Mrs J Elvin

St Lawrences Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 17 August 2016 and was unannounced. A previous inspection, undertaken in June 2014, found there were no breaches of legal requirements.

St Lawrence's Lodge is registered to provide care and accommodation for up to 20 people. However, we noted that due to the upgrading of accommodation there were now a maximum of 16 single rooms for use at the home. The home provides care for older people some of whom are living with dementia or short term memory loss. The home is situated in a residential area, close to the centre of Denton, Manchester.

The home had a registered manager in place and our records showed she had been formally registered with the Care Quality Commission (CQC) since April 2014. A registered manager is a person who has registered with the CQC 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 said they felt safe living at the home and said the staff treated them well. Staff had received training regarding safeguarding and the protection of vulnerable adults. They said they would report any concerns to the registered manager. We found a number of issues with infection control and safety at the premises. The laundry area was small and cramped and inappropriate facilities were available to deal with the cleaning of commodes.

Discarded equipment had been left in a yard at the rear of the home, which could be accessed by people living there. People did not have personal evacuation plans in place in the event of a fire or other emergency.

Suitable recruitment procedures and checks were undertaken, to ensure staff had the skills and experience to support people. People said they received appropriate care and thought there were sufficient staff to meet their needs.

Medicines were not always dealt with safely and appropriately. Some dates were over written making it unclear when medicines had been given and "as required" medicines did not have detailed care plans for their administration. Checks on the temperature of the clinical room, where medicines were stored, were not made daily.

People were happy with the standard of food and drink provided at the home and could request alternative dishes, if they wished. People who required alternative diets were supported.

People told us staff had the right skills to look after them. Staff confirmed they had access to a range of training and updating. Regular supervision took place, although formal annual appraisals did not occur.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS are part of the Mental Capacity Act 2005 (MCA). These safeguards aim to make sure people are looked after in a way that does not inappropriately restrict their freedom. The manager told us no one at the home was subject to DoLS. However, we observed some people who may fit the criteria for a DoLS application. Best interest decisions processes were not consistently applied.

People's health and wellbeing was monitored, with regular access to general practitioners and other specialist health or social care staff.

People told us they were happy with the care provided. We observed staff treated people appropriately, supportively and with a good understanding of them as individuals. People said they were treated with respect and their dignity maintained during the provision of personal care. Security cameras were in use at the home, but people had not been asked explicitly if they were happy for them to be in place.

Care plans reflected people's individual needs, although details in care plans were not always specific enough to ensure staff could provide care safely and consistently. Reviews of care occurred regularly but were often lacking in detail. All staff supported people in engaging in activities. There had been no recent formal complaints and relatives said they could approach the manager if they had concerns.

The registered manager did not carry out substantial formal checks on people's care and the environment of the home. This meant shortfalls highlighted as part of the inspection process had not been identified. Staff felt positive about the manager and the homely nature of the service. They told us the manager was approachable and supportive. The manager said there were no regular 'residents' or relatives'' meetings, although events did take place approximately twice a year. Relatives they said they could speak to the manager at any time. Daily records were well maintained, contained good detail and were stored appropriately.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to Safe care and treatment, Need for consent, Person-centred care and Good governance. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

Laundry facilities were cramped and not well maintained. Systems for cleaning commodes were not appropriate to limit cross infection. Discarded equipment was accessible to people living at the home presenting a risk and some items were stored on a fire escape. People did not have personal evacuation plans.

Medicines were not handled safely and effectively. Records relating to the administration were unclear and temperatures to ensure storage was effective were not regularly monitored.

Suitable recruitment processes were in place to ensure appropriately skilled and experienced staff worked at the home. People said there were sufficient staff to meet their care needs.

Is the service effective?

Requires Improvement

The service was not always effective.

The registered manager was aware of the Mental Capacity Act 2005 (MCA) and said there had been no applications under the Deprivation of Liberty Safeguards. We noted some people may meet the criteria for consideration of DoLS. Best interests processes were not consistently applied to ensure people's rights were protected.

People told us food and drink at the home was plentiful and they enjoyed the meals. People requiring a more specialist diet were supported.

