Darsdale Carehome Limited

Darsdale Home

Inspection report

Chelveston Road
Raunds
Wellingborough
Northamptonshire
NN9 6DA

Tel: 01933622457
Website: www.darsdale.org.uk

Date of inspection visit:
23 July 2018
30 July 2018

Date of publication:
07 September 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Darsdale Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

Darsdale Home accommodates up to 30 older people in a converted building which has two floors. Most of the bedrooms and all communal areas were based on the ground floor. At the time of our inspection there were 27 people staying there.

At our last inspection in August 2017 the service was rated as overall 'Requires Improvement'. Although we found there have been some improvements at this inspection we found there were areas that still needed to improve, so overall the service remains rated as 'Requires Improvement.'

The service did not have a registered manager, however, a manager was in place who was in the process of completing their application to become the registered manager. 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.

People received care from staff who were kind, compassionate and respectful. However, the care was task focussed and there was limited interaction with people outside of completing care tasks.

People's needs were assessed prior to coming to the home and detailed care plans were in place, however, these did not always reflect the current care needs of people. Risks to people had been identified and measures put in place to mitigate any risk but staff were not always aware of the risks and did not follow the guidance given.

The systems in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of people using the service had not been consistently kept.

Staffing levels had improved but needed to be maintained and account taken of people's needs outside of basic care and mobility. There was a high usage of staff from a staffing agency which had impacted on the consistency and standard of care delivered.

Staff were supported through regular supervisions and undertook training which helped them to understand the needs of some of the people they were supporting, training needed be widened to cover the needs of a diverse group of people.

There were appropriate recruitment processes in place and people felt safe in the home. Staff understood their responsibilities to keep people safe from any risk or harm and knew how to respond if they had any

concerns.

People are supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service support this practice. People's health care and nutritional needs were carefully considered and relevant health care professionals were appropriately involved in people's care.

People were cared for by staff who were respectful of their dignity. Relatives spoke positively about the care their relative received and felt that they could approach management and staff to discuss any issues or concerns they had.

The manager was approachable and people felt confident that any issues or concerns raised would be addressed and appropriate action taken.

The service strived to remain up to date with legislation and best practice and worked with outside agencies to continuously look at ways to improve the experience for people.

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.

There was not always sufficient staff deployed throughout the day to care for people safely.

People told us they felt safe and there were risk assessments in place to mitigate any identified risks to people but these were not always fully understood by staff

Recruitment practices ensured that people were safeguarded against the risk of being cared for by unsuitable staff.

There were safe systems in place for the administration of medicines and people could be assured they were cared for by staff who understood their responsibilities to keep them safe.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not always supported by staff who had the skills and experience to meet their needs.

People were involved in decisions about the way in which their care and support was provided.

People had access to health professionals and were assisted to attend medical appointments.

Is the service caring?

Requires Improvement

The service was not always caring

People's care was often task focussed and staff had limited time to interact with people outside providing care.

Staff were kind and respectful; people were able to make choices and decisions about their care and their dignity was protected.

Visitors were welcomed at any time.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care plans were not always updated to reflect their current needs.

People were encouraged to maintain their interests and take part in activities.

People were aware that they could raise a concern about their care and there was written information provided on how to make a complaint.

Is the service well-led?

Requires Improvement

The service was not always well-led

The systems in place to monitor the quality of care had not been maintained and any shortfalls had not been picked up in a timely way and addressed.

People and their families were encouraged and enabled to give their feedback and were kept informed about the development of the home.

Darsdale 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 23 and 30 July 2018 and was unannounced. The inspection was undertaken by one inspector, an assistant inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this instance, our expert-by-experience had cared for an older relative.

Before the inspection, we asked the provider to complete a Provider Information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the completed PIR and took this into account when we made our judgements.

We checked the information we held about the service including statutory notifications. A notification is information about important events which the provider is required to send us by law.
We also contacted the health and social care commissioners who help place and monitor the care of people living in the home.

