Mrs Dahiya

Sailaway Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Inadequate

Overall summary

This inspection took place on 9 and 15 April 2015 and was unannounced. The home provides accommodation for up to 18 people, including people living with dementia. There were 9 people living at the home when we visited. The home is owned by the registered provider who also acts as the manager.

At our previous inspection on 22 and 23 October 2014, we identified breaches of nine regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We took enforcement action and required the provider to make improvements. We issued three warning notices in relation to care and welfare, infection control and quality assurance. We also set compliance actions in relation to safeguarding, meeting nutritional needs, safety and suitability of premises, consent to care, requirements relating to workers and supporting workers. The provider sent us an action plan on 29 January 2015 stating they would be meeting the requirements of the regulations by 1 February 2015.

Summary of findings

At this inspection we found the provider had not completed all the actions they told us they would take. As a result, they were continuing to breach regulations relating to fundamental standards of care.

People's safety was compromised in some areas. The kitchen door was wedged open contrary to advice from the fire service; the needs of two people whose safety would be at risk in the event of a fire had not been catered for; not all staff had received fire safety training; and the garden fence, intended to protect people from the risks of traffic on a nearby road, was not secure.

Infection control guidance issued by the Department of Health had not been followed, and infection control risk assessments had not been completed. Not all staff had been trained in infection control. Cleaning check sheets had not been completed, although we found the home was clean.

Suitable arrangements were in place for managing medicines, but the recording of some medicines did not follow guidance issued by the National Institute for Health and Clinical Excellence. The risk of people falling was not always managed safely. People's risk assessments were not reviewed following falls and specialist advice was not always sought.

Recruitment procedures were not effective as appropriate checks were not always completed before staff were employed. People felt safe and most staff had an understanding of how to safeguard people from abuse. However, not all staff had received training in how to identify, prevent and report abuse.

Staff did not follow legislation designed to protect people's rights and ensure decisions taken on behalf of people were made in their best interests. The manager was not clear about the legal process used to deprive people of their liberty, in order to keep them safe.

People felt staff were competent and skilled in their roles, although not all staff had received essential training. For example, some staff were using a hoist to move people when they were not trained in its use. Other training records were disorganised and the provider could not confirm which training staff had received. Not all staff were supported appropriately through the use of one-to-one sessions of supervision, and none had received an annual appraisal.

There was a lack of information about the support needed by people who displayed behaviour that challenged staff. The care plans for two people had not been updated to reflect their current needs. Consequently, people may not have received appropriate, consistent care and support.

Effective systems were not in place to enable the provider to assess, monitor and improve the quality and safety of service. The provider did not send us information we requested about action they had taken in response to health and safety concerns identified by an external specialist.

There were enough staff to meet people's needs. People and their relatives felt staff provided effective care. Care plans contained information about people's personal histories, preferences and interests and comprehensive guidance about how people liked to receive personal care. Records were up to date and confirmed people had received all care and support that had been planned.

People spoke positively about the variety of activities they could access and parties were held for special occasions. The manager sought feedback from people through 'residents' meetings'. These showed people were listened to and changes made to menus and activities as a result.

People liked the manager and spoke with them often. Visitors were made to feel welcome. The manager and deputy manager promoted positive values and attitudes towards people which helped create a family atmosphere in the home.

People were cared for with kindness and compassion and treated with affection. All interactions were warm, friendly and respectful. Staff knew people well and communicated effectively, using appropriate techniques. People's privacy and dignity were respected and they were involved in planning the care and support they received.

Most people were satisfied with the quality of the food. People received appropriate support to eat and drink enough. Staff closely monitored the food and fluid intakes of people at risk of malnutrition or dehydration and took appropriate action where required.

Summary of findings

People were able to access healthcare services. Some adaptations had been made to make it suitable for older people, such as a stair lift and level access to a garden with an area of decking, which people enjoyed using.

The manager spent most of their time working with staff on a daily basis, helping to deliver care and support to people. Staff appreciated this and described the manager as “approachable”. They felt able to make suggestions to help improve the quality of service provided.