People said staff had the right skills to support them. A range of training had been provided and staff received regular supervision although formal annual appraisals did not always take place. People had access to a range of health and social care professionals for assessments and checks.

Is the service caring?

Good

The service was caring.

People told us they were happy with the care they received and felt well supported by staff. We observed staff supported people fittingly and recognised their individual needs.

People and relatives told us they were involved in their care through reviews. There were no regular meetings with relatives or people because the manager said these were not what people wanted. People said they could raise issues anytime.

Care was provided whilst maintaining people's dignity and respecting their right to privacy. Security cameras were used at the home, although people had not been specifically asked if they were happy with this.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People told us the home was responsive to their needs and care plans reflected people as individuals. Details in care plans, about how staff should support people, were not always clear or specific. Plans were reviewed and updated, although the review details were sometimes limited

All staff supported people with activities and events. Some people went out into the community and entertainers visited the home. People told us they were able to make choices about their care.

People and relatives were aware of how to raise complaints or concerns but said they had not made any recent formal complaints. They said the manager dealt immediately with any concerns.

Is the service well-led?

Requires Improvement

The service was not always well led.

The registered manager told us she did not undertake formal checks but did walk around the home. These informal checks had not identified shortfalls highlighted by the inspection.

Staff and people talked positively about the support they received from the manager and described her as approachable and supportive. People and staff commented on the homely nature of the service.

Records contained good detail and were stored securely and confidentially.

St Lawrences Lodge

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 17 August 2016 and was unannounced. This meant the provider was not aware we were intending to inspect the home.

The inspection team consisted of one inspector.

Before the inspection, the registered provider completed a provider information return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the information we held about the home, in particular notifications about incidents, accidents, safeguarding matters and any deaths.

We spoke with two people who used the service to obtain their views on the care and support they received. Additionally, we spoke with three relatives who were visiting the home on the day of the inspection. We also spoke with the registered manager, two care workers and the cook on duty on the day of the inspection.

We observed care and support being delivered in communal areas and viewed people's individual accommodation. We reviewed a range of documents and records including; three care records for people who used the service, nine medicine administration records (MARs), three records of staff employed at the home, accidents and incident records and a range of other safety audits and management records.

Requires Improvement

Is the service safe?

Our findings

When we first entered the home and walked around it we were aware that certain areas were not clean and some rooms had unpleasant odours. The manager stated the regular domestic staff member was on leave and a care worker was working an additional shift to carry out cleaning. We noted later in the day the rooms smelt fresher and the cleanliness of the home had improved.

The manager told us the home had been reconfigured recently and most rooms on the upper floors were now en-suite. She said four rooms on the ground floor were not en-suite and people used commodes to support their personal care needs during the night. We could find no dedicated sluice area for the home and so asked the manager how commode pots were dealt with in the morning and how were they effectively cleaned. The manager told us pots were emptied into the toilet close to the rooms and then taken to the domestic/sink area located in a small cupboard area, just off the home's main entrance. This involved carrying commode pots that had not been cleaned across the main lounge area of the home. The domestic area was unsuited to effective cleaning as it was cramped and used to store a range of equipment and mops. We asked the manager what the commode pots were cleaned with. She said they were cleaned with normal toilet cleaner, rather than a recommended solution for cleaning commodes. This meant there was a risk of cross infection because unwashed equipment was being taken through public areas to be cleaned and appropriate guidance for the effective cleaning of commodes was not being followed.

We looked in the laundry area of the home. The laundry was cramped and untidy and not suitable for a flow through system that ensured that soiled clothing did not mix with clean clothing. Clean clothes were stored in the laundry area, protected only by a shower curtain. We also noted the flooring of the laundry area was vinyl which did not fit properly and was torn and cut, meaning it could not be cleaned effectively. This meant there was a risk of cross infection because appropriate systems were not in place to ensure soiled clothing and linen were appropriately separated from clean clothing and linen. Furthermore, the laundry area was not clean causing a further infection risk. We spoke with the manager about these issues and asked if the home had spoken with the local infection control team about safe practices. She said the home had not engaged with the local infection control team and that issues about the laundry had not been raised before, but she would learn from the inspection and look to address them.