During our inspection we spoke with nine people who lived in the home, 15 members of staff which included seven care staff, four senior care workers, an activities co-ordinator, a cook, a kitchen assistant and a domestic, plus the manager and provider. We also spoke to two people's relatives and two health professionals who were visiting at the time of the inspection.

We observed care and support in communal areas including lunch being served. A number of people who used the service lived with a dementia related illness and so some of them could not describe their views of what the service was like; we undertook observations of care and support being given.

We looked at the care records of three people and three staff recruitment records. We also looked at other

information related to the running of and the quality of the service. This included quality assurance audits, maintenance schedules, training information for care staff, staff duty rotas, meeting minutes and arrangements for managing complaints.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in August 2017 safe was rated as requires improvement and the provider was in breach of Regulation 18 (1) of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014, Staffing. People could not be assured that there were sufficient numbers of staff working within the home to provide their care and support in a consistently personalised or timely manner.

At this inspection, the rating remains requires improvement. The provider had reviewed and increased the staffing levels to meet people's individual needs. However, there was still times in the day when there was not always sufficient staff to meet people's needs in a timely and personalised way. This was specifically so at night time. People told us that they felt the staff were rushed and at night time they had to wait for assistance as there were only two staff working who were very busy. One person said, "Staff are always rushing especially at night time. I have help to get ready for bed then I sit in my chair from 7pm. There should be more staff."

At the time of the inspection the provider had identified that to safely support one person at night they needed to deploy an additional member of staff. The staff team had welcomed this, but felt that a third member of staff was needed at all times, not just at night. We spoke to the provider about this who agreed to ensure that there would be a minimum of three staff deployed at night.

The provider needed to ensure that they maintained sufficient staffing levels to meet the individual needs of people. Account needed to be taken of the environment and lay out of the building along with supporting people's holistic needs and not just basic care needs. One person said, "Staff don't have time to chat to me. I don't need much physical care but I need the time to talk." Another person said, "Staff are busy all the time, there may be enough to get the work done, but they never have time to chat with me."

We received an assurance from the provider that they would continue to keep staffing levels under review and make the necessary adjustments where required. We were satisfied with the action the provider took and have judged the service to no longer be in breach of regulation.

There were a range of individual risk assessments in place to identify areas where people may need additional support to manage their safety. For example, people identified as being at risk of falls or who were at nutritional risk had been assessed. However, staff did not always follow the risk assessment in place. For example, where a person had been identified as at risk of choking, staff were not always following the guidance given. They were not positioning the person correctly when assisting them to eat, thickener for the person's drink was not being prepared properly and staff did not ensure the person was fully supported to access a drink. We also found that a person assessed at risk of falling was left without their walking frame in reach; there was a risk that they may try and mobilise without the assistance they needed. The provider needed to ensure that detailed instructions were in place and effectively communicated to staff.

There were regular health and safety audits in place and fire alarm tests were carried out each week. However, the maintenance records were not always accurate and could not be fully relied upon. For

example, records kept in relation to the checking of the fire alarm system indicated the system had been checked on dates in the future. We spoke to the provider about this and they agreed to address this with the maintenance person and ensure that all records accurately reflected when systems were tested.

People told us they felt safe in the home. One person said," It feels very safe here, staff are good" Another person said, "I feel pretty safe here I'm not frightened at all. No rudeness or rough treatment, I stand up for myself and watch out for others. I'd kick off if I wasn't happy"

Staff understood their roles and responsibilities in relation to keeping people safe from any harm or abuse. In our conversations with staff they told us about the types of abuse that could happen and knew how to report concerns if they had any. We saw from staff training records that all the staff had undertaken training in safeguarding and that this was regularly refreshed. There was an up to date policy and the contact details of the local safeguarding team was readily available to staff. The manager knew to contact the local safeguarding team if any concerns were raised and where the local authority had requested investigations to be undertaken these had been completed in a timely manner. Any lessons learnt had been recorded and shared with staff, for example following one investigation a new system had been put in place to record people's weights and people were now being weighed monthly or more often if needed.

People were safeguarded against the risk of being cared for by unsuitable staff because there were appropriate recruitment practices in place. All staff had been checked for any criminal convictions and satisfactory employment references had been obtained before they started work at the home.

