

Cornwall Old People'S Housing Society

Perran Bay Care Home

Inspection report

St Pirans Road
Perranporth
Cornwall
TR6 0BH

Tel: 01872572275






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Ratings

Overall rating for this service

Requires Improvement 

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

Summary of findings

Overall summary

This unannounced comprehensive inspection took place on 24 April 2017. The last inspection took place on 3 and 4 December 2014. The service was meeting the requirements of the legislation at this time.

Perran Bay is a care home which provides care and support for up to 42 predominantly older people. At the time of this inspection there were 34 people living at the service.

The service had transferred people's care plans from a paper based format on to an electronic system in July 2016. Staff had been provided with training on how to use the system. Some people did not have a current accurate accessible care plan or risk assessment in place to guide and direct staff on how to meet people's needs. Some specific guidance in people's care plans was not being followed by staff. However, we judged that staff had a good knowledge of people's needs and that these needs were being met. Staff monitored people's needs and reported any changes in a timely manner.

Some people had been assessed as being at risk from pressure damage to their skin and the service had provided pressure relieving mattresses for them. However, the correct settings for these mattresses were not being effectively monitored. The risk associated with accidents and incidents and the self administration of medicines were not robustly managed.

The processes for managing medicines were not robust. There had been a medicine error reported by the service in April 2017. Out of date medicines were found to be available for use. Handwritten entries on to the Medicine Administration Record were not always signed by two staff to help ensure the risk of errors was reduced. The service was not auditing their management of medicines.

People's rights were protected because staff acted in accordance with the Mental Capacity Act 2005. The principles of the Deprivation of Liberty Safeguards were understood and applied correctly. However, the service did not hold an accurate up to date DoLS policy. The service was not following its own policy as had not provided training in this legislation for all staff.

Meals were appetising and people were offered a choice in line with their dietary requirements and preferences. Staff monitored all food and drink taken by people who lived at the service.

The service was not regularly auditing areas such as care plans and medicines management therefore had not identified the areas of concern found at this inspection.

We walked around the service which was warm, comfortable and personalised to reflect people's individual tastes. People were treated with kindness, compassion and respect. People reported that the management team and staff, "Went the extra mile" when supporting people's individual needs and wishes. The management team were passionate about providing good care and helping people to live the life they chose. People were encouraged to be active both mentally and physically where possible.

Staff were supported by a system of induction training, supervision and appraisals. People were supported by staff who knew how to recognise abuse and how to respond to concerns. Staff received training relevant for their role and there were good opportunities for on-going training and support and development. Staff meetings were held for all staff groups and allowed staff to air any concerns or suggestions they had regarding the running of the service.

The service had identified the minimum numbers of staff required to meet people's needs and these were being met.

The premises were well maintained. The service had reduced the number of people living there in order to reduce the amount of disruption which may occur when the planned extension of the service begins soon. There was also a planned re-design of the décor of each floor/corridor to aid people's orientation around the building. The service did not currently have any additional pictorial signage to aid people's recognition of specific areas of the building such as toilets and bathrooms. People's bedroom doors had their names and a number upon them. There were people who moved around the service independently as they chose, some of these people had a degree of cognitive impairment and may benefit from additional signage to aid their independence.

People had access to meaningful activities. An activity co ordinator was in post who arranged regular events for people. These included a range of activities such as quizzes, bingo, games and musical entertainment. Trips out in to the local area were arranged regularly. Volunteers from the local community and school children regularly visited the service to support activities such as art and craft. People and their relatives were positive about the care and support they received at Perran Bay. Comments included, "I love it here," "If I could live anywhere I would chose to live here" and "I am delighted with the care (the person) gets here, it feels like a warm blanket wrapping you up when you come in."

The registered manager was supported by an assistant manager, senior team leaders and a team of care staff. All the staff were positive about the support they received from the management team. The provider regularly spent time in the service talking with people who lived there and supporting the manager. Relatives were positive about the staff and management at the service.

We found there were breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014. You can see the action we have told the provider to take in order to meet the requirements of the regulations at the end of this report.