Following the inspection, we discussed our concerns with West Sussex Fire and Rescue Service.

At this inspection we found several breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, some of which were continued concerns from our previous inspection. You can see what action we have told the provider to take at the back of this report.

The overall rating for this provider is ‘Inadequate’. This means that it is in ‘Special measures.’ Special measures in Adult Social Care provides a framework within which CQC can use our enforcement powers in response to inadequate care and can work with, or signpost to, other organisations in the system to help ensure improvements are made.

Services in special measures are kept under review and, if we have not taken immediate action to cancel registration, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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?

Inadequate

The service was not safe. Fire safety arrangements were not adequate. The grounds were not secure. Infection control risk assessments had not been completed. Not all staff had been trained in infection control, although the home was clean.

The managements of medicines was safe, but some records were not completed properly. The risk of people falling was not managed safely as risk assessments had not been reviewed effectively.

Appropriate checks were not always completed before staff were employed. People felt safe, although not all staff had received safeguarding training. Staffing arrangements were adequate.

Is the service effective?

Requires Improvement

The service was not effective. Staff did not follow legislation designed to protect people's rights. The manager was not clear about the process used to deprive people of their liberty.

People felt staff were competent, but not all staff had received appropriate training, supervision and appraisal. Training records were disorganised.

Most people were satisfied with the quality of the food and received appropriate support to eat and drink. They could access healthcare services when required.

Some adaptations had been made to make the home suitable for older people.

Is the service caring?

Good

The service was caring. People were treated with affection and cared for with compassion. Staff communicated with people effectively, using appropriate techniques.

People were able to make choices and were involved in decisions about how they spent their day. They were encouraged to be as independent as possible and were involved in planning their care and support.

Appropriate policies were in place to protect people's privacy and dignity. Records were kept securely.

Is the service responsive?

Requires Improvement

The service was not always responsive. There was a lack of information about the support needed by people who displayed behaviour that challenged. The care plans for two people did not reflect their current needs.

Summary of findings

People felt staff provided effective care and care plans provided comprehensive guidance about how people liked to receive personal care.

People enjoyed a variety of activities. They contributed to the planning of activities and menus. People and their relatives had regular contact with the manager and felt able to approach them to discuss concerns.

Is the service well-led?

Inadequate 

The service was not well-led. The provider had not completed all the actions they told us they would take to meet the requirements of the regulations. Quality assurance systems were not effective.

The provider did not send us information we requested about action they had taken in response to a health and safety audit.

Staff described the manager as “approachable” and appreciated the time they spent working with staff. This created a “happy, family atmosphere”.

A deputy manager had recently been appointed to support the manager and acted as a good role model for newer staff to follow.

Sailaway Residential Care Home

Detailed findings

Background to this inspection

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

This inspection tool place and 9 and 13 April 2015 and was unannounced. The inspection team consisted of an inspector and an expert by experience in dementia care. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we reviewed information we already held about the service including previous inspection reports and notifications. A notification is information about important events which the provider is required to send us by law.

We spoke with eight people living at the home and two family members. We also spoke with the registered provider, the deputy manager, the administrator and four care staff members. We looked at care plans and associated records for six people; staff duty records; four staff recruitment files; records of complaints, accidents and incidents; policies and procedures; and quality assurance records. We observed care and support being delivered in communal areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Inadequate

Is the service safe?

Our findings

At our previous inspection on 22 and 23 October 2014, we identified breaches of regulations. Infection control guidance was not being followed; incidents of potential abuse were not reported to the local safeguarding authority; risks were not managed effectively and recruitment procedures were not safe. We issued warning notices and required the provider to make improvements. The provider sent us an action plan on 29 January 2015 stating they would be meeting the requirements of the regulations by 1 February 2015. At this inspection we found that sufficient improvements had not been made or sustained and the provider remained in breach of the regulations.