People received their medicines, as prescribed, in a safe way and in line with the home's policy and procedure. We saw staff spent time with people explaining their medication and ensuring they had taken their medicines. One person said, "The senior care staff do my tablets, I always get asked if I need painkillers."

Medicine records provided staff with information about a person's medicines and how they preferred to take them. There was also information about medicines people could take on a flexible basis, if they were required and when and how they should be used. People's medicine was stored securely in a locked cabinet within a locked room. Staff competencies to administer medicines were tested on a regular basis and audits of the medicines undertaken. If any issues were identified they were dealt with in a timely fashion to ensure medicine errors did not happen, and if they did, they could be rectified. There was a system in place to safely dispose of any unused medicines.

Each person had a personal evacuation plan in place with pictures included to assist staff easily to identify what support people needed in the case of an emergency. Equipment used to support people, such as hoists were stored safely and regularly maintained. Hoist slings were clean and odour free.

Any accidents/incidents had been recorded and appropriate notifications had been made. The provider collated the information around falls and accidents/incidents monthly and acted as appropriately when necessary taking action to prevent reoccurrence.

The home was clean and free from any unpleasant odours. The staff wore protective clothing when required and there was information around the home for people, staff and visitors in relation to infection control. The provider had systems in place to monitor the cleanliness of the home and all staff received regular training in relation to infection control.

Requires Improvement

Is the service effective?

Our findings

At the last inspection effective was rated as good. At this inspection we found that the service had deteriorated and there were areas that required improvement.

People did not always feel that staff fully understood their needs and had undertaken sufficient training to meet these. Many experienced staff had left and there were several staff vacancies. Whilst recruitment was on-going the provider needed to deploy staff from a staffing agency. Although some of the staff from the agency regularly worked at the home, a number did not, so there was a lack of continuity in the care given. One person said," I don't think the staff are as knowledgeable as the ones before the changes. The regular staff tell me they go to training and tell me what they've been doing." A relative said, "The continuity of staff has gone, so many staff have left and so many staff from an agency are used. I'm sure they don't understand it's not the same care here."

The provider was making efforts to recruit suitable staff but needed to review the use of staff from an agency to ensure more continuity of care. They needed to ensure that staff were equipped with the knowledge of people's needs and supported and supervised sufficiently when working.

During the inspection we saw staff from an agency providing people's support. Some demonstrated their knowledge and understanding of people's needs and had worked at the home on several occasions, others however, had not and were given minimal support and information. For example, one care assistant from an agency was asked to prepare hot drinks for people, they were unsure which people may be diabetic and who may need thickener in their drinks. This meant people were put at potential risk of receiving the incorrect care.

Staff training needed to fully reflect the needs of the people they were supporting. We saw that training around dementia, epilepsy, diabetes and dysphagia was in place. New staff had an induction which included shadowing more experienced staff and undertaking training in manual handling, first aid, food hygiene and equality and diversity. We observed more experienced staff using sign language. On member of staff said," It is important that we all use basic sign language; not all new staff have had that training." However, the staff needed training in supporting people with learning disabilities and brain acquired injuries to be able to fully support all the people now living at Darsdale.

People's dietary and nutritional needs had been assessed. We saw that referrals to a dietitian and speech and language therapist had been made when required. However, staff were not always aware of the advice given and therefore did not follow it. For example, a person who required food that needed to be pureed because they had problems swallowing was given food that had only been mashed; their care plan indicated they needed support to eat, however, we saw that their meal and drink was left for them and the person was offered minimal support. We spoke to the senior staff on duty who assured us that they would make sure that all staff, including the kitchen staff were fully aware of the person's needs. On the second day of our inspection the person had the appropriately prepared food and drink and support they needed.

People could choose where they ate their meals and adapted equipment was available to assist people to maintain their independence. However, people did not always have the choice and variety of meals they would like. We found that there was not always the food and ingredients available to make the meals that were on the menu. The kitchen staff told us they did not always have the food supplies they required. We found that some food was out of date in the kitchen. We spoke to the manager and provider about this, they were unaware that food was out of date and assured us that they would make sure that sufficient food was ordered to cater for the meals on the menu.

