Southcrest Care Ltd

Churchill House

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 19 September 2017 and was unannounced. This was the first inspection of the service since registration with the new provider.

Churchill House is registered to provide accommodation and personal care for a maximum of 24 people. At the time of the inspection, there were 20 people using the service. Churchill House is close to local amenities and bus routes into Hull city centre; there is a car park at the rear of the property. There are two sitting rooms, one of which has a designated dining area at one end. All bar one of the bedrooms are for single occupancy and there are sufficient bathrooms and toilets on each floor which are close to communal areas.

The service had 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.

We found that staff knew how to gain consent for day to day care activities with people. However, when people lacked capacity to make their own decisions the provider had not always worked within the law and best practice guidelines. Mental capacity assessments had not always been undertaken and decisions made in people's best interest regarding restrictions placed on them had not been recorded. A deprivation of liberty safeguard (DoLS) application had been made for some people but not for all people that met the criteria. This meant some people may be deprived of their liberty unlawfully. The registered manager told us applications for people this applied to would be made to the local authority straight away. You can see what action we have asked the provider to take at the back of the full report.

We found some areas of the environment that required attention to make sure risk was minimised for people who used the service. The registered manager acted promptly when we told them about these issues and most were addressed during the inspection or shortly afterwards. However, the quality monitoring system needed to be more robust to ensure checks of the environment highlighted areas of risk so these can be addressed quickly. We have made a recommendation about this.

We saw there were some activities for people to participate in but these did not meet everyone's needs. We have made a recommendation about this.

We found staff knew how to safeguard people from the risk of abuse and they knew who to refer any concerns. Staff had completed safeguarding training. Staff also completed risk assessments to help minimise the risk of accidents and incidents occurring. There were plans in place to guide staff should they need to evacuate the building in emergency situations.

Staff were recruited safely with employment checks carried out before they started work. There were sufficient staff on duty although they were busy. The registered manager was recruiting additional care staff,

a deputy manager and an activity coordinator to complement the staff team.

We saw the staff approach was kind and caring which was confirmed in discussions with people who used the service. People told us their privacy and dignity were respected and they were able to make choices and decisions for themselves.

We found people's health needs were met by access to a range of community health care professionals. Communication between staff and the health professionals was good. Medicines were managed safely and people received them as prescribed.

People told us they liked the meals provided to them and menus evidenced choices and alternatives were available. The support provided to people by staff at mealtimes was appropriate to their needs.

Staff had access to training, supervision and support. This enabled them to feel skilled and confident when delivering care to people. The training records indicated the courses staff had completed and when updates were due. There were training plans for the next few months.

The provider had a complaints procedure and people told us they would complain if required. Everyone spoken with said they did not have any complaints.

We found the environment was clean and tidy. Staff had equipment to use to prevent and control the spread of infection and cleaning schedules were in place. Equipment used, such as moving and handling items, was maintained and serviced appropriately.

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 consistently safe.

The service was clean and tidy, however there were some concerns that had not been identified in environmental checks which could pose a potential risk to people. Most of these were addressed during the inspection or very shortly afterwards.

Staff knew how to keep people safe from the risk of abuse. They had completed safeguarding training and knew how to respond to concerns. Assessments were completed to help guide staff in minimising people's individual risk although bedrail risk assessments required more information.

There were safe systems in place for the management of medicines. People received their medicines as prescribed and on time.

Staff were recruited safely and there were sufficient numbers on duty to meet the current needs of people who used the service.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The provider had acted within mental capacity legislation and safeguards were in place to protect some people when they lacked capacity to make their own decisions; however, this had not been consistently applied for everyone who lacked capacity. Staff recognised their responsibilities in gaining consent prior to care tasks but capacity assessments and best interest decisions for the restrictions some people had were not always completed.

People's health and nutritional needs were met. They had access to community health care professionals when required. People said they enjoyed their meals and had choices and alternatives.

Staff had access to training, supervision and support to ensure they had the skills required to support people.

Is the service caring?

Good

The service was caring.

The staff approach was kind, caring and patient. People who used the service confirmed staff treated them with respect and maintained their privacy and dignity.

People were provided with explanations and information about their care so they could make informed decisions.

Staff maintained confidentiality and personal information was stored securely.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

The provision of meaningful activities for people was minimal. We have made a recommendation about this.

People had assessments of their needs carried out and care plans were formulated to guide staff in how to meet their needs in an individualised way.

The provider had a complaints procedure and people spoken with told us they would feel able to complain if required.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

A quality monitoring system had started to be implemented which included audits, checks and surveys. A more robust checking of the environment was required to help identify and minimise risk to people who used the service.

The provider had developed a refurbishment plan for the next 12 months, which will help to improve the environment.

There was an open culture within the service. Staff, people who used the service and their relatives felt able to raise issues in the knowledge they would be listened to and action would be taken.