We found improvements had been made to procedures to be followed in the event of a fire, including the provision of new fire escape signs. However, the door to the kitchen was wedged open throughout the first morning of our inspection, contrary to advice from the fire and rescue service. The needs of a person who was deaf, who would not be able to hear the fire alarm ringing, had not been catered for. The needs of a person whose mobility had changed had not been updated in their personal emergency evacuation plan; this stated they were fully mobile but staff told us the person had not been able to walk independently for two months. The person's bedroom was on the first floor and no equipment was available to evacuate them if the stair lift they normally used was not working. In addition, not all staff had received fire safety training.

A fence that was erected around the front garden of the home, following our last inspection, was not secure. In one place it had not been completed and there was a gap of two feet. In another place a fence panel had become dislodged leaving a gap of six feet. People could access the front garden via a door in the conservatory that was not locked during the day. Beyond the front garden was a main road, less than 100 meters away. Staff told us some people living with dementia would not be safe leaving the garden without staff supervision as they were unable to appreciate the potential dangers from the road. People were therefore put at risk by the insecure fence.

Providers are required to take account of the Department of Health's publication, 'Code of Practice on the prevention and control of infections'. This provides guidance about measures that need to be taken to reduce the risk of infection. The code of practice requires providers to complete an annual statement detailing what policies and infection control risk assessments are in place, and any staff training or outbreaks of infection that have occurred. The provider had not completed an annual statement or any infection control risk assessments. A new infection control policy had been introduced, but this was a standard product purchased from an external supplier and had not been adapted to meet the needs of this home. Not all staff had been trained in infection control techniques. Cleaning check sheets, used by staff to show they had completed all the required cleaning, contained numerous gaps. Consequently the provider could not demonstrate that the risks of people acquiring an infection had been identified, assessed and managed effectively.

Although we identified concerns, people told us they were satisfied with the cleanliness of the home. One person said, "I think it's beautiful and clean." The environment was visibly cleaner and sanitising hand gel, disposable gloves and aprons were available throughout the home. The laundry had been tidied and clean linen was kept in a separate room to prevent the risk of cross contamination from soiled linen entering the laundry.

Suitable arrangements were in place for the obtaining, handling, safe keeping and disposal of medicines. However, medication administration records (MAR) had not been signed for medicines given to two people on the first day of the inspection. Handwritten entries on MAR charts were not signed or counter-signed by the staff making the entries, which was contrary to guidance issued by the National Institute for Health and Clinical Excellence (NICE). The records for two medicines which are subject to additional legal controls had not been fully completed. They did not specify which record related to a 10mg pain relief patch and which related to a 5mg pain relief patch. This could have caused confusion to staff when administering them.

The risk of people falling was not always managed safely. Risk assessments had been completed to assess the likelihood of people falling. For one person this stated they had a history of falls, but did not say when, where or how they had occurred and did not include any actions to minimise the risk. Staff told us the person fell "about every two weeks" and records confirmed they had fallen twice in the month prior to our inspection. However, their risk

Inadequate

Is the service safe?

assessment had not been reviewed or updated to reflect this. Another person had fallen four times in the seven weeks prior to our inspection. Their risk assessment included measures to reduce the risk, such as encouraging the person to use walking aids, which we observed staff doing. However, the person's risk assessment had not been reviewed following their recent falls. Staff had not referred either person their GP or the specialist falls service for advice. Therefore, the provider was not taking all practical steps to mitigate risks to the health and safety of people.

The above issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Recruitment procedures were not safe. Appropriate checks were not always completed before staff were employed. An administrator, who had regular contact with people living in the home, had been employed without a Disclosure and Barring Service (DBS) check. DBS checks identify if a prospective staff member has a criminal record and help employers make safer recruitment decisions. References for two staff members had not been obtained from their previous care service employers. The recruitment record for another staff member included an unexplained gap in their employment history. The provider was not operating effective recruitment processes to ensure staff employed were fit to carry out their roles and did not pose risks to people.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us there were enough staff to meet their needs and that they "don't usually have to wait long" for a response to their call bells. Two care staff were employed throughout the day, plus a cook. At night, two care staff were on duty, but one was allowed to sleep between 11:00 pm and 6:00 am and could be woken if needed. Staff absence was normally covered by staff working additional hours. For example, on the first day of our inspection the cook had reported sick, so another member of staff had been called in to do the cooking. Very occasionally, agency staff were also used to provide cover. Two people needed the support of two staff members to transfer between chairs, to get in and out of bed and to use the toilet. When staff were supporting these people, we observed that other people were left alone in the lounge for up to 20 minutes. Staff acknowledged this was a risk, but said they had not known people to have come to harm during these times. The provider told us they worked "most days" to provide additional support in the home.