People were generally positive about the food. Some of the comments made by people included "I like the food its lovely. I like the choice of cold things for tea, it's well presented. Always enough drinks." "They [Kitchen staff] try and accommodate my preference for meat. I have bacon at breakfast, its better when the male chef is here. I only drink coffee and they make it for me whenever I ask. If I'm hungry I get biscuits." And "I like the food. I never remember what I've chosen."

The home liaised with other health professionals which ensured people's health care needs were met. A GP visited regularly and District Nurses visited daily. People also had access to a chiropodist and were assisted to attend medical and dentist appointments. One person said," They [staff] came with me to my hospital appointment and I know I can see the GP here if I need to." A relative told us, "[Relative] never misses hospital appointments and goes with the family or a care assistant. The District Nurse comes to do their insulin." We saw from people's care records that when health professionals had visited this was recorded, there was a need however to ensure that any actions taken because of a visit was clearly recorded. We spoke to the manager about this who gave us assurance that this would be addressed.

Permanent staff told us they received regular supervision and had annual appraisals and records confirmed this. One member of staff said, "I have supervision about once a month, I can raise anything I need to."

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 decisions 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 procedure for this in care homes is called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and we saw that they were. The manager was aware of their responsibilities under the MCA and the DoLS Code of Practice. We saw that DoLS applications had been made for people who had restrictions made on their freedom. Some staff had limited knowledge of the MCA and would benefit from further training.

People's consent to care had been sought and we observed staff asking people what help they would like throughout the inspection.

Darsdale was not purpose built but adaptations had been made to ensure people could access various areas of the home and we saw signage to help people identify which room was theirs and where the bathrooms and toilets were. There was an accessible garden and outdoor space for people to use in good weather. People had been encouraged to personalise their bedrooms; people had brought in personal items from their own home when they had moved in which had helped them in feeling settled in the home.

Requires Improvement

Is the service caring?

Our findings

There was a friendly and welcoming atmosphere around the home. People looked happy and relaxed and we observed positive relationships between people and staff. Overall people spoke positively about the staff. Comments included "I like living here. The staff are helpful and friendly."" I think the staff are kind, I'm content to be in here." However, from our observations the interaction with people and staff was task focussed and there was very little interaction outside of the task.

We spent time in communal areas. There were periods of time where there were no staff and people waited for attention. One person said," Staff are ok, but I sit in this lounge for too long, my bottom is sore and I need more help" We spoke to a senior member of staff who ensured that the person was assisted to be made more comfortable and checked for any potential pressure sores. A relative said, "Staff need more time to spend with people; they (provider) need to review the mix of residents."

People who were unable to communicate with us looked relaxed and comfortable around staff. However, staff were not always available to tend to their needs in a timely way. We saw one person banging their cup on a lap table trying to get the attention of staff, after 10 minutes a member of staff attended and asked the person to wait whilst they got someone to assist them. The person remained anxious and continued to try to summon help, after two minutes the person was assisted and the staff were understanding of their needs.

People were not always valued and encouraged to express their views and to make choices. Although we saw staff offering people a choice of drinks they did not always take the time to speak clearly to the person and wait for them to make their choice. The choice was made for them. However, when we spoke to people they did feel that they were able to make choices, one person commented 'Yes, I choose what I want.'

People's individuality was respected and staff responded to people by their chosen name. We saw in care records that people had been asked about their preferences as to how they would like to be addressed which the staff followed. The staff who had worked at the home for some time knew people well and understood their individual needs. They spoke fondly of people and could explain people's likes and dislikes to us. One person said, "The regular staff seem to know me well but there are lots of new ones and agency too"

Care plans contained information to inform staff of people's history, likes and dislikes, their preferences as to how they wished to be cared for and their cultural and spiritual needs. People's preferences were recorded such as whether they liked their bedroom door open or closed and whether they had a preference of a female or male carer. One person said," I have only female carers to wash me that works ok."