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 entirely safe. The management of risk was not always robust.

The management of medicines was not always robust.

People told us they felt safe using the service.

Staff knew how to recognise and report the signs of abuse. They knew the correct procedures to follow if they thought someone was being abused.

There were sufficient numbers of suitably qualified staff to meet the needs of people who used the service.

Is the service effective?

Good ●

The service was effective. Staff were well trained and supported with regular supervision and appraisals.

People had access to a varied and nutritious diet.

The management had a clear understanding of the Mental Capacity Act 2005 and how to make sure people who did not have the mental capacity to make decisions for themselves had their legal rights protected.

Is the service caring?

Good ●

The service was caring. People who used the service, relatives and healthcare professionals were positive about the service and the way staff treated the people they supported.

Staff were kind and compassionate and treated people with dignity and respect. Staff respected people's wishes and provided care and support in line with those wishes.

Is the service responsive?

Requires Improvement ●

The service was not entirely responsive. Care plans were not available for some people living at the service. Staff were not always provided with guidance and direction on how to provide

for people's assessed needs. Specific care required by some people was not always recorded.

Staff provided personalised care and support which was responsive to their changing needs.

People were able to make choices and have control over the care and support they received.

People knew how to make a complaint and were confident if they raised any concerns these would be listened to. People were consulted and involved in the running of the service, their views were sought and acted upon.

Is the service well-led?

The service was not entirely well-led. The management team were not able to easily access electronically held information relating to people's care needs.

Quality assurance systems were not robust. The service was not regularly auditing areas such as care plans and medicines management therefore had not identified the areas of concern found at this inspection.

There were clear lines of responsibility and accountability at the service.

Requires Improvement 

Perran Bay Care Home

Detailed findings

Background to this inspection

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

This unannounced inspection took place on 24 April 2017. The inspection was carried out by one adult social care inspector.

Before the inspection we reviewed information we held about the service. This included past reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with three people living at the service. We looked around the premises and observed care practices. We spoke with seven staff and four visitors.

We used the Short Observational Framework Inspection (SOFI) over the lunch time period. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We looked at care documentation for eight people living at Perran Bay, the medicines records for 34 people, three staff files, training records and other records relating to the management of the service.

Following the inspection we spoke with one healthcare professional.

Is the service safe?

Our findings

People's care plans together with their assessed risks had been transferred from a paper format to an electronic records system in July 2016. Staff had received training on how to use this system.

The registered manager and assistant manager were not able to effectively access current information that related to some people's care and support needs. Some people did not have current and accessible risk assessments in place to guide and direct staff on how to help ensure the risks were reduced. For example, one person who was being cared for in bed did not have any risk assessments in place for their pressure area care or their moving and handling risks. The registered manager confirmed this had not been done. There were no paper records for this person that staff could refer to if required. This meant that staff were not provided with adequate direction or guidance on how to help reduce the assessed risks. However, we judged that this person was receiving the care they needed and staff knew about individual people's needs.

The processes for managing specific risks to people such as falls were not robust. Accidents that took place in the service were recorded. These records of individuals accidents were all held together in the same file. This is contrary to the guidance provided by the Data Protection Act 1998 regarding the storing of people's confidential information which should be held in their individual care files and not held together with other people's information. Some people had experienced repeated incidents but there was no recorded guidance provided for staff on how to reduce the risks of re-occurrence. One person had fallen from their chair/wheelchair six times between January and April 2017. There was no risk assessment in place for this person regarding their falls. However, staff confirmed they had been given verbal guidance on how to help reduce the risk of further falls. This demonstrated the service did not have robust systems in place to comprehensively ensure the safety of people using the service.

Some people had been assessed as being at risk of pressure damage to their skin and the service had provided pressure relieving mattresses for them. However, the setting for one of these mattresses had not been regularly reviewed by staff and was not set correctly to the weight of the person using it. This meant the mattress was not offering the optimum protection for that person's skin.