Churchill House

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 inspection took place on 19 September 2017 and was unannounced. The inspection team consisted of one adult social care inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their field of expertise was caring for an older person living with dementia.

Prior to the inspection, the provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used the PIR to help in the planning of this inspection. We also checked our systems for any notifications that had been sent in as these would tell us how the provider managed incidents and accidents that affected the welfare of people who used the service.

Prior to the inspection, we spoke with the local authority safeguarding, and contracts and commissioning team, about their views of the service. We also received information from a specialist tissue viability nurse and a social care worker.

During the inspection, 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. We observed how staff interacted with people throughout the day and at mealtimes. We spoke with six people who used the service and one of their relatives. We spoke with the registered manager, three care workers and the cook. During the inspection, we also received information from a community nurse and a social worker.

We looked at five care files for people who used the service. We also looked at other important documentation relating to people who used the service. These included medication administration records (MARs) for 19 people, daily notes of care provided and monitoring charts. We looked at how the service used the Mental Capacity Act 2005 to ensure that when people were assessed as lacking capacity to make their

own decisions, best interest meetings were held in order to make important decisions on their behalf.

We looked at a selection of documentation relating to the management and running of the service. These included six staff recruitment files, training records, the staff rota, menus, minutes of meetings with staff and people who used the service, quality assurance audits and complaints management. We completed a tour of the environment.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living in Churchill House. Comments included, "There's always somebody around and my room is safe", "Perfectly safe, there's always someone about", "Nobody can harm me and my belongings are safe", "You're never alone; just ring the call bell and staff answer" and "Staff make me feel safe." A relative said, "I know she is safe; she would tell me otherwise."

Health and social care professionals spoke about the service being a safe environment and ensuring that they signed a book when entering and leaving. Comments included, "Staff have volunteered to assist us whilst we were with the patient to ensure familiarity and offer reassurance to the patient" and "Yes, [it is safe] I have no concerns at this time."

During the environmental check we noted some areas that required attention. For example, some wardrobes were lightweight and were not secured to the wall which meant there was a risk of them being pulled over. Plastic gloves used by staff were in wall-mounted containers which made them accessible and posed a risk of ingestion for those people living with dementia. Some store rooms were accessible to people which could pose a trip hazard. There was an unpleasant odour in a bedroom; the registered manager was aware of this and was trying to address it. The arm padding on a commode chair had perished which meant it would be difficult to keep clean. The risk assessment for legionnaires disease and water checks to make sure there was no presence of legionella was out of date. These issues were mentioned to the registered manager and they told us they would address them quickly. Following the inspection, we received information that wardrobes had been made secure, plastic gloves locked away, the commode had been replaced and a legionnaires risk management plan had been initiated. The bedroom with the unpleasant odour had been re-carpeted. The provider's refurbishment plan detailed that all bedrooms were to be redecorated and re-carpeted within the next 12 months.

Equipment used in the service was maintained and checked to make sure it was in working order and there were cleaning schedules for housekeeping staff. The laundry had three domestic-type washing machines and one drier. The registered manager told us they had received quotes for a commercial washing machine with a sluice wash function and this would be fitted when the laundry room was reorganised. A room had also been identified as a sluice room and a bed pan washer was to be purchased and fitted. These measures will help to prevent and control the spread of infection. Staff had personal, protective equipment such as gloves, aprons, hand sanitiser, liquid soap and paper towels to use. Staff had completed infection prevention and control training.

In discussions with staff it was clear they knew how to safeguard people from the risk of harm and abuse. Staff had received safeguarding training and could describe the different types of abuse and the signs and symptoms that would alert them to concerns. Staff had a good understanding of how to pass on information about concerns to the registered manager and other agencies. The registered manager contacted the local authority safeguarding team for advice when required.

We saw people had risk assessments in place for areas such as nutrition, falls, moving and handling, fragile

skin, communication difficulties and health related issues such as continence and bowel care. There was a risk assessment for bedrails but this was more a document to state the person was at risk of falling out of bed rather than an assessment of their suitability for bedrails and if they were safe using them. This was mentioned to the registered manager to address. Staff knew about the risk assessments and the care people needed to minimise risk.

Each person had a personal plan to guide staff and other professionals in how to safely evacuate them from the building in an emergency.

There were safe systems in place for the management of medicines and we found people received their medicines as prescribed. People confirmed they received their medicines on time. Comments included, "I get asked every day if I want a Paracetamol; I get four tablets every morning and two at night without fail" and "It's all pretty good with the times and pain relief if needed." Medicines were stored securely at the correct temperature, and returned to the pharmacy when unused. Staff had received training in medicines management. We saw clearer guidance for staff to aid their decision-making was needed for medicines prescribed to people 'when required' or with a variable dose. This was mentioned to the registered manager to address.

Staff were recruited safely and full employment checks were in place prior to new staff starting work. These included an application form so gaps in employment could be explored, references, an interview and a disclosure and barring service (DBS) check. DBS checks highlight any previous convictions and help the provider to make safer recruitment decisions.