During our inspection we noted there was a gate, which could be accessed from the garden area that led to a yard at the back of the home. This wooden gate had swollen and warped and could not be locked. The yard was crammed with discarded furniture and old equipment, such as wheelchairs. There was also a broken shed which contained rolls of fibreglass. These items presented a serious and immediate risk to people living at the home. We spoke to the manager about the yard area and she said she would arrange for the area to be made secure and cleared as soon as possible.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 12. Safe care and treatment.

The manager showed us the medicines management system for the home. Medicines were kept in a locked

trolley in a locked room close to the home's main office. The majority of medicines administration records (MARs) were printed by the local pharmacy. Where MARs were hand written these were very clear and had been double signed to ensure the information transcribed onto the MAR was correct. For some medicines, which had been commenced half way through a cycle, additional dates had been written over the printed dates, meaning it was not always possible to be sure when medicines had been given. Some people were prescribed "as required" medicines. "As required" medicines are those given only when needed, such as for pain relief. We noted that whilst there were some instructions on how these medicines should be administered, the information was limited and records did not always detail how much medicine had been given when the dose was variable. Some medicines were stored in a fridge and the temperature of the fridge was monitored daily. However, the temperature of the room where medicines were store was only monitored weekly, so we could not be sure medicines were always kept in an environment that kept them safe and in good condition.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 12. Safe care and treatment.

Risk assessments were in place for the environment and checks were undertaken on fire equipment, electrical systems, gas safety systems and water systems. There were regular checks on fire alarm points, automatic door closure systems and emergency lighting. Small electrical items had been subject to portable appliance testing (PAT) and lifting equipment had been checked to ensure it complied with Lifting Operations and Lifting Equipment Regulations 1998 (LOLER). Whilst there were risk assessments in people's care records, we found people did not have personal emergency evacuation plans (PEEPs) in place. These plans provide vital information to the fire service in the event of an emergency and detail any health or mobility issues that could affect a person's evacuation from the home. We spoke with the manager about this. She said she would look to implement these as soon as possible.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 12. Safe care and treatment.

People we spoke with told us they felt safe living at the home and were well treated by the staff who worked there. Relatives also felt people were safe. One relative told us, "I know she is safe and looked after. I have never left here thinking she is not safe." The provider had a safeguarding policy in place. The manager told us there had been one recent safeguarding and described how the issue had been dealt with. We noted an appropriate process had been followed and action taken where necessary. Care staff told us they had received training in relation to safeguarding vulnerable adults and were aware of the types of incidents they should be observant for with regard to potential abuse. They told us they would immediately raise any concerns with the manager. This meant the provider managed safeguarding issues appropriately and staff were aware of the responsibilities in protecting vulnerable adults.

Accidents and incidents were recorded effectively and monitored by the manager. Falls were monitored in terms of how many had occurred each month, but also under each individual person, so the manager could identify if a people were having an increased number of falls. This meant systems were in place to monitor accidents and falls and determine if further action was needed to prevent future events.

We looked at personnel files for staff currently employed at the home. We saw an appropriate recruitment process had been followed, with two references requested, identity checks and Disclosure and Barring Service (DBS) checks undertaken. DBS reviews ensured staff working at the home had not been subject to any actions that would bar them from working with vulnerable people. Records showed prospective staff had been subject to a formal interview process. Staff confirmed they had been subject to a formal induction

process prior to commencing work at the home. The manager told us recently recruited staff were now following the Skills for Care programme. Skills for Care is a national set of standards that all care staff are expected to work to when supporting people. This meant the provider had in place an effective system for recruiting appropriately qualified and experienced staff.