The processes for managing medicines were not robust. There had been a medicine error reported by the service in April 2017 where staff had not followed safe processes before giving a person a repeated dose of a medicine that had already been administered. Four people were self administering their own medicines. However, only one of these people had a risk assessment in place for this. A senior staff member told us that this concern had been highlighted in February 2017 by an external pharmacist but that these assessments had not been done yet. This meant that three people were self administering their own medicines when they had not been assessed as safe to do this. Out of date medicines were found to be available for use. One prescribed cream, found in the medicines refrigerator, and a liquid that required stricter controls, were out of date. Not all prescribed creams were dated upon opening. This meant that staff would not be aware when the item was no longer safe to use.

Ten handwritten entries had been made on to the Medicine Administration Record (MAR) following

information provided by healthcare professionals. These were not always signed by two staff in accordance with best practice guidance to help ensure the risk of errors was reduced. The service was not auditing their management of medicines and the service had not identified the concerns that were found at this inspection.

The above is a breach of Regulation 12 (2) (a) (b) (g) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Visiting healthcare professionals commented that the needs of people who lived at Perran Bay were becoming more complex with a greater requirement for nursing support than in the past. This was in line with the needs of people across all residential care services as people lived to a greater age than previously. There was some concern however, that more dependent people living at the service were not always identified in a timely manner as requiring closer monitoring and recording of their care. For example, moving people who required closer monitoring to a bedroom where they could be visited by staff regularly and easily.

The service was holding medicines that required stricter controls. We checked the records of these medicines against the stock held and they tallied. However, the service was not regularly auditing the stock of such medicines against the records. This meant that any errors such as out of date medicines were not identified in a timely manner. There were no gaps in the MAR and staff signed to show prescribed medicines had been given. The cold storage of medicines was recorded and monitored daily to ensure they were held safely. Staff training records showed all staff who supported people with medicines had received appropriate training.

The service held the personal money for people who lived at the service. People were able to easily access money to use for hairdressing, toiletries and items they may wish to purchase. The money was managed by the management team. It was not possible to check the cash held for people against the records kept at the service as it was held in the bank. However, individual records for each person were held and people were able to access any money from the petty cash float held by the service. The accounts were audited regularly internally and annually by an external account service.

People and their families told us they felt it was safe at Perran Bay. Comments included, "The staff are lovely, no rush," "I can get my money at any time if I want it" and "It is perfectly safe here I have no concerns at all."

Staff were confident of the action to take within the service, if they had any concerns or suspected abuse was taking place. They were aware of the whistleblowing and safeguarding policies and procedures. Staff had received recent training updates on Safeguarding Adults and were aware that the local authority were the lead organisation for investigating safeguarding concerns in the County. There were "Say no to abuse" leaflets displayed in the service containing the phone number for the safeguarding unit at Cornwall Council.

People were provided with telephones in all bedrooms to enable them to call anyone they wished to at any time. This meant that people could raise any concerns they may have directly to their families or external agencies.

The service did not have any locked front or rear doors, this helped ensure people living at the service and their visitors could come and go as they wished. The service was in the centre of the town and right next to the beach and municipal green space used by the public. The service had installed CCTV equipment in the corridors of the service which was not routinely monitored but used if there was an unobserved incident or

event. There were signs that informed people entering the building that CCTV was in place in public areas.

We looked around the building and found the environment was clean and there were no unpleasant odours. Personal protective equipment (PPE) such as aprons and gloves were available for staff and used appropriately to reduce cross infection risks.

Perran Bay was well maintained and all necessary safety checks and tests had been completed by appropriately skilled contractors. Fire safety drills had been regularly completed and all firefighting equipment had been regularly serviced.

Recruitment systems were robust and new employees underwent the relevant pre-employment checks before starting work. This included Disclosure and Barring System (DBS) checks and the provision of two references.

