the registered manager who told us that the system introduced should ensure that staff are putting the correct decision to be made at the beginning so that it is clear. We spoke to senior staff who had started to complete the new forms. Those that had been completed included appropriate decisions such as consent to bed rails; it showed all the options to be considered so that the least restrictive option could be identified in a best interest meeting that was also documented with those that attended.

Staff asked people for consent when it was required. Staff would ask for permission before carrying out personal care or assistance with daily tasks. For example one member of staff asked a person if it was ok to assist them with cutting their dinner. The provider had ensured that systems were in place to obtain formal consent from people for sharing information with other professionals and the use of photos. People who had capacity signed the forms and these were available in care plans.

The provider had ensured there were appropriate systems in place to support staff. Staff told us they had regular supervisions and appraisals. We looked at eight staff files and the provider's supervision tracker. We noted staff received four supervision sessions and appraisals through the year. There was also clinical supervision provided for registered nurses, in addition to group supervision. The staff we spoke with were

satisfied with this process. One staff member told us, "It's open and honest, yes. I can say what I like". Staff received a full training schedule and records showed that staff were up to date with their mandatory training. Staff told us that the provider had good training opportunities on offer to them. One staff member told us, "The training is very good here and there's plenty of it". A National Vocational Qualification (NVQ) assessor told us, "There are currently 15 people on a NVQ and we are enrolling more." The registered manager spoke positively about the way staff could develop at the service. Staff we spoke to were positive about their progression and could tell us how they could progress their careers.

The provider ensured that people's nutritional and hydration needs were being met and care plans contained nutritional assessments. In one care plan it identified that the person had type two diabetes, and that this was controlled by diet and should be monitored. The people we spoke with were happy with the standard of food provided. One person told us, "The food is lovely". Another person said, "The food here is really good, I must say. If you don't like something, they will make you something else". The menu was based on a four week rota. Food was prepared on the premises. We were told there was a choice of meals on offer and that care staff completed a Daily Menu Choice Form the day before. Whilst this was appropriate in most cases, it was not relevant to the needs of people with dementia, who may not have remembered choices made at an earlier point. We asked how special diets were managed and how people's opinions on food were sought. We noted people's likes and dislikes and special diets were documented and kept in the kitchen, accessible to staff. There were also separate ethnic menus, vegetarian options and a range of other alternatives on offer. In addition, the home had instigated weekly 'takeaway days' in which people could order food, such as Indian or Chinese cuisine if they liked, cooked on site. We noted the home had also arranged for an ice cream van to call to the home regularly. We observed staff 'take orders' from people for the ice cream of their choice. The home also provided 'high tea' on occasions and cakes on the occasion of people's birthdays.

We examined temperature recordings for fridges and freezers. These were displayed in the kitchen. We noted all surfaces and food preparation areas were clean and tidy and subject to a cleaning rota, signed off by kitchen staff when completed. There were also audits in place to ensure the ongoing safe and effective management of food and drink provision.

People at the service were being supported by staff to attend routine health visits and were being referred to health professionals when appropriate. Care plans identified that the provider involved a wide range of external health and social care professionals in the care of people. These included speech and language therapists (SALT), community psychiatric nurses and NHS Tissue Viability Nurses. People we spoke to told us they had regular appointments with their GP, opticians and chiropodist. Each person had a professional visit log that identified that a person had been seen by a health professional and recorded any guidance given. Care plans were updated accordingly to reflect any change. For example, following a reassessment from SALT a person's thickening liquid was reduced.

Good

Is the service caring?

Our findings

People at the service told us they were very happy with the staff. One person told us, "The staff are all very friendly." Another person told us, "The carers are brilliant, you cannot fault them." One relative told us, "The staff build good relationships with the people that live here."

Staff were kind, compassionate and spent time with people. We observed good interactions between people and staff who consistently took care to ask people's permission before intervening or assisting. There was a high level of engagement between people and staff. Consequently people, where possible, felt empowered to express their needs and receive appropriate care. It was evident throughout our observations that staff had enough skill and experience to manage situations as they arose and meant that the care given was of a consistently high standard. For example, we observed staff assisting people to eat at lunchtime in a discreet and caring manner. When people needed assistance to go to their rooms or toilet staff would assist in a caring way and were never rushed. Staff would communicate clearly to people and tell them what they were doing before they did. Transfers involving hoists or standing aids were completed in a dignified way.

People's cultural and religious preferences were respected. Records showed that religious services took place at Wombwell Hall. The food menu incorporated people's cultural preferences and the service had two volunteers who attended once a week from a local Sikh temple. People's care plans stated if they followed any religious beliefs and documented any cultural preferences such as food choices.

Staff communicated well with the people they provided support to. We observed two members of staff assisting a person with a transfer using a standing aid. During the transfer, staff were giving clear guidance to the person as to what they were doing. Staff also spoke to the person about their day that led to jokes being told during the transfer involving all parties. When the person was in their chair, staff asked clearly if they felt comfortable and the staff followed the person's instructions to ensure that they were comfortable in their chair. There is a keyworker system in place at the service. A keyworker is someone who has a focus on specific people living at the service. One member of staff told us they were the keyworker for three people. The member of staff told us, "As a keyworker I build up a good rapport with the people so that I get to know them well." Another member of staff told us, "I do not lose the focus of the person."