People told us there were enough staff to support them. Relatives told us they felt there were always enough staff at the home to support their relations. The manager told us there were two care staff plus herself on duty during the day and two care staff on duty throughout the night. During the day there were also ancillary staff for kitchen and domestic duties. Most people who lived at the home were independently mobile and only needed the support of one care worker for assistance with personal care. The manager told us she often worked beyond her contracted hours to ensure appropriate care was provided. She also stated that if a person needed to attend hospital in an emergency, because she lived close by, she would often be the person to accompany the individual to hospital. Staff we spoke with said they felt staffing levels were appropriate. We spent time observing care and saw staff were not rushed during the delivery of care and were able to sit and chat to people at times. This meant staffing levels were effective to deliver the required care.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

The manager told us no one at the home was subject a DoLS and no applications for DoLS had been made. As part of people's care assessment we saw there was a section that made reference to the MCA. However, this section was limited and did not fully consider the areas that needed to be considered in relation to DoLS. During our inspection we observed a number of people living at the home who may have fallen under the DoLS guidance and may have met the criteria of being under constant supervision or potentially lacked capacity to make decisions. We asked the manager if all people living at the home would be able to go out unaccompanied, if they wished or were able to do so. The manager told us she felt a number of people would not be safe leaving the home unaccompanied as they would not be safe near traffic or may get lost or confused. This meant an appropriate assessment of people's capacity had not been undertaken in relation to DoLS and people may be unlawfully detained.

The manager told us a best interests meeting was due to take place later in the week with regard to one person's care at the home. We noted a person was receiving medicines covertly. Covert medicines are given to a person disguised in food or drink, because they may otherwise refuse them. The manager said the person did not have any immediate relatives and the person did not have the capacity to always understand the importance or making their medicines. The issue had been discussed with the person's general practitioner, who had written a letter supporting the use of covert medicines to help maintain the person's health. The manager agreed the process followed was not wholly in line with best interests guidance as laid out by the MCA and agreed to review the matter.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 13. Safeguarding service users from abuse and improper treatment.

We saw where people did have capacity to make their own decisions then they had signed consent forms to say they agreed to actions being taken or had signed their care plans to say they agreed to the care being delivered. We noted one care plan referred to a relative having legal Power of Attorney (PoA) to make decisions on the person's behalf, but could not find a copy of the PoA in their file. We asked the manager about this, who eventually found the PoA in archived filing. She said she would ensure a copy was kept in the current care files to safeguard that appropriate decisions were made in relation to the person's care.

People and relatives told us staff had the right skills to support them or their relations. One relative told us, "She is looked after well. Nothing is too much trouble."

The manager had a training matrix on the wall of the office which detailed each staff member, the training they had undertaken and the date the training had been completed. From this she had a regular reminder of what training was required or when refresher training was needed. Both the manager and staff told us a range of updating training had been completed in 2016 and we saw courses on health and safety, food hygiene, moving and handling and infection control had been undertaken. One care worker told us they had been supported to attend catch up training as they had recently been off for a period of time. The manager said all care staff at the home were qualified to National Vocational Qualification level two and most were now moving on to complete level three. An assessor was at the home on the day of the inspection. Staff personal files contained copies of certificates of training they had undertaken.

Staff files also contained evidence of regular supervision sessions and staff confirmed these took place. We saw from supervision records staff had the opportunity to comment on their practice and raise any issues they wished to discuss. They could also request additional training or skills development. Supervision records also included a section for the manager to comment on staff performance. The manager told us they did not have a meeting specifically identified as an annual appraisal, but used the regular supervisions sessions to review staff performance on an ongoing basis.

We recommend the provider considers the introduction of an annual appraisal system to review staff performance at the home.

There was evidence in people care files of action being taken to support their health and well-being. We saw confirmation people had attended outpatient and hospital appointments or community health staff had visited the home. We saw on one person's care records they had been particularly unwell. We saw staff had recorded observations about the person and also contacted the person's general practitioner for advice. Records then indicated the person had been supported to attend a hospital appointment for further investigations. Relatives told us staff were quick to seek further advice if they were concerned about people's health. One relative told us, "They always get the doctor out. There is no issue about that." This meant appropriate action was taken to support people to maintain their health and well-being whilst living at the home.

