Dovecote Care Homes Limited

Longmead Court Nursing Home

Inspection report

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Braintree
Essex
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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**

Overall summary

This inspection took place on 9 and 16 December 2015 and was unannounced. The last inspection of this service took place on 5 June 2014 when no breaches of regulations were found.

Longmead Court Nursing Home provides care and accommodation for up to 54 older people including people living with dementia. There were 47 people receiving care at the time of our inspection.

Summary of findings

There was not a registered manager in place. The recently appointed manager is seeking registration. 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 who used the service had not felt safe in the past but his had improved particularly with the increase of nursing staff from one to two being on duty. People living at the service, staff and visitors described the new management of the service as open and approachable. All staff were now receiving supervision.

New staff to the service had not received induction training in particular training with whistle-blowing and safeguarding. The service was addressing this issue as well as providing training for staff regarding Parkinson's disease. This was important as some people using the service had this diagnosis. Some risk assessments were not in place to specific needs regarding actions to take in the event of choking. Nutrition records were not accurate but again this was being addressed at the time of our inspection.

People had their mental health needs monitored. The senior staff of the service were knowledgeable with regard to Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The service had made referrals and worked with the Local authority to support people who used the service with regard to (MCA) and (DoLS).

Considerable work had taken place in the reviewing and writing of care plans so they were person-centred. The manager had also arranged with a GP for all peoples health needs to be reviewed which had resulted in some major changes to people's medication. Medicines were administered safely and since the increase in staffing medicines audits were now in place.

Relatives and people who used the service were consulted about the way in which the service should provide activities for people. The views of the meals were mixed but people thought there was sufficient food and choice.

Before moving to the service an assessment of people's needs was carried out from which a care plan was written and reviewed regularly.

Staff had worked with people to support them to access and be visited by healthcare professionals, including mental health staff with specific knowledge in the care for people with challenging dementia needs. Four people in the service were receiving dedicated 1:1 care and had their individualised needs met.

Relatives and people told us that they were confident in the manager and senior staff who they saw regularly.

There was a statement of purpose and an on-call service in place to support staff.

We found a breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not always safe.

Not all staff had been trained by the service in safeguarding and whistle-blowing.

Although being addressed specific risk assessments were not in place for all people.

Medicines were administered safely according to the service policy and procedure.

Requires improvement

Is the service effective?
The service was not always effective.

New members of staff had not received an induction training which was being addressed.

The manager and senior staff were knowledgeable about the requirements of the Deprivations of Liberty Safeguards (DoLS). The service was arranging for all staff to have training in the Mental Capacity Act 2005 and DoLS in the next year.

Nutrition records had not been maintained but this was being addressed.

Requires improvement

Is the service caring?
The service was caring.

People were supported by caring staff who respected their privacy, dignity and who knew people individually.

Staff spoke with people in a pleasant, professional and friendly manner and people were not rushed.

People who lived at the service and their relatives were involved in decision about their care from reviews and the running of the services.

Good

Is the service responsive?
The service was responsive.

People received care and support which was personalised to their wishes.

There was an activity programme including group activities.

There was a complaints policy and procedure. Relatives we spoke with told us they would be comfortable to make a complaint.

Good

Is the service well-led?
The service was well led.

Good

Summary of findings

The management team were open and approachable.

The environment was checked regularly so that it was suitable.

Peoples care records were reviewed monthly as part of an audit and changes were made as required.

Professionals had been invited into the service to review peoples care and work with the service met identified needs.

Longmead Court 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 inspection took place on 9 and 16 December 2015 and was unannounced.

This inspection was carried out by two inspectors.

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.

During our inspection, we spoke with seven people who used the service, two visiting relatives, two visiting professionals the manager, the deputy manager a team leader and four members of staff. We looked at eight records which related to people's care, we also viewed health and safety records including fire and water temperature records regarding the safe running of the service. We used the Short Observational Framework for this Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires improvement

Is the service safe?

Our findings

One person told us. "I feel safe with the staff." A relative told us. "At home [my relative] was not safe, but they are here."

Staff told us that they had received training and regular updates in safeguarding vulnerable people. They had a good understanding of the different types of abuse that could occur. They said that they would be confident about reporting abuse or poor care practices within the service. A nurse said that they would whistle blow if they needed to do so and knew how to report concerns to external organisations if necessary. However a carer we spoke with did not understand whistle blowing and did not know how and where to report concerns externally. The manager said that all staff would be reminded about whistle blowing and provided with the numbers of external authorities. This would be done through supervision and staff meetings within the month.