People told us they felt safe, free from harm and would speak up if they were worried or unhappy about anything. One person confirmed this by saying: "Oh I'm not frightened or anything here." The provider had an appropriate safeguarding policy in place and access to guidance issued by the local authority. Most staff had an understanding of how to safeguard people from abuse. However, one staff member was not clear about the meaning of safeguarding and not all staff had received training in how to identify, prevent and report abuse.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection on 22 and 23 October 2014, we identified breaches of regulations. Care plans did not provide sufficient information about people's nutritional needs and action was not always taken when people lost weight. Staff did not follow legislation designed to protect people's rights. The design and decoration of the building did not support the needs of people living with dementia. Staff were not supported by regular supervision and appraisal. We issued warning notices and required the provider to make improvements. The provider sent us an action plan on 29 January 2015 stating they would be meeting the requirements of the regulations by 1 February 2015. At this inspection we found that some improvements were made but not all requirements had been met or sustained.

Staff were not following the Mental Capacity Act, 2005 (MCA) or its code of practice. The MCA provides a legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision should be made involving people who know the person well and other professionals, where relevant. Most people living at the home had cognitive impairment to some degree. Staff sought consent from people before providing care by using simple questions and giving them time to respond. People who had capacity had signed their care plans to indicate their agreement with it. Capacity assessments had been conducted for two people living with dementia, indicating they lacked capacity to make decisions about their care and treatment, but these had not led to best interest decisions being made. Assessments of the capacity of other people living with dementia to make decisions had not been conducted. Agreement to one person's care plan had been signed by a relative who did not have lawful authority to make decisions on the person's behalf. Another person had signed their care plan, indicating their agreement to it, although a capacity assessment stated they lacked the capacity to make this decision. From discussions with the manager and staff, it was clear they did not understand the MCA, which posed a risk that people's rights were not being protected.

The manager told us they had made applications for Deprivation of Liberty Safeguards (DoLS) for three people. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. The authority that assesses the applications told us no applications had been received and restrictions had not been authorised for anyone living at the home. When we discussed this with the manager, they said they was not clear about the process for applying for DoLS and said they would take advice from the authorising body. Consequently, people may have been subject to restrictions that had not been authorised.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People felt staff were competent and skilled in their roles. The relative of one person said, "I've every confidence in them, even the new girl is getting there". However, we found not all staff had received appropriate training.

A number of new staff had been recruited since the last inspection. National guidance issued by the Social Care Institute for Excellence and Skills for Care recommended that new care staff employed before April 2015 follow Common Induction Standards (CIS). CIS are the standards employees working in adult social care need to meet before they can safely work unsupervised. This was replaced by the Care Certificate for staff employed after 1 April 2015. Training records showed new staff did not follow CIS or the Care Certificate when they started work at the home. They did not always receive training in essential topics such as safeguarding people from abuse, moving and handling, dementia awareness and infection control. Some staff were using hoists to move people without having been trained in their use. This put people and staff at risk of injury and was contrary to the provider's policy.

Training records for more experienced staff were disorganised, so the provider was unable to confirm which staff had attended training in key subjects. The provider had registered online for staff to complete online training with an external training provider in some subjects. However, records showed only one of these courses had been completed by one staff member. Other staff, including the cook, had not received up to date training in food safety and did not hold food safety certificates, yet were preparing meals for people.