The staff team had an appropriate mix of skills and experience to meet people's needs. During the inspection we observed people's needs were usually met quickly. We heard bells ringing during the inspection and these were responded to effectively. There were six care staff on duty at the time of this inspection supported by a team leader and a manager on each shift. There were three staff who worked at night. Shifts were from 7 am to 3 pm, 3 pm to 10 pm with night staff working 9.45 pm to 7.45 am. This provided time for shifts to handover to each other. Staff told us they felt they were a good team and worked well together.

Is the service effective?

Our findings

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People's care records did not clearly record if there had been any capacity assessments carried out to check if people could make specific decisions for themselves.

We checked whether the service was working within the principles of the MCA , and whether any conditions on authorisations to deprive a person of their liberty were being met. The service had not needed to make any applications for authorisations to the local authority for anyone living at the service.

The registered manager was aware of changes to the legislation but this had not been reflected in the recent review of the DoLS policy which had not taken account of the criteria now used for when a person should be considered for an authorisation for a potentially restrictive care plan. This meant that staff were not provided with current and accurate guidance on this legislation.

The service held an MCA policy which stated, "All new staff receive training in the principles of consent and Mental Capacity Act during induction." The training records stated seven staff had attended MCA training. This meant the service were not following its own policy as not all staff had received specific training on the MCA and associated DoLS and were not clear on this legislation. At the time of this inspection this training was not planned. However, staff were able to tell us both how they cared for people ensuring their rights were protected and always requested consent before providing care.

We recommend that the service follow its own policy and provide training on the MCA and associated DoLS legislation to all staff.

Some people were observed leaving the service to visit the local shops. People chose how they spent their time. Visitors were welcome at any time and we saw visitors chatting with people and staff throughout the inspection.

Perran Bay was well maintained. There were plans to extend the service. For this reason some of the bedrooms had been left vacant to minimise the disruption which may occur when the planned extension of the service began. There was also a planned re-design of the décor of each floor/corridor to aid people's orientation around the building. The service did not currently have any additional pictorial signage to aid people's recognition of specific areas of the building such as toilets and bathrooms. People's bedroom doors had their names and a number upon them. There were people who moved around the service

independently as they chose, some of these people had a degree of cognitive impairment and may benefit from additional signage to aid their independence. There was outside space that could be easily accessed by people living at Perran Bay. A new ramp had been installed to assist people who used wheelchairs to access the public green area before the sands. A decked seating area had also been added with wind breaking screens so that people could sit outside and enjoy the sun. Raised flower beds were well maintained.

Despite the lack of recorded care plans and assessments staff demonstrated a good knowledge of people's needs and told us how they cared for each individual. Staff told us the training they received was good. Training records held on the computer were not accurate. Training that had taken place was not recorded onto the training matrix. This meant that the registered manager did not have an effective overview of when specific training updates may be required for specific staff. However, we were able to judge that staff had attended the mandatory training subjects such as health and safety, moving and handling and infection control. The registered manager assured us that the training records would be brought up to date and record recent training that had been undertaken by staff.

People living at the service were not always able to communicate their views and experiences to us due to their healthcare needs. So we observed care practices to help us understand the experiences of people who used the service.

Staff received regular supervision and appraisals. They told us they felt well supported by the registered manager and were able to ask for additional support if they needed it.

Newly employed staff were required to complete an induction before starting work. This included training identified as necessary for the service and familiarisation with the service and the organisation's policies and procedures. New staff without previous care experience completed the care certificate. The care certificate is a training scheme for staff in social care which is recommended for all staff new to care. There was also a period of working alongside more experienced staff until such a time as the worker felt confident to work alone. Staff told us they had completed or were working towards completing the care certificate and had shadowed other workers before they started to work on their own.

We observed the lunch time period in the dining rooms. People were asked where they would like to sit. People were provided with wine with their meal if they wished. The food looked appetising. Staff were available to support people with their meals if needed. People told us they enjoyed the food provided at the service. One visitor commented, "(the person) needs a special diet and they manage this no problem, they love the food."

The cook was knowledgeable about people's individual needs and likes and dislikes. Where possible they tried to cater for individuals' specific preferences. People told us that if they did not care for what was provided at a meal they could ask for an alternative and it would be provided.