People said they enjoyed the food at the home and relatives told us they thought the food was of a good standard. One relative told us, "The meals are good and home cooked." On the day of the inspection the main lunchtime meal was a full roast chicken dinner with roast potatoes, two vegetables and trimmings. The food looked hot and appetising and people told us they were enjoying the food. The tea time meal consisted of a Spanish omelette and accompaniments. We noted there was no immediate alternative indicated on the home's menu board. The cook told us there was a set meal eat day, but if people did not want the planned menu they could request something else and this would be cooked individually for them. They told us, "One person doesn't like fish on Friday, so she is offered lamb or something like that instead." The cook told us there was no one currently living at the home who required a softer or pureed diet. She said some people did require diabetic diets and she had ingredients to prepare diabetic versions of meals, such as diabetic custard. People's weight was regularly monitored and action taken if staff were concerned about any significant weight loss.

People described the service as 'homely' and the manager told us they tried to maintain a "friendly and homely atmosphere." Some redecoration had been undertaken and rooms on the upper floors had been converted and expanded to accommodate en-suite toilet areas. However, other areas of the home were in

need of some refreshing and redecoration. The manager said this was being done as part of an ongoing programme. Audit documents indicated rooms were periodically repainted. People had access to a level and enclosed garden space and we saw people making use of this area throughout the inspection. This meant the home was adapted to meet the needs of people living there.

Good

Is the service caring?

Our findings

People told us the staff were kind and caring. One person told us, "The girls are lovely. I don't mind coming here because they look after you." Relatives told us, "I am happy that she is here. I have got peace of mind. The care workers are good" and "We are very satisfied. It is small and homely." Staff told us they enjoyed caring for people living at the home. One staff member told us, "I love my job. It's not like work. I enjoy seeing the residents. I see them as who they are and not as an old person."

We spent time observing care at the home and saw staff treated people patiently and with both respect and courtesy. We saw staff sat with people and had conversations with them or spoke to people as they passed. We observed one meal time and witnessed various friendly exchanges between staff and people they were caring for. The care worker who was covering for the domestic on the day of the inspection also chatted to people she encountered whilst about her duties.

Staff told us no one at the home had any particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010 that applied namely; age, disability, gender, marital status, race, religion and sexual orientation. We saw no evidence to suggest that anyone who used the service was discriminated against and no one told us anything to contradict this. We saw that as part of the home's initial assessment people were asked about any particular religious observances they required support to keep. Some people had indicated they would like to attend church or attend a religious service and this was supported. This meant people's diversity was protected and supported. Information about how people could contact a local advocacy service was available in the main entrance to the home.

People and relatives told us they had been involved in determining their care. One person told us, "They asked me what I wanted when I came here." Where people had capacity to make decisions for themselves we saw they had signed care plan agreements to say they agreed with the plan of care to be delivered. One care worker described how she took extra time to speak with an elderly person, who despite their age was fully able to understand and participate in making decisions. Relatives told us they were kept up to date or involved in people's care and any changes. They told us, "They keep in touch if there is any problem. If necessary they would get the GP first and then let me know" and "We feel involved. We are here every day, so we feel very involved with the care." This meant people and relatives were kept up to date and supported to be involved in care decisions.

Information about the service was available in the home's entrance, including a copy of the provider's Statement of Purpose. Additional information about other local services was also available in the entrance area.

The manager said there were no regular 'residents' or relatives'' meetings, although events did take place approximately twice a year. She said the office was immediately adjacent to the main living areas of the home so people would just speak to her if they wanted to discuss anything. Relatives confirmed they could speak to the manager at any time if they had any issues they wished to discuss.

Staff had a good understanding of how they should support people's privacy and dignity. They were able to describe the actions they would take to ensure people's dignity was protected during the delivery of personal care. For example, staff talked about always ensuring people were covered and supporting people to choose the clothes they wished to wear before delivering care, to ensure there were no unnecessary or embarrassing delays. The manager told us about a system to allow staff to know discretely which people had Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) agreements in place. She said the system involved adding butterflies to the person's door. Whilst full documentation was available in people's care records, it gave a discrete and unobtrusive guide for staff in the event of an emergency. She said a staff member had put forward the suggestion.