We saw that since the new manager and deputy manager had come into post they had begun work to update and increase the training for all staff. Some staff had not received training with regard to safeguarding people or whistle-blowing but we saw from the work delivered and planned that this was in hand.

Accidents and incidents which occurred in the service were recorded and analysed. We saw at our inspection that the fire doors were checked to be in working order every week and all fire safety certificates were up to date. We also inspected the records kept for routine maintenance, testing of electrical equipment and water temperatures and they were all up to date or within acceptable limits. This meant that the service had taken steps to provide a safe environment in which people lived. The deputy manager told us that the service was due for decorating in some areas.

People's needs had been assessed and risk assessments were in place in relation to a range of needs. However, some of the risk assessments we saw were not fully accurate and did not reflect the level of risk identified in the care plans. The service did not have a choking risk assessment despite the fact that people with advanced dementia were at increased risk of swallowing problems. We were aware that the new management team were working upon this situation with putting in place both a specific risk assessment and staff training. The management team were also seeking the support of professional staff such as the Speech and Language Therapy Team (SALT) to support with these situations. Speech and Language Therapy Teams offer expert assessment and management of communication and swallowing problems associated with progressive neurological conditions.

People's risk of falls was assessed. The new management team had commenced as well as looking at patterns of falls and writing specific individualised care plans with information regarding how to reduce falls. The service had built a store close to the main lounge to house handling and lifting equipment. This meant that the equipment was close most of the time to the majority of people. We saw that people had their own slings but we were concerned that the service did not have sufficient hoists for the number of people using the service. We raised this with the management and they said that they would discuss this with the provider as a matter of urgency to acquire an additional hoist. We saw that the existing equipment had been serviced appropriately.

We were aware that during our inspection call bells were rarely heard. Staff told us that due to some people's illness it was probably that they would not be able to summon assistance. Hence the staff being mindful of this checked people regularly to be assured of their well-being. We noted that some people received their care in bed on a permanent basis.

We looked at the staff rota for day and night duty and saw that the service was consistently staffed to the levels as explained to us by the manager and staff. The manager explained to us individual dependencies of people were carried out which was confirmed in the care plans.

The majority of people living in the service had a diagnosis of dementia. All the people in the service required nursing care and their dependency was generally very high. Four people living with dementia were receiving 1:1 care and support for all or part of the day. There behaviour was sometimes distressed and could be very unpredictable. The 1:1 support was provided in order to protect them and other people in the home from harm. The care staff providing 1:1 care were in addition to the usual staffing levels. The manager told us that there were now two nurses on duty in the day time. This was occasionally reduced to one nurse on the evening shift. Until recently the service had only one qualified nurse on duty. From the

Requires improvement

Is the service safe?

dependency levels of people's needs and discussions with the staff, the management had approached the provider to increase the qualified nursing staff on duty to two. This meant that the service which had two units, now had a qualified nurse on duty for each unit and in turn they were supported by the manager and deputy manager who were currently not included in the staffing compliment for direct care.

There were 12 care staff on the day of our inspection. Staff provided the support and care in an unhurried manner. One member of staff said that there were usually enough staff, another considered that at times they could do with two more staff. Other staff including team leaders and qualified nurses thought that the staffing was satisfactory certainly compared to the past. They felt that so long as the 1:1 care continued that the service had sufficient staff on duty. The manager told us that they were keeping the staffing compliment on duty under close review especially night staffing. They felt supported by the provider that should they need to increase this, it would be done.

The service had a safe policy and procedure for recruiting new staff to the service. A member of staff explained to us how they had been recruited. They had completed an application form, were aware their references had been checked after the interview and they had been given a job description and contract of employment. The deputy manager explained to us the recruitment process and they followed the company procedure which included seeking clearance from the disclosure and barring service for each applicant. We saw the service held staff recruitment files which included a job description

and contract of employment. The deputy manager explained to us the recruitment process and they followed the company procedure which included seeking clearance from the disclosure and barring service for each applicant. We saw the service held staff recruitment files which included a job description, contract of work and information for the applicants references.