People had their weight monitored and this was recorded. Food and fluid charts were kept by staff for all the people living at the service. However, there was no evidence that these monitoring charts were monitored or totalled so that a judgement could be made about whether someone had had sufficient intake. The registered manager and assistant manager agreed that these records should be monitored and assured us this would be done.

People had access to healthcare professionals including GP's, district nurses, opticians and chiropodists. The visits of healthcare professionals was recorded by care staff and shared at shift handovers.

Is the service caring?

Our findings

Perran Bay took pride in providing a caring environment for people living at the service. The management team, members of the board and staff were committed to supporting people to live the life they chose. Relatives told us of the registered manager and the staff going, "The extra mile" to provide for individuals needs and wishes. For example, some people were enabled to spend time being photographed to advertise the services provided at Perran Bay, enjoying being made up, photographed and treated to lunch in a hotel. Other people enjoyed supporting the varied activities and entertainment which were arranged regularly at the service. Outside space had been designed to encourage people to spend time enjoying the beach setting but being protected from the wind by clear screening. The management team and staff were clearly passionate about providing the best care they could to people living there.

We spent time in the communal areas of the service during our inspection to observe how care was delivered and received. Throughout the inspection people were comfortable in their surroundings with no signs of agitation or stress. Staff were kind, respectful and spoke with people considerately. We saw relationships between people were relaxed and friendly and there were easy conversations and laughter heard throughout the service. People and their families were positive about the care provided and told us, "(the person) is just so much more with it, brighter and more cheerful since moving here" and "It is very good here, far superior to other homes I have been to."

People's dignity and privacy was respected. Staff ensured doors and curtains were closed when personal care was being provided. People's bedrooms were decorated and furnished to reflect individual personal tastes. People and their families were told that as long as they lived there they could decorate their bedrooms how they wished.

When offering support staff made efforts to ensure they were at the person's eye level. People in the home were smartly dressed and well cared for. People told us the staff respected their wishes. Comments included, "The staff are wonderful" and "I can do whatever I want." People had made friends at the service and enjoyed sitting with them chatting and reminiscing.

Visitors told us they called regularly at different times and were always greeted by staff who were available to speak with them about their family member knowledgeably. People were well cared for. Staff took time to explain to people what was about to take place and ensured they knew what was happening at all times. Staff were not rushed and showed great patience and understanding when supporting people. During the inspection staff were seen providing care and support in a calm, caring and relaxed manner. Interactions between staff and people at the service were caring. Staff were clear about the backgrounds of the people who lived at the service and knew their individual preferences regarding how they wished their care to be provided.

People and their families felt involved in decisions about the running of the service as well as the care of their relative. Families told us the registered manager would invite them to attend any care plan review meeting if they wished. The service had held residents meetings to seek the views and experiences of people

living at the service. Suggestions were listened to and changes took place in response to such comments. The service also sought the views and experiences of relatives and healthcare professionals who visited the service. Surveys that had been carried out over the past year had positive responses.

Is the service responsive?

Our findings

The service had installed an electronic records system since the last inspection. They had begun a process of transferring people's care plans from a paper based format on to the electronic system in July 2016. All staff and management had been provided with training in how to use the system. At the time of this inspection the registered manager and assistant manager were not able to effectively access current information that related to some people's care and support needs. An administrator was called in to the service on the day of inspection to help identify the whereabouts of any paper based care files. The paper based care plans had been taken to the basement for archiving before they had all been completely transferred to the electronic system. The archived paper records were not held in alphabetical order, so could not easily be found if needed.

Some people living at the service did not have a current accurate accessible care plan or risk assessments in place on the electronic system, to guide and direct staff on how to meet people's needs. Also there were no paper based care records available for some people as these had been archived and were not accessible. This meant there were no records to advise staff on some people's current care and support needs. The registered manager and the assistant manager agreed that important information relating the the care of people at the service was not available.