We noted the home had closed circuit television cameras installed, some of which covered the lounge and dining area. We asked the manager if they had sought people's permission to cover these areas with cameras, as the service was people's home and cameras may be construed as an infringement of people's privacy. The manager told us she had not thought of the cameras in those terms, only in terms of safety. She said she would speak to people and relatives to ensure they were happy for the system to be in place.

Requires Improvement

Is the service responsive?

Our findings

People and their relatives told us staff were responsive to their needs. One relative told us, "The staff work hard, she is well looked after. Nothing is too much trouble for them. I wouldn't move her, I'm very happy with things. She has improved and has social contact with people." We observed care and support and saw staff responded to people's day to day needs. Staff encouraged people during meal times and supported them, if necessary. One person was mildly upset and said they did not want the meal they had been provided with. Staff offered a range of alternatives and eventually tempted the person with a chicken sandwich, which they slowly ate. The manager and staff both told us about one person who enjoyed chips and sometimes scallops from the local fish and chip shop. They said that if she said she would prefer this for her tea, then staff would pop to the shop and bring her some back. We saw from daily records staff had done this on a number of recent occasions.

Care plans were person centred and related to the individual needs of the people. Records contained assessments of areas such as moving and handling, nutrition, emotional well-being and medication. From the initial assessment, individual needs were identified and any risks associated with these particular needs. For example, one person who had some visual impairment was noted to be at a higher risk of falls because of this. Care plans contained actions for staff to follow to support people's needs. However, these were not always detailed and did not always have clear instructions for staff to follow. For example, one person was noted to have previously suffered a stroke. The care plan stated staff should monitor the person to make sure they were not having a further stroke and act fast if they felt the person was not well or having a second stroke. However, there were no clear indications of a possible stroke for staff to make a comparison with and no clear actions on what staff should do if they felt the person was unwell. Another person was sometimes noted to suffer with hallucinations, but there were no clear instructions on how staff were to support the individual in these circumstances. A third person was recorded as sometimes striking out when receiving personal care. Again there were no clear actions on how staff should manage this, both for their own safety and the safety of the person receiving care. Whilst we could find no evidence people had suffered significant harm because of these omissions, this meant records did not always contain sufficient information to ensure people always received the care they required.

Care plans and risk assessments were reviewed on a monthly basis. However, the detail of these reviews was sometimes limited. For example, for one person's nutritional risk assessment the previous five entries read, "no concerns". Other reviews did show actions. For example, one person, who was at risk of falls had been supported by the use of a high/low bed and the positioning of a safety mat beside their bed at night. This meant reviews of care were not consistent and not always in effective detail.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 9. Person centred care.

Staff we spoke with were able to demonstrate they had a good understanding of people's needs, their particular likes or dislikes and their personalities. Staff were able to tell us in detail about people's histories, their family and work backgrounds and any particular personal interests. Care plan assessments contained

questions of people's preferences, including whether they wished to be supported by male or female care staff.

The manager told us there was no dedicated activities worker, but that all staff supported people to enjoy activities personal to them. She told us, "We don't play bingo. If they never played bingo outside why should they be forced to play bingo when they come into a home?" During our inspection we witnessed staff sat with people, chatting with them or going through the local paper together. One person was engaged in some colouring. Other people were sat watching an old films and some people were simply charting amongst themselves. The manager told us that entertainers did come into the home on occasions. She also told us the local school children came in at Christmas to entertain people. At one point in the afternoon some swing music had been put on and staff and the manager were dancing with people. The manager also told us that if people wanted to go out to the shops then staff would support them to go out. She said a number of people went out with their families.

The provider had a complaints policy in place and a copy of the policy was on display in the home's main entrance. The manager said there had been no recent formal complaints. She said any issues were dealt with immediately to prevent them getting to the stage of a formal complaint. The manager said, "We are what we are. If we are doing something wrong then tell us so we can sort it out. We don't worry about getting things wrong, we just put it right." Relatives we spoke with told us they had not made any formal complaints, but could raise concerns if they were worried about anything. One relative told us, "If there are ever any problems you just go to her (manager) and it is sorted out straight away." This meant where people had concerns these were dealt with speedily and effectively by the manager.