We observed medicines being administered to people. The records of administration had been accurately recorded and there were no gaps in the records that we looked at. We saw that the nurse was only signing the medicine administration when they had administered the medicines. Some people were being given their medicines in the form of a skin patch. Staff had records showing that the patches were always placed in different positions. This reduced the likelihood of skin reactions. One person who had their painkiller administered through a patch told us. "I don't have any pain."

The controlled medicines were stored securely. The deputy manager and a nurse informed us of the ordering procedure for medicines and how controlled medicines were administered. We saw the records for each person taking controlled medicines and the physical stock balance agreed with the records.

Staff told us that they received medicines training and an assessment of competence before they handled and administered medicines on their own. We saw a nurse was very patient when encouraging people who were reluctant to take their medicines. One person was given their medicines in yoghurt as they usually refused to take them. GPs and relatives were consulted for permission before covert administration of medicines was used. The nurse told us that the pharmacist would also be consulted about the safety of giving the medicines covertly. The service had a policy and procedure for the administration of medicines in this way. Covert administration was only used when the person living with dementia was refusing medicines that were vital to their medical condition or their physical or mental wellbeing.

People had their photograph and room number on a laminated sheet of paper on front of the MAR sheet, which meant that staff could identify people correctly before giving medicines to them. The temperature of the medicines room and fridge were recorded daily and were within the acceptable temperature limits.

Requires improvement

Is the service effective?

Our findings

We saw staff supporting people with empathy with regard that they were sitting comfortably to receive their meal. They also supported the person's independence to do as much for themselves as possible while also ensuring there were options of choice for both food and drink. One person told us, "The food's not bad here." Another person said, "The food is edible." The meal times were well organised with staff highly attentive and supportive to ensuring people had a choice of meals and drinks. We saw staff communicating with each other to clarify and record what people had consumed before recording in food diaries. One person sat in front of their meal for over 15 minutes not eating. When we asked them if they liked the meal they said. "It's tasteless." Staff spoke to them and gave them a sandwich, which they pushed away immediately. Ten minutes later they were offered a pudding which they ate fairly fast. A relative told us. "The meals are very good and a lot of time is taken with the preparation. I visit regularly and eat here with my [relative]."

However, we found that overall the service was not able to evidence that they were meeting people's nutritional and hydration needs. Staff had records of what people were eating and drinking if there were any concerns about a person's nutrition or hydration. However, it was difficult to assess whether people were being provided with adequate nutrition from the records we looked at. If people had been prescribed supplements there was not always an accurate record of this on their food chart. Staff were recording the amount a person had eaten, for example a quarter or half a main meal. However, there was no estimate of the size of the meal to start with so it was impossible to establish how much had been eaten. The food chart also gave no information about whether any of the food or meals had been fortified in order to provide additional calories. One person whose BMI was 16.9 regularly refused their meals. They had been prescribed a nutritional supplement. Their care plan stated that they should be provided with homemade milk shakes and their food fortified in addition to the supplements. There was only occasional reference to the supplements on their charts and no mention of milk shakes or fortification of their food. On one day they were recorded as only having had one sandwich all day. There was no information on how many slices of bread they had eaten or what the sandwich contained. The manager told us that they would look into this particular situation and use the information for the staff training with regard to staff following and accurately recording in the care plan.

The food and fluid charts were combined on one form but the time for meals on one side was different from the times for the drinks on the other half of the form. Staff were recording the type of fluid on the food chart side but it was not always possible to establish which amount of fluid this linked with on the other side of the chart. We looked at the fluid charts for one person for five days. There was no total of people's fluid intake every 24 hours and no guide for care staff on the amount fluid a person needed every day to prevent dehydration. Nurses were not monitoring the food and fluid charts and providing guidance to care staff when necessary, in order to improve the care and support that people were receiving.

Some of the weight charts were extremely confusing so it was not possible to establish people's current weight. On some occasions staff had repeatedly written 'poorly' on the chart because a person had not been well enough to be weighed for a period of time. However, care staff had not discussed this with the nurses and their weight had not been estimated using the MUST tool. This meant that that at a time when people were unwell and possibly not eating, their weight was not being monitored. There was evidence that some people's weight was well maintained and in a number of cases increased. The manager had begun to address this issue with the GP's. We spoke with a GP and they were reviewing the needs of each person to identify issues of concern and support the staff to deliver the care required. They told us. "The new manager has invited me into the service to review people's needs, the staff are working with me and things are improving."