People and their relatives were involved with the planning of their care. One person told us, "My daughter and I are involved with the care plan." Each unit had a 'resident of the day' and every person living at the service would experience this once a month. People and their relatives were involved with the planning of their care. Care plans and daily records showed that people and their families were involved with their care as much as possible. Care plans and risk assessments were reviewed regularly and signed by staff and relatives or representatives. We found evidence that people or their representatives had regular and formal involvement in ongoing care planning or risk assessment.

At our previous inspection on 14 July 2014, the provider was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We found that people were having their eyes checked at the dining table whilst others were receiving their lunch. At this inspection improvements had

been made.

People's privacy and dignity was always maintained and staff encouraged people to be as independent as possible. One person told us, "I can wash myself but the staff assist with my back, when they have done they leave me to do the rest. I push my buzzer to let them know I am done." Another person told us, "They try to help me be as independent as possible. They assist a little with my food but I can still lift a pint of bitter." A third person told us, "They always knock before they come in and if you want some quiet time they leave you to it." A member of staff told us, "I knock before entering a person's room and ask if they are ready for their care. I let people know what I am going to do next; I show them the flannel or the towel to help them understand what we are going to do". When staff were delivering personal care people's doors were always shut. We observed one member of staff offering to assist a person cut their meal, the staff member waited for consent to be given before doing so. After this, the person could finish their meal independently. People's private information was stored in rooms that were locked when not in use by staff. Staff were never seen discussing people's private matters in public areas. All staff meetings and handovers took place in private areas of the service so that they could not be overheard by people of visitors.

Good

Is the service responsive?

Our findings

People told us they took part in activities that were suited to their choices and preference. One person told us, "The activities are good. In the afternoon two care workers help me to go to the activities in the other units." Another person told us, "The activities are very good. We get to do quizzes, stories and other things we like doing." People received the Wombwell gazette three or four times a year that listed upcoming events and had short articles on events that had happened. People had been given activity plans for the week which they could refer to when they wanted to see what was happening during the week. The activities for the day were written on the white board every day for people to refer to. The monthly and weekly planner were displayed on notice boards in each if the units; however they were A4 size and did not include pictures to help people with visual or cognitive difficulties. There were monthly themes for activities including art and craft, fun of the fair, spring, natural world, The Darling Buds of May, happy days, summer fete, art of fashion, friends of the earth, tell me a story, and Christmas. For the drama theme residents played a two day murder mystery game and a game of Cluedo that involved staff and props. For the art of fashion there was a fashion show and residents who couldn't participate enjoyed watching the show. This was shown in people's daily notes. The activity coordinator knew people well, approached them individually and offered them a choice of activities. Some people watched television while others read books or magazines and other people were colouring or doing puzzles. The activity coordinator told us, "We try to have external entertainment monthly, but, it is difficult as we have limited funds. We try and raise money for activities through raffles and ask for donations to use as prizes." Externally sourced activities took place at least once a month. Activities included historians, singers, a dog performing act, gardening show and a pianist. Some people we spoke to told us they would like more opportunities to go out on visits. The registered manager told us, "We have only had one visit out this year and that was for a pub lunch." Staff told us that limited funds and no guaranteed use of a mini bus make visits difficult to organise. However, staff were trying to source a mini-van for regular use so that they could do more visits out of the service.

People were empowered to make choices and have as much control as possible. One person told us, "If there is something I want to go and do, I do it, and if it is not to my taste I do not." Another person told us, "Staff respect my decision." A member of staff told us, "If a person does not want to join in with activities they do not have to." We observed one person choosing to not have their meal at lunch. The member of staff respected the person's choice, ensured they were okay and told the person they would check on them again later. Just before the end of the lunch service the member of staff went back to the person to see if they were okay and asked if they wanted something to eat. The person told the member of staff they wanted something small. The member of staff gave a list of options and the person chose what they wanted and this was prepared and brought to the person promptly.

At our previous inspection on 14 July 2014, the provider was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We found that people were left sitting in their wheelchairs for up to three hours. We were also told that family members had to cut fingernails and clean dentures. At this inspection improvements had been made.

People were not being left in their wheelchairs for long periods of time. People who had restricted mobility

were being risk assessed and supplied with equipment that was appropriate to their needs. People also supplied their own equipment to improve their own experiences living at the service. One person we spoke to told us, "I bought my own ramp so that I could go outside whenever I wanted to. The man from maintenance made a handle for it so I can take myself out around the grounds if I want to. It means I can do the things I like to do, like feeding and watching the birds. People had oral risk assessments that identified to staff the level of support that was required to support people, such as assistance with brushing teeth. People's records showed that people were receiving personal care that was appropriate for their needs. People's pre-admission assessments were thorough and identified what support people needed prior to placement at the service. The pre-admission assessments gave a clear account of people's needs and associated risks that included mobility, skin integrity, communication, nutrition and medicines. Before people moved to the service meetings took place to ensure that all necessary equipment was in place and that staff were aware of the person's identified needs.