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection there was a registered manager in place. Our records showed she had been formally registered with the Commission since April 2014. The registered manager was present and assisted us with the inspection.

The manager told us that the location was registered to accommodate up to 20 people. However, the provider had recent spent money on reconfiguring the accommodation and adding en-suite accommodation to the majority of the rooms. She said this had cut the home's capacity to 16 individuals. We noted that the provider's registration had not been updated to reflect this change.

The manager had a list or areas that should be checked and audited on a regular basis pinned to the wall of the office. She said she had recently put the list together in collaboration with the new deputy manager when they were going through what should be audited, as part of the deputy's development process. She told us she did not carry out substantial regular audits, although some documents were available, as she was regularly at the home, often including weekends. She said she was regularly involved in the delivery of care and so had a clear understanding of what went on at the home. She told us, "I don't do an audit just to add a tick to a box; I just have a list. I walk round the sluice and the laundry, check the medicine trolley is clean and tidy, look at the kitchen folder. I check the bedrooms are clean every day, along with chairs and wheelchairs." She also told us she regularly walked around the home to check on fire safety and means of escape and then wrote the checks in the fire book. However, these informal checks and formal audit documents had failed to identify the issues we had found at inspection with the laundry and infection risks. The checks had also failed to identify the safety risk from the discarded equipment in the yard area. This meant there were no substantial audits and checks on the safety at the home and the delivery of care.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 17. Good governance.

The manager told us the ethos of the service was to allow people to, "Treat the place as their home." She said she felt the home was part of the community. She told us the families of people who had sadly died, still came back to visit the home and they had even had wakes at the home, at families' requests, when they supplied everything they wanted. She said the home never advertised and that all enquiries came from word of mouth. She said they regularly got local groups donating to the home, including the local allotment society, who often donated fresh vegetables. Relatives told us they always felt welcomed at the home and could call in at any time. Comments included, "You get offered a drink; hot or cold. They have even offered food when I have been here. It doesn't matter when you come, you can visit or phone any time" and "We feel welcome. We come every day. It has a family feel about it."

Staff told us they enjoyed working at the home and felt well supported by colleagues. Comments include, "It's a good group of staff. I like the girls I work with. (Manager) is very approachable, quite hands on and will help you in any way she can"; "It's a brilliant staff team. Very good morale; very good. It's a smaller home, so everyone gets on team-wise and knows what they are doing" and "(Manager) is a brilliant boss and very

approachable. You can go to her in confidence. If you were doing something wrong she would tell you, but in a fair and appropriate way." A relative told us, "(Name), the manager is very, very good."

The manager told us there were only approximately three or four staff meetings a year, because it was a small staff team and there was always opportunity to discuss things. She said anything of importance, whether about a person's care or changes in the home could be recorded in the communications book, which staff always read when they came on duty. Staff said they received information on people's current health and any updates at the shift hand overs, which were "very detailed."

Records were stored correctly and kept securely. Daily records contained good detail about how people had been during the day. Where there had been any concerns or health issues these were fully detailed and there was a clear note of action taken or any observations that need to be continued.

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 9 HSCA RA Regulations 2014 Person-centred care Care and treatment was not always designed in a way that met service users' needs or reflected their preferences. Regulation 9(1)(a)(b)(c)(2)(3)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems were not in place to ensure that care and treatment was provided in a safe way for service users. Risks to health and safety had not been assessed, systems were not in place to manage and prevent risks associated with acquired infections and medicines were not always managed safely and effectively. Regulation 12 (1)(2)(a)(b)(c)(g)(h).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Service users were not always protected from improper treatment because appropriate assessments had not been undertaken to determine if people met the criteria for DoLS under the MCA. Regulation 13(1)(5).

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 17 HSCA RA Regulations 2014 Good

personal care

governance

Systems had not been established or operated effectively to assess, monitor and improve the quality and safety of the service and monitor and mitigate risks relating to health, safety and welfare of service users. Regulation 17 (1)(2)(a)(b)