This is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Meeting nutritional needs.

One person told us. "Some staff are more experienced than others." Another person told us. "I like the staff they are kind and helpful."

Staff who had previously worked at the service through an agency told us that they did not receive an induction when they started at the service but did shadow another member of staff. The manager told us that they accepted the training carried out by the agency if that was where staff

Is the service effective?

had previously worked. However, they did not have systems to check the quality of the training or to assess the competency of new recruits. The manager and deputy had prioritised issues that needed addressing when they came to work at the service. They accepted that staff needed to have induction training from the service to be sure that staff were trained and previous training was a welcome bonus but could not be relied upon as sufficient. We saw that the service had commenced a new induction package for staff which included training and would lead into on-going training. The manager was also making arrangements for all staff to have training which had not been given during the induction to catch up.

One member of staff told us that they had recently had good dementia training that specifically related to the type of care that they were providing in the service. They said. "The training had been very helpful." There were a number of people with Parkinson's disease in the service but some staff had not received training on the condition. This might mean that they would not have an understanding of how much their physical abilities could vary from day to day and how much they could be affected by the timing of their medication. One of the nurses said that they would be keen to do more advanced dementia care training. They felt confident that they would be able to meet the revalidation requirements for registered nurses. We were aware that the management team had commenced addressing this issue from the new training plan.

Staff told us that they had supervision once a month. One member of staff said that they discussed people's individual needs with their supervisor and they were also asked if they needed any additional support. They told us. "I find the meetings very helpful." The manager told us that they were planning to train individual staff so they could be champions for aspects of health care or safety within the home. For example, for moving and handling and nutrition. This would mean that they could act as a resource for other staff and help to promote consistent standards within the service.

People's mental capacity to make day to day decisions had been assessed. However, the wording at times made it sound as if people were not always involved in decisions as much as their capacity would allow. For example, one person's assessment for personal care stated that they sometimes refused to have care. Therefore staff will assist [the person] with washing. There was no mention of discussing this with them and encouraging them or of possibly providing care at another time. There had not always been consultation with people's next of kin. We were aware that the new management had commenced care reviews with the relatives of people and this would be happening in the forthcoming months.

People who did not have the mental capacity to make decisions for themselves had their legal rights protected because the manager had received appropriate training. The manager informed us that training for the staff in Mental Capacity Act and Deprivation of Liberty Safeguards was being arranged for the coming year. In the meantime the manager and deputy had informed staff about Mental Capacity and Deprivation of Liberty Safeguards at team meetings. Two members of staff informed us that they were aware that they started from the point that people had capacity to make decisions. When they were unsure they had discussed this with the manager or deputy. We saw that the service had focussed upon collecting evidence and writing the appropriate documents regarding the Mental Capacity Act 2005. Information had been clearly recorded in the person's care records to ensure all staff were aware of the person's legal status. The service had worked with the local authority to make sure people's legal rights were protected.

Staff told us that they had good support from the local GP surgery. Records showed that people were seen by the GP when there were any health concerns. They also confirmed that people were supported to access the services of a range of healthcare professionals, such as dieticians, therapists and specialist nurses. For example, one person had been referred to the tissue viability nurse because they had a wound that was not healing. We saw that people had input from the local mental health team where concerns about their mental health had been identified. One person who was receiving 1:1 care, due to the unpredictability of their distressed behaviour, had been regularly reviewed by a senior community mental health nurse. People had chiropody every six weeks and regular checks of their eyesight. Community dental visits for people in the home were also arranged.

Good

Is the service caring?

Our findings

People who lived at the service were supported by kind and caring staff. One person said: “The carers are very nice to me, especially the deputy manager.” We saw that staff were respectful, caring and friendly. One person told us. “Some staff chat to me everyday.” Another person said, “The staff are quite good here.”

We observed staff knocked on bedroom doors before entering and ensured doors were shut when they assisted people with personal care. A relative told us. “My [relative] needs a great deal of support, the staff know them well and treat them with dignity and kindness.”

People told us that they had been asked what they enjoyed doing and the staff arranged activities with them. We saw staff inter-acting with people and talking to them about previous times and things they use to do. People receiving one to one care were supported by going for walks and staff reading to them.