People were supported by staff to maintain their personal relationships. This was based on staff understanding who was important to the person, their life history, and their cultural background. Throughout the inspection we saw family and friends welcomed. People told us they could have visitors whenever they liked.

Staff spoke politely to people and protected people's dignity; staff knocked on bedroom doors before entering and checked with people whether they were happy for them to enter. People were offered a serviette or clothes protector at lunchtime. One person said," The staff generally knock on my door. When I have a shower, it's kept very private."

If people were unable to make decisions for themselves and had no relatives to support them, the provider had ensured that an advocate would be sought to support them. An advocate is an independent person who can help people to understand their rights and choices and assist them to speak up about the service they receive. At the time of the inspection we saw that one person had an advocate who had supported them around decisions about their care.

Requires Improvement

Is the service responsive?

Our findings

People's needs were assessed before they came to live at Darsdale Home to ensure that all their individual needs could be met. People and their families were encouraged to visit the home if possible before making the decision as to whether to live there.

The care plans contained all the relevant information that was needed to provide the care and support for the individual and gave guidance to staff on everyone's care needs. However, we found that staff were not always reading and following the instructions given and the care plans were not being kept up to date when changes in people's care needs had been identified. For example, we read in one person's care plan that they needed to see a dentist as they had lost their bottom dentures, there was no record of a dentist ever being contacted and the person was without any dentures. It was also stated that the person walked with the aid of a walking frame. Staff told us the person no longer walked, the plan had not been updated which posed a risk they would receive incorrect care.

Care records which related to people's nutritional needs and repositioning to support people's skin integrity were not always being consistently kept. We saw gaps in information which meant the manager could not be assured the level of care and support required had been delivered. We saw that the provider and manager had raised this with staff at a recent staff meeting, however, this continued to be an issue. The provider and manager needed to ensure that staff understood the importance of maintaining records and have effective systems in place to monitor so any shortfalls could be addressed quickly.

The permanent and established staff demonstrated an understanding of each person in the home and their care and support needs. For example, when a person needed guidance and encouragement to walk to the dining room the staff member got the person to sing with her which helped the person to continue walking. The member of staff told us that the person loved to sing which motivated them when walking. One person said," The regular staff seem to know me well but there are lots of new ones and agency too."

The home continued to care for people at the end of their lives. People were asked as they came to live at the home what their wishes were in relation to end of life care. If people were happy to discuss this, a care plan was put in place and any advanced decisions recorded. We spoke to staff about their understanding of providing end of life care, they spoke about following people's wishes, making sure they were kept comfortable and supporting their families. At the time of the inspection there was one person receiving end of life care.

People were encouraged to follow their interests and take part in activities. We saw that entertainment came into the home, there were theme days, such as 'a day at the seaside' and there was a weekly trip out to local garden centres and cafes and most recently people had enjoyed a boat trip. One person said, "Some things are good, I like it when there are trips. We had a good boat trip, other than that I don't do anything, I like to be on my own but I go out with my family." Another person said," I take part in as much as I can. Singing and games and we had a lovely boat trip." Some people did say that they would like more activities and more opportunities to go out into the garden. We spoke to the activities co-ordinator who told us that

they tried to spend individual time with people and had a volunteer from a local college to assist them once a week.

The service looked at ways to make sure people had access to the information they needed in a way they could understand it to comply with the Accessible Information Standard (AIS). The AIS is a framework put in place from August 2016 making it a legal requirement for all providers of NHS and publicly funded care to ensure people with a disability or sensory loss can access and understand information they are given. Information was available in audio form and large print and some staff had been trained in basic sign language.

People were aware that they could raise a concern about their care and there was written information provided on how to make a complaint. One person said," I would go straight to the owner as there's a new manager. He comes in a lot so I feel I could chat to him." Another person said," I haven't complained but I do get very down sometimes and the senior care staff sits and chats to me and we sort things out." The manager told us that they tried to resolve any concerns as quickly as possible and we saw that where complaints had been raised, the manager had responded promptly and took the appropriate action. For example, when someone had complained about the way an agency worker spoke to them, the manager had spoken with the agency and agreed that the worker would no longer work at Darsdale Home.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection we rated 'Well-led' as requires improvement. At this inspection 'Well-led' remains as requires improvement.