Staff were not supported appropriately to carry out their duties. The deputy manager had started to conduct one to one sessions of supervision with staff. These provided an

Requires Improvement

Is the service effective?

opportunity for staff to discuss their performance and their training and development needs. However, some staff had not received a session of supervision and no staff member had received an appraisal in the past year.

The failure to support staff appropriately, through training, supervision and appraisal, was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people were satisfied with the quality of the food. One person said, "I've always had a bacon sandwich every morning and I get one here if I want one". The relative of another person said of the staff, "I thought it was good that they knew [the person] doesn't like pork, but one day wanted gammon so they were confused; but I was impressed that they spoke to me about it" We observed the lunchtime meal and heard a person comment afterwards, "I enjoyed bits of that but it was a bit stodgy". A staff member offered to let the cook know.

People received appropriate support to eat and drink enough. People who chose to eat in the dining room sat round a large table set with napkins, cutlery and glasses. This created a family feel and helped make the mealtime experience pleasant for people. They were offered varied and nutritious meals. Drinks were available to people throughout the day and staff prompted people to drink often. People were encouraged to eat well and staff provided one to one support where needed, for example by offering to help people cut up their food. They closely monitored the food and fluid intakes of people at risk of malnutrition or dehydration and took appropriate action where required. However, we had concerns about the dietary needs of a person with diabetes as reflected elsewhere in the report.

People were able to access healthcare services. Relatives told us their family members always saw a doctor when needed. Care records showed people were referred to GPs, community nurses and other specialists when changes in their health were identified, for example if they started to lose weight or became anxious.

Some adaptations had been made to make it suitable for older people, such as a stair lift and level access to a garden with an area of decking, which people enjoyed using. One person said, "Oh its lovely out there; we have peacocks, rabbits and squirrels to look at." Signage around the home had been improved since our last inspection to help people find their way to the bathroom. A large mirror had been covered that may have caused anxiety to some people living with dementia. The main bathroom had been refurbished and was bright and welcoming. However, there was a lack of colour contrast elsewhere in the home and all bedroom doors looked alike, which could confuse people when trying to find their bedrooms.

Good

Is the service caring?

Our findings

People were cared for with kindness and compassion. One person said, "The staff are lovely, very helpful, we get on well." Another person told us "Oh we have a laugh here, it's very happy and the girls are nice." A third person said of the staff, "They're very good here really and you know you can ask them to do things." This was confirmed by visitors and relatives, who described staff as "very friendly".

We observed people being treated with affection. All interactions were warm, friendly and respectful. Staff smiled as they went about their work, gently held people's hands and laughed with them. Conversations between people and staff were engaging and people were given good eye contact. There was a sharing of experiences and they talked about each other's families and interests, showing staff knew people well. One person said of the staff, "They know I like to sing a lot and what songs I like." Staff told us they enjoyed spending time with people and their families, "treating them like you'd treat your mum or dad".

During one of the drinks rounds, staff noticed a person was asleep and said they would return when the person was awake. 15 minutes later, the person woke up and the staff member retuned to offer them a drink. When supporting people to transfer from a wheelchair to a lounge chair, staff reassured them using their preferred names. They explained what they intended to do, checked the person was ready to move and talked them through the process. Once transferred, they made the person comfortable in their new position and offered them cushions or blankets. The care plan of a person who became particularly frightened when using the hoist acknowledged their fear and provided guidance about how staff could reduce the person's anxiety. Staff were clear about this and explained how they followed the guidance in practice. Information was available about how people liked to receive their medicines and these were given in the way people preferred.

Staff communicated with people effectively, using simple questions where appropriate. One person had been given large print books to make it easier for them to read. Another person was unable to hear well. Their care plan contained detailed guidance about how staff should communicate with them and we saw this being followed. Staff wrote questions down for the person and at lunchtime they were given a written menu from which to make their choice. Desserts were offered to people from a trolley, so they could see and choose them at the time. This supported people living with dementia, who may not have been able to remember choices they had made in advance.