One person who was cared for in bed at all times was in an upstairs bedroom. This person was unable to communicate easily and unable to use a call bell. The electronic records system did not hold a care plan for this person and there were no paper based care plan records available. This meant that staff were not provided with written guidance or direction on how to meet this vulnerable person's needs. However, staff were able to tell us how they cared for this person and met their needs. The district nurses visited this person regularly and confirmed this person was cared for on a pressure relieving mattress and was well cared for by staff. Staff and the management were not clear what the setting for this person's pressure relieving mattress should be so that it could be recorded in their care plan, then regularly checked to ensure it was correct. The district nurses confirmed to us after the inspection that they would support the service with this information.

Where care plans were in place some specific guidance was not being followed by staff. For example, one person's care plan stated they should have, "Skin bundle to be done weekly." Skin bundles are charts that are completed by care staff when they examine a person's whole body for any signs of redness or skin damage. There were no skin bundle records in this person's room and staff confirmed they were not recording a monitoring check weekly. Records on the electronic system did not evidence that this person was having their skin monitored weekly. However, we judged that this was a records issue as staff had a good knowledge of this persons needs and that these were being met. Staff confirmed these people did not have any skin damage at the time of this inspection.

Care plan reviews that were overdue were highlighted on the front page of the person's electronic care records. However, where people did not have a care plan there was no 'flag' to highlight this issue. Where care plans had been recently reviewed on the system it had not been identified that risk assessments were

not present, as reported previously in the Safe domain of this report.

This is a breach of Regulation 17 (1) (2) (b)(c) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Daily notes were consistently completed by care staff on hand held electronic devices. This enabled staff coming on duty to get a quick overview of any changes in people's needs and their general well-being. There was a staff handover meeting at each shift change. We observed an afternoon handover meeting which was built into the staff rota to ensure there was sufficient time to exchange any information. During this meeting staff shared information about changes to some people's individual needs, any information provided by professionals and details of any outstanding task that were required that day. A handover record was completed on the hand held devices to enable staff to refer to this information later in the shift if necessary. We noted that the most dependent person living at the service who was cared for in bed all the time was not referred to. The senior carer told us that this was because there had been no changes in their care needs.

Staff confirmed that they did not refer to people's care plans and were unaware that some were not available to them. They knew the people living at the service well and were able to refer to the daily notes which formed an overview of the person's needs on their hand held devices.

People were supported to maintain relationships with family and friends. Staff were seen greeting visitors throughout the inspection and chatting knowledgeably to them about their family member. Perran Bay had a social media page where staff posted photographs and video of people doing activities and going on outings. Visitors told us that having this record of such events held on social media was useful when reminiscing with their family member to remind them of things they had enjoyed in the past but may have forgotten.

The registered manager told us this social media page was only visible to people who applied to join the group and such applications were only granted as appropriate by the service. For example, family and friends of people living at the service. However, the page was visible to the public. It was not clear what assessments had been carried out to ensure that people were competent to agree to this and fully understood how social media sites worked and that their images were available publicly. The registered manager was unaware of the public access to this site until informed by the inspector and acted immediately to change this to a closed site.

People had access to a range of activities both within the service and outside. An activities co-ordinator was employed and organised a programme of events including regular trips out and visits from entertainers. On the day of the inspection some people went out to the memory café in the town. One person who loved horses had a visit planned to enjoy a pony and trap experience. Other animals were brought in to the service such as ponies and lambs. Volunteers helped with quizzes and bingo regularly at the service.

The registered manager had arranged for some of the people living at the service to represent the service and take part in filming and meeting up with other organisations to share working practices. People involved in this work enjoyed this greatly.

The local art group visited the service along with children from the local school who brought in artwork that they had done with materials that the service had provided for them. The walls of the service were displaying the artwork done by the children.

People had access to quiet areas, a well maintained garden area with raised beds and a sun deck protected

from the wind by screens.

Some people chose not to take part in organised activities and therefore were at risk of becoming isolated. During the inspection we observed some people either chose to remain in their rooms or were confined to bed because of their health needs. The activity co-ordinator told us they visited people in their own rooms for a chat.