The registered manager had left in December 2017 and a new manager had been appointed in April 2018 who was in the process of applying to become the registered manager. 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.

In the absence of the registered manager the systems in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of people using the service had not been consistently kept. Audits which had been in place were undertaken on a less regular basis. This meant that the manager and the provider did not have the oversight of the service they needed to ensure that effective care, of sufficient quality was being delivered. For example, if audits had been regularly undertaken gaps in care records and out of date information in care plans would have been picked up and could have been addressed.

People's daily care records such as fluid and food intake charts were not consistently kept and updated. However, we saw from recent minutes of a staff meeting the new manager and provider had raised this with staff and were beginning to take steps to address this. We were unable to assess the effectiveness of this as it had yet to be embedded and sustained.

Although, since the last inspection the provider had identified the need for more staff and recruitment was on-going; the tool they were using to identify the level of support people needed focussed on people's care needs and mobility, but did not consider people's social and emotional needs. The provider needed to ensure that there were enough staff with sufficient time to holistically care and support people.

The criteria for admission to the home had been widened which meant that the provider needed to ensure that the admission process considered all the different needs of the individuals. Staff deployment needed to be closely monitored.

There needed to be improvements in the way staff from a staffing agency were deployed. The provider needed to improve the communication systems and induction process for staff from staffing agencies to ensure they were fully equipped to support people. Whilst agency staff were needed the provider needed to ensure some consistency of the staff deployed to bring stability to the staff team and provide a consistent standard of care people required and expected.

These concerns constitute a breach of regulation 17: Good governance (1) of the HSCA 2008 (Regulated Activities) Regulations 2014.

Staff were positive about the new manager, one member of staff said "[Name of manager] is very supportive,

she really cares about the residents and the staff." Staff meetings were held on a regular basis and we could see from minutes that the new manager had raised any areas which needed improving. Some staff did not always feel they could speak up at the meetings but the provider had also put a suggestion box for staff and people to use if they had any suggestions on how to improve the service.

The atmosphere around the home was friendly and welcoming which led to an open and transparent culture. People and their families were asked for their feedback through surveys and care reviews. We saw that following a recent survey people were overall very satisfied with the service. One comment read 'Very nice care home and all staff are very nice and friendly.'

The provider kept everyone informed about how the service was developing and regularly spent time at the home. We saw that people and staff knew the provider and were happy to talk to them if they wanted to. One person said," The manager is new I see her around, she's nice. There are three directors and they are here a lot." A relative said, "We feel well informed and can talk openly. The staff seem to get on and I see them chatting and laughing."

There were regular meetings held with people living at the home. One person said, "I know when the meetings are and I go to get information. I have also done a survey/questionnaire." The minutes of the last meeting were available on the noticeboard along with other information about activities planned and undertaken. There was also information available on how to raise a complaint and make any suggestions.

Staff demonstrated their knowledge and understanding around such things as whistleblowing, safeguarding, equalities, diversity and human rights. The supervision process and training programme in place for regular staff ensured that staff received the level of support they needed and kept their knowledge and skills up to date.

We saw that people were encouraged to be part of their local community visiting local garden centres, cafes and visiting local places of interest. The manager worked with the local authority, district nurses and GP. We spoke to a health professional visiting at the time of the inspection, they told us they felt the home was pro-active is seeking their advice and support when needed. The home had recently been selected to be part of a trial supported by the local GP practice, which involved the home being responsible for insulin management for people with diabetes. The home had also sent staff on training delivered by the local clinical commissioning group in relation to using a 'Frail Toolkit' to equip staff with better understanding around supporting frail older people some living with dementia.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgements. We found the provider had displayed their rating at the service; however, the website needed up dating as it referred to the previous owners and the rating they had achieved, not the current rating and new ownership. We spoke to the provider about this and they said they would address this.

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	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance and audit systems had not been maintained and sustained which meant the provider did not have full oversight over the standard of care being delivered. Daily records were poorly maintained and communication of people's needs needed to be strengthened.