There were choices of hot and cold drinks and the staff also visited people in their rooms to check upon their well-being. In the afternoon people watched a film in the TV lounge. The staff interacted with people and served drinks and biscuits. One person told us. “This is a regular event and we all enjoy it.” All the staff were pleasant and communicated well, for example talking to people at eye level and using gestures to explain to people that had reduced hearing in order that they understood.

We saw staff engaged people with activities which stimulated conversation and laughter. People were supporting in a kind and unhurried fashion especially during meals and when staff observed the person required some personal care. All staff we spoke with had a good knowledge of the people they cared for. They were able to tell us about the individuals and aspects of their life history.

A relative told us. “The cleaning staff work incredible hard and take a pride in their work.” We spoke to a member of the cleaning team, they told us they had enough equipment and improvements that had been made to the flooring. They told us. “This is how I care to make sure all is clean and nice for the people that live here.”

People’s privacy was respected. All rooms were single occupancy. This meant that people could spend time in private if they so wished. Rooms we were invited to see had been personalised with people’s belongings, including photographs, pictures and ornaments which all assisted people to feel this was their home. We noted that bedroom doors were always kept closed when people were being supported with personal care.

Another relative told us: “The manager and the carers are lovely, very kind.” They also informed us that staff treated their relative with care and attention to detail and they had attended a recent care plan review, which had been newly introduced and was happy that the staff kept them informed of events between visits.

Good

Is the service responsive?

Our findings

The management team had been revising and improving the care documentation. Work had been done on the assessment forms to identify people's needs and to determine from this information if the service could meet the person's needs. The care plans were of a generally good standard because the emphasis had been placed upon writing them in a person centred way. The deputy manager explained to us that the care plans also now focussed upon what people could do for themselves and how this was to be supported, as well as what they need assistance with.

Where people lacked mental capacity, people's families, other professionals, and people's historical information were used to assist with their care planning. The care plans were person centred demonstrating people's preferences, for example one care plan gave a person's preferences for sleeping with two pillows and said that they sometimes liked a snack of strawberries or bananas at night.

The care plans also gave details of their abilities and how staff should support them. However, a member of the care staff said that they never referred to the care plans. This would increase the likelihood of inconsistent care. The care plan for 'mental health and cognition' for a person receiving 1:1 care was mainly an assessment of their needs. It did not give details of any actions staff could take to reduce the likelihood of distressed behaviour or the ways that staff could defuse or lessen their unpredictable behaviour.

Other staff including the nursing staff told us that they did read and write in care plans and the work that had been to improve the plans was considerable and meant that staff were now using them far more than in the past. The manager told us that a care plan would be examined and discussed at handovers and some plans still needed work doing as now that needs had been accurately identified they were writing the plans regarding the identified needs. The management team were also involving the nursing staff to be further involved in care planning to use their specific skills and knowledge.

We saw care plans which were presented in a consistent and user-friendly format and contained a full assessment of people's needs. Care plans had been developed from the assessments of need that covered important areas of care such as personal care, mobility and dietary requirements. The care plans had been reviewed on a monthly basis.

The service had two activity coordinators and the main activities were held in the conservatory. One member of staff told us that people living upstairs did not join in activities much or go to the entertainments very often. We saw a carer on the first floor providing an activity during the afternoon of our inspection. The manager said that they had joined the National Providers Activity Association (NAPA). They were using NAPA as a useful resource for developing activities in the service and a possible future source of staff training.

The service had a complaints policy. One person told us. "I haven't needed to make any complaints. They do their best here, nice place." There was information on how to make a complaint on notice boards in the service. The register of complaints ended when the previous manager left eight months previously. The deputy manager told us that they had received no formal complaints. They said that they dealt with concerns as they arose. However, if concerns were not recorded together with any actions taken it would be less likely that they would be shared with staff and used to improve the quality of the services and the care.

The management team and care staff we spoke with were aware that some people were not able to complain or make their feelings known easily due to their illness. Staff were aware of the need to get to know people and observe changes in their non-verbal communication or behaviour and responding accordingly to try determine the difficulty

One relative informed us that the staff were highly responsive to requests and grumbles and through this attentive approach and care, matters did not escalate to a complaint. A relative explained to us that they had never needed to make a complaint and they found the staff helpful to any issue they raised at the time.

Good

Is the service well-led?

Our findings

Staff told us that they felt supported by the new management team and found them approachable. One member of staff told us, "The management is good. You can go to them with anything." Two members of staff told us that Longmead Court was a better service than ones they had worked in previously. This was because they were encouraged and supported to care for people by the managers.