People and their relatives told us that they could visit at any time. This means that people could keep relationships with their families and friends. Relatives told us there were no restrictions on visiting and they could come and go whenever they wanted. One person told us, "I see my family every day." Another person told us, "My family come and go as they please." One relative told us, "There are no restrictions on visiting; the care staff are always welcoming to us."

People and their relatives were encouraged to communicate their views on the service they received. Resident meetings took place on each unit and family members were welcome to attend these. From a recent meeting people told staff that new cushions and throws were required. These were purchased as an outcome. The provider ensured that the improvements from meetings and surveys was communicated to people through 'you said, we did' boards that are located in each unit. The most recent improvement communicated was the addition of the ice cream van visiting once a week and that this had been extended until the end of October due to the popularity. The provider had a complaints procedure in place that was available to people using the service. People and their relatives told us they knew how to complain and if they had any concerns they would tell the management. All recorded complaints were kept in a complaints file and included all investigations, outcomes and how this was communicated to the people involved.

Good

Is the service well-led?

Our findings

People and staff spoke positively about the registered manager and the service. One person told us, "The manager is great. Well, all the staff really but it comes from the manager." One member of staff told us, "This is a very rewarding job; it makes me go home with a smile." Another member of staff told us, "I feel supported by the manager. The whole management team have given us support with learning the paperwork systems and processes. I like it here and I feel we have built up a good team. A third member of staff told us, "Things have changed for the better. The atmosphere had improved, they have put a much better structure in place and we feel more supported. I really enjoy working here now."

At our previous inspection on 14 July 2014, the provider was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We found that infection control audits and quality assurance systems in the home had not been effective in identifying shortfalls within the service. At this inspection improvements had been made.

The registered manager had ensured that audits were taking place to make improvements across the service in line with the provider's policy. Senior staff on each of the four units updated a 'home manager quality metrics' report on a daily basis. The report included updates on safeguarding, infections, wound care, medicines, accidents and incidents. These were forwarded to the management team and put into a computerised system so that any trends or patterns could be identified. The management team would complete a walk around each morning to identify any clinical concerns, falls, hospital admissions, GP referrals, safeguarding concerns, staffing numbers and times of the medicine round. These were then discussed at the senior staff team meeting that followed the walk around. There was also contract compliance monitoring and this ensured that all people have a care and support plan in place within five days of entering the service, appropriate DoLS referrals were being requested and reviewed along with referrals to primary, secondary or specialist health services. A monthly quality assessment was being completed by the registered manager that identified any trends or patterns with pressure sores, hospital admissions, people on end of life care, deaths and ensuring people were having their annual health checks.

People's records were not always being updated by staff. Care plans did not always contain detailed information about people's care needs and actions required in order to provide safe and effective care. For example, we noted one person had a catheter in place. They had developed a urinary tract infection and were seen by their GP and prescribed anti-biotics. There was no subsequent entry in the care plan concerning this. This means it was not possible from the records to ascertain if the person had recovered. We spoke to staff who showed good knowledge of this situation, and the outcomes, but this had not been clearly recorded in the care plan. There were examples of people's personal history, likes and dislikes not being completed. When we spoke to staff they could tell us the reasons why, in these cases, some sections of care plans were not completed but this was not recorded. We did see examples in other people's care plans that identified that the people were unable to answer the questions given to them and their families could not provide the answer.

We recommend that the registered persons ensure that all people's records are accurate and up to date and

identify any reasons for gaps.

The provider ensured that people, relatives and staff voices were heard through surveys and meetings. A recent resident survey identified that people would like to meet or visit groups and clubs outside of the home. Staff told us that they are approaching local clubs in regard to this request and trying to work towards a solution as there is a restrictive budget from the provider for activities. This has been communicated to people through the 'you said, we did' boards throughout the service. A recent staff survey identified that 91% of staff agreed with the statement 'my work gives me a feeling that what I do makes a real difference.' There were home manager, senior sister, team, catering and activities staff meetings held at the service. The purpose of these meetings was to discuss any changes to the service, upcoming training and allow staff to talk about any concerns they may have or to identify any potential improvements. For example, in a recent activities team meeting a member of staff suggested that coffee mornings would be a good addition to the activities schedule and to look into obtaining a mini bus so that people can go on visits. Records showed that the coffee morning had started at the service and staff told us they are still exploring different avenues to obtain a mini bus.

The registered manager was seen to open and transparent. The registered manager told us, "I have an open door policy and anyone can come and speak if they need to." People, relatives and staff told us they were aware that they could approach the registered manager with a concern and were confident that they would be listened to. We observed staff and relatives approach the registered manager throughout the inspection. The registered manager had ensured that all notifications required as per the Health and Social Care Act 2008 legal requirement were being made to the care quality commission. All the providers' policies were up to date and these were communicated to the staff team.

The registered manager ensured that there were maintained links with the local community. The service was actively recruiting volunteers and advertising these posts in the local community. The registered manager had built up a positive rapport with local schools. This included students taking part in work experience at the home and participating in activities that included garden parties and summer fetes.