It was clear from our discussions, observations and from looking at records that people were able to make choices and were involved in decisions about their day. Examples included decisions about when they got up, how they spent their day, where they ate their meals, activities and clothing choices. At lunchtime, people were asked if they wanted a cloth napkin to protect their clothes and their choices were respected. People were encouraged to be as independent as possible, in accordance with their needs, abilities and preferences.

The provider had appropriate policies in place to help ensure people's privacy and dignity were respected. Staff described how they did this in practice, for example by making sure doors were closed when people received personal care. Where people were able to attend to their own personal care, staff waited outside the bathroom until or in case the person asked for support. We observed staff knocked and waited for people to answer before entering their rooms. We saw confidential information, such as care records, was kept securely and could not be accessed by people who were not authorised to see it.

When people moved to the home, they (and their families where appropriate) were involved in discussing and planning the care and support they received. Comments in care plans showed this process was on-going to help ensure people received the support they wanted. Family members were kept up to date with any changes to their relative's needs.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection on 22 and 23 October 2014, we identified breaches of regulations. Care plans did not contain sufficient information to allow staff to deliver personalised care and some care plans were incomplete. People's continence was not managed effectively and there was a lack of mental stimulation for people. We issued warning notices and required the provider to make improvements. The provider sent us an action plan on 29 January 2015 stating they would be meeting the requirements of the regulations by 1 February 2015.

At this inspection we found the provider had made some improvements. However, we identified a continuing breach of one regulation.

There was a lack of information about the support needed by people who displayed behaviour that challenged staff. The way such behaviour presented was detailed in people's care plans, but no information was available about how staff should respond, in order to support the person effectively. As a result, a new member of staff was "slapped" by a person they did not respond to appropriately. More experienced staff told us they knew how to support this person safely, but this information had not been recorded. Records of when the person displayed such behaviour were not made in a way that allowed the provider to analyse the incidents to identify the causes and triggers, or the responses that supported the person most effectively. This meant they were unable to plan or design strategies to provide effective care and support to the person. The care plan for another person stated they "could become agitated" when they were unable to express themselves or when they found it difficult to perform certain tasks. However, there was no guidance to staff about how to support the person at these times and no information about the person's diagnosis. One staff member thought the person was psychotic, while another thought the person had a learning disability. Consequently, the person may not have received appropriate, consistent care and support.

The care plans for two people had not been updated to reflect their current needs. One person was no longer able to weight bear or walk independently. Staff were aware of this and provided appropriate support, but this was not recorded in the person's care plan. The manager told us about a person who had started sitting on another person's lap as it gave them comfort, but this was not recorded in either person's care plan. Therefore, new staff or agency staff did not have had access to key information about people.

The dietary needs of a person who was diabetic were not always met. Staff told us the person's diabetes was controlled through tablets, but we found the medicine they thought was for diabetes was for a heart condition. The manager confirmed that this person no longer took tablets and said their diabetes was "diet controlled". However, this was not recorded in their care plan, staff were not aware of it and no information was available to advise them how to support the person's dietary needs. This posed a risk to the person's health.

The failure to provide appropriate, consistent care in a way that met people's individual needs was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives felt staff provided responsive care. A family member said, "The atmosphere is very friendly and the care is good. Yes, I'm happy that [the person] is well looked after and safe here." Another relative told us "I would recommend the home, it's much better than where [the person] was before" A person told us staff were responsive in the morning because "they might just pop in and see if you're ready to get up; but I like to lie in a bit, so they come back later". Another person said they were able to "have a shower twice a week or when I want."

Care plans contained information about people's personal histories, preferences and interests. They provided comprehensive guidance to staff about how people liked to receive personal care, how they liked to dress and where they preferred to spend their day. Initial assessments had been completed using information from a range of sources, including the person, their family and other health or care professionals. Daily care records were up to date and confirmed people had received all planned care and support. People received personalised continence care. Staff knew people's individual needs, promoted their independence and supported them appropriately. People's rooms now smelt fresh and clean, where previously this had not always been the case.