Staff told us that communication between the different groups of staff had been poor but was improving. This was because previously there had only been one nurse on duty per shift. Now that there were two this had provided the time and opportunity for staff to communicate with each other and work together. This meant that staffing groups were not working in isolation from one another.

One of the nurses told us. In the past nurses did not organise and monitor care or carry out observations of care practices on a regular basis. This meant that they had very little knowledge of the care that they were accountable for. They were please this had changed and they were now able to demonstrate their skills and fulfil their role. Care staff told us that the senior care staff, "Don't usually provide direct care. They do more supervising and paperwork." This meant that none of the senior care were working regularly with the care staff to support them and monitor standards. We spoke with senior staff who were aware of this and that a priority had been given to clarify the needs of people and for this to be accurately recorded. Now that this was near completion, they had started to pay much more attention to their role of working with and leading the care staff. A team leader told us. "I enjoy providing care but know the documents must be done, it is a much better balance now. I became a team leader to do just that lead the team because of my knowledge and experience which I want to share with other staff."

A person told us. "I see the manager often, most days they come around, so you can talk and discuss anything that you wish." A relative told us. "The manager and staff could not have done more and been more helpful to them." Two members of the care staff said that the manager was approachable and often worked with them when needed to provide direct person care. They saw this as good positive leadership.

The service was working upon continuing to improve an open and empowering culture. The manager told us that upon appointment they had worked with the deputy to review the service and what needed to be done. They said they had asked the provider to visit more regularly which was done and they now reported to them weekly in order that improvements could be planned and implemented. One of the first things they did was to recognise that the service needed two nurses on duty and now this had been established this had improved communication. The nurses were able to move from a task orientated approach to working with staff upon person centred care. For example in the past with one nurse it took well over four hours for medicines to be administered to everyone. This was now done in an hour and a half and gives the nurses time to audit the medicines and to work with staff directly upon peoples care needs.

The service had encouraged links to be built with supporting professionals. We were informed by the manager that the service worked well with other professionals, sought advice and acted upon it to make sure people's needs were met. We saw from the care records that professionals from other services, including mental health staff and district nurses had responded to requests and worked with the staff advising upon best practice to support staff through sharing their knowledge to meet people's needs. Care records showed that appropriate professionals had been involved in the review of care plans as had relatives.

A GP had been invited into the service to undertake a review of each person's medicines. This had commenced and the GP told us about changes they had made to people's medicines having reviewed their medical history and current condition.

One person who did not have any relatives was being supported by an independent advocate. This had been arranged by the service. Advocates are people who are independent of the service and who support people to decide what they want and communicate their wishes.

The service undertook weekly checks of the environment including fire safety. We noted that the firefighting appliances were within date and the service emergency lighting fire doors were checked to be in working order appropriately.

Good

Is the service well-led?

There was a management structure in the service which provided clear lines of responsibility and accountability. The manager and deputy had put a supervision structure in place for all staff and they were providing an on-call telephone for support for staff when they were not on duty to the staff in charge of the service. The manager was provided a regular report regarding aspects and issues of the service for discussion with the provider to discuss and manage challenges and issues. The impact of this report was that the provider and manager could work together to resolve problems and to support the smooth running of the service.

We observed that staff had a good knowledge of the people who used the service and people were very comfortable in their presence. The manager explained that part of their role was to tour the building each time they were on duty and to have time to check people's well-being.

The manager and senior staff carried out quality assurance and monitoring systems which had been put into place to monitor care and plan on-going improvements. The maintenance team worked closely with management colleagues carrying out audits and checks to monitor safety of the service which included lifting equipment and that water temperatures were within acceptable ranges. We noted how the auditing information was recorded and shared between staff so that action plans to resolve problems as they were identified were clear.

Relatives and friends were invited to attend meetings, including reviews with the person's consent. We saw that care plans were discussed and plans changed according which were then signed. This meant the service communicated with people in an open and transparent way and people's views were recorded, considered and acted upon. There were also regular staff meetings. Staff members told us that there was an open door style of management and they could raise matters freely at any time. Meetings were a valued opportunity to do this so that information could be shared and discussed as a team.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2014 Meeting nutritional and hydration needs. The nutritional and hydration needs of service users must be met. Regulation 14