People and their relatives were positive about the care and support they received at Perran Bay. Comments included, "I love it here," "If I could live anywhere I would chose to live here" and "I am delighted with the care (the person) gets here, it feels like a warm blanket wrapping you up when you come in."

People and families were provided with information on how to raise any concerns they may have. Details of the complaints procedure were available. People told us they had not had any reason to complain. The service confirmed they had not received any complaints recently.

Is the service well-led?

Our findings

The service is required to have a 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. The service had a registered manager in post.

The registered manager and the assistant manager were unaware of the concerns identified at this inspection regarding people's missing care plans and risk assessments, the inaccurate training matrix, that pressure relieving mattresses were not being monitored, there was public access to the social media site and that medicines were not always being safely managed. There were no regular audits being carried out of care plans or medicines management to help identify any issues in a timely manner. These concerns are detailed in the previous domains of this report. This meant that the management team did not have an effective overview of the service provided.

This contributed to the breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The service was provided by a charitable organisation set up by members of the local community to provide a home for elderly people. Strategic leadership was provided by a volunteer board of directors whose specific responsibilities were clearly defined. The director and president were present in the service on the day of this inspection along with volunteers who were chatting with people.

Each month a quality assurance visit was carried out by directors and volunteers to monitor the quality of the care provided by the service and to identify any areas where improvement could be made. The concerns identified at this inspection had not been found by such visits.

Relatives and staff told us the registered manager was approachable and friendly. Everyone we spoke with was positive about the management and staff at the service. Comments included, "It doesn't feel like a care home," "I can always chat with the manager or senior staff if I want to about the care of (the person)" and "There are always people about and someone you can call upon."

There were clear lines of accountability and responsibility both within the service and at provider level. The registered manager was supported by an assistant manager, senior team leaders, care staff and ancillary staff. Some staff had worked at the service for many years and were very happy with the good support they had been provided with by the registered manager over the years. The registered manager told us of the pastoral support the service provided for all staff, people and their families in times of need.

Staff told us they felt well supported through supervision and regular staff meetings. Staff commented, "You can go to them at any time" and "I feel they listen to us."

The registered manager worked in the service every day providing care and supporting staff this meant they were aware of the culture of the service at all times. Daily staff handover provided each shift with a clear picture of each person at the service and encouraged two way communication between care staff and the registered manager.

There were systems in place to monitor the quality of the service provided. Surveys had been carried out regularly of people living at the service, families and healthcare professionals with positive responses received.

People's care records were kept securely and confidentially, and in accordance with the legislative requirements. Services are required to notify CQC of various events and incidents to allow us to monitor the service. The service was notifying CQC of any incidents as required, for example expected and unexpected deaths.

There was a maintenance person in post with responsibility for the repair and auditing of the premises. Equipment such as moving and handling aids and wheelchairs were regularly serviced to ensure they were safe to use.

The environment was clean and well maintained. People's rooms and bathrooms were kept clean. The provider carried out regular repairs and maintenance work to the premises. The boiler, electrics and water supply had been tested to ensure they were safe to use.

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	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>Care and treatment must be provided in a safe way for service users. The registered person must assess the risks to the health and safety of service users of receiving the care or treatment and do all that is reasonably practicable to mitigate any such risks. Not all service users had appropriate risk assessments in place. Medicines were not always managed safely. An administration of medicines error had occurred at the service as staff did not follow safe practice processes. Out of date medicines were being used. Entries on to the MAR were not always signed by two staff to ensure any errors would be identified. People who were self medicating had not been assessed to ensure they were competent and safe to do this. Health and Social Care Act 2008 (regulated Activities) 2014 Regulation 12 (1) (2) (a)(b)(g).</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>Systems or processes must be established and operated effectively. The registered manager and assistant manager were unable to effectively access current information related to some people's care and support needs. Some people did not have care plans available for staff to refer to. Specific risks to some people had not always been assessed, monitored or action recorded to mitigate the risk. Health and Social Care Act 2008 (Regulated Activities) 2014 Regulation 17</p>

(1)(2)(b)(c)