People spoke positively about a variety of activities they could access, including board games, crafts and music. One person talked about a quiz they had taken part in, which

Requires Improvement

Is the service responsive?

they described as “fun” and another person told us of an Easter egg hunt which was “really enjoyable too”. People spoke of having their hair and nails done and we observed staff offering people hand massages. Another person’s main interest was painting and they showed us pictures staff had supported them to paint. We observed sing-songs which people joined in with and one person played along with a tambourine, which they clearly enjoyed. Parties were held for special occasions, which relatives were invited to.

The manager sought feedback from people by talking to them on a daily basis and holding ‘residents’ meetings’.

These were held monthly and records showed people were listened to. For example, people had made individual requests for menus and activities. Arrangements had been made for each to be catered for and we heard music being played that people had requested. The provider had a complaints policy in place. People and their families confirmed they knew how to make a complaint but said they had not had cause to. They had regular contact with the manager and felt able to approach them to discuss concerns and any time.

Inadequate

Is the service well-led?

Our findings

At our previous inspection on 22 and 23 October 2014, we identified breaches of regulations. Quality assurance systems were not effective. We issued warning notices and required the provider to make improvements. The provider sent us an action plan on 29 January 2015 stating they would be meeting the requirements of the regulations by 1 February 2015.

Whilst some improvements were noted, the provider had not completed all the actions they told us they would take to meet the requirements of the regulations. These included actions to ensure: care and treatment was only provided with people's consent; people's care and treatment was provided in a safe way; staff recruitment was effective; and staff received appropriate training and support. As a result, the provider was continuing to breach regulations relating to fundamental standards of care.

Effective systems were not in place to enable the provider to assess, monitor and improve the quality and safety of service. Care plans were reviewed monthly by senior staff, but they were not audited or checked by the manager to ensure they were fit for purpose. Medicines were audited monthly, but the last audit had not picked up the issues we identified with medication administration records. Audits of other key aspects of the service, such as the application of the Mental Capacity Act, infection control, staff recruitment and staff training had not been completed.

Following the inspection, the provider sent us a health and safety inspection report, conducted in January 2015 by an external specialist. It identified a number of concerns that were in contravention of statutory requirements and could lead to injury or ill health. We asked the provider for information about plans they had to manage or eliminate the risks identified but they did not respond to our request.

The above issues were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People felt the home was well run. They said they liked the manager and felt able to speak up if they needed to. One person said, "[The manager] is very nice to me, we're great friends and I can talk to her." Visitors told us they were "always made to feel very welcome" and could visit at any time.

Staff felt the home ran "more smoothly" now than previously, but aspects of the service were still "a little bit unorganised". They told us the manager was approachable and described the manager's ability to interact with people as "amazing". They said the manager took action when concerns were brought to their attention, for example when a staff member was not complying with the provider's uniform policy. A senior member of staff was either on duty or available on call to provide advice at all times.

The home was owned by the registered provider who also acted as the manager. From our observations, it was clear that people and staff knew the manager well. She spent most of her time working with staff on a daily basis, helping to deliver care and support. They said this allowed them to continually assess how people were being cared for and how staff were working. Staff appreciated this and said the manager displayed positive values and attitudes towards people which helped create a "happy, family atmosphere".

A deputy manager had recently been appointed to support the manager. We observed the deputy manager was skilled in communicating with people, set high standards and acted as a good role model for newer staff to follow. They were quick to respond to issues raised during our inspection. For example, they started updating people's care plans and drafted new guidance for recording and monitoring incidents where people displayed behaviour that challenged.

The provider sought feedback from people about the quality of the service by placing a comments box in the reception area. This had not proved successful as no comments had been received. No other formal arrangements for in place to seek feedback, although people told us they spoke with the manager regularly.

Regular staff meetings were held which provided an opportunity for staff to make suggestions for improving the service. These included the introduction of a key worker system that was being implemented. This is a system that gives each person a nominated member of staff who takes a particular interest in their care and support and acts as a point of contact for the family.