We found there were sufficient staff on duty for people's current needs, although the registered manager was in the process of recruiting additional staff to make sure they were available for late evening shifts up until 10pm. This was to assist the two night staff help people to settle in bed; the night staff were on duty from 8pm to 7am. There were four care staff on duty during the day and the registered manager worked Monday to Friday during usual office hours; they were available on call if required out of hours. Staff told us they had time to spend with people although it was busy. They also said morale was very good and they enjoyed working at the service. There was ancillary staff such as catering, housekeeping, maintenance and administration on duty each day. The registered manager told us they did not use agency staff but had their own bank staff to cover short notice absences. The registered manager was also recruiting a deputy manager and an activity coordinator.

Comments from people who used the service about staffing levels were generally positive. They said, "There's always plenty around and if there are any problems they will talk to me; they always ask if you want to see visitors", "I use the call button if I need care and they always come within five minutes, even at night; we often banter together" and "Yes definitely, [enough staff] but they don't sit and chat." Other people said they would like to see more staff but they did state there had been no adverse impact on them regarding staffing numbers. A relative stated, "Its [staffing levels] okay, I have been visiting for 14 years; staff are very busy and there have been lots of changes."

Visiting health and social care professionals said, "As I have only visited twice for short periods, I feel I cannot give a consistent answer, however on both occasions a carer has been available to assist in our visit" and "Yes, [there are sufficient staff on duty]."

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 so that they can 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 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. We found the provider and registered manager were working within MCA on some occasions and had made appropriate applications for DoLS to the local authority. However, there were other people who met the criteria for DoLS and this had not been recognised and applications had not been made. This meant the people may have deprived of their liberty unlawfully.

We also found there was an inconsistency regarding the completion of documentation for restrictions such as bedrails and sensor mats, when people lacked capacity to agree to them. This was discussed with the registered manager who told us they would audit the care files of people this applied to and check capacity assessment and best interest decision-making records were in place.

Not consistently working within the MCA and DoLS was a breach of Regulation 11 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. You can see what action we have asked the provider to take at the back of the report.

Staff knew how to gain consent from people during their day to day interactions and people who used the service told us staff asked their permission before carrying out care tasks. They also said they could make their own choices and decisions. Comments included, "Yes, I can go out with people", "I choose what I do; I fill in a diary every day and I please myself", "I get up at 6am every morning and I watch television at night; nobody bothers me", "I choose, nobody tells me what to do; I do as I like" and "It's my choice completely [to get up or stay in bed]." A relative said, "She is in control."

We found people's health care needs were met. Care records showed people had access to a range of health care professionals such as GPs, community nurses, dieticians and opticians. Staff contacted emergency services as required and used the out of hours call centre for advice. In discussions, it was clear they were knowledgeable about how to prevent pressure ulcers and urinary tract infections from occurring and the actions to take should they occur. People confirmed staff contacted their GP when required. A relative said, "They went to hospital a couple of weeks ago with chest pains; the home were very quick to call an ambulance."

When asked if staff provided effective care, health professionals said, "Staff within the home are very

effective at recognising actual and potential problems and referring on. Any advice provided is followed, for example pressure area care" and "The patient I have visited was admitted with pressure ulceration of various stages. From assessment to first review [four weeks] the pressure damage had reduced from 11 areas to four and all areas appear healed or healing. All records, positional change chart and diet and fluid chart, hygiene checks have all been documented and patient's wounds have improved."

We found people's nutritional needs were met. Each person had an assessment to establish any nutritional risk such as a poor food and fluid intake or weight loss. People were weighed in accordance with risk analysis either weekly or monthly. We saw people had been referred to dieticians as required for advice and treatment. The menus were set over a four week period and provided people with choices and alternatives. The cook showed us the information they had been given by care staff regarding people's nutritional needs and told us that any changes were written in a communication book and checked daily. The cook catered for special diets such as for those people with diabetes or those that required a pureed diet. The cook confirmed staff had access to the kitchen after they had gone home so that people who used the service could have additional food if they requested it.

We observed the mealtime experience for people and saw this was a calm and social time. All meals taken to bedrooms, for people who chose to eat them there, had plate covers on to help keep them warm. However, we noted the plates were cold. This was mentioned to the registered manager to address with catering staff. Staff assisted people to eat their meals in a sensitive way; they chatted to people and encouraged them when required. Comments from people about the food included, "There's always choice and they ask if you want any more; the fishcake, chips and peas are really nice" and "There are good choices and enough to eat; I can eat anything and you can ask for a sandwich anytime." One person told us they were on a special diet and the staff knew what they could and could not eat.

We saw staff had access to appropriate training, supervision and support. The training record indicated when staff had completed training and when updates were required. Staff confirmed they received an appropriate level of training and supervision. The registered manager told us appraisals were yet to be completed. People who used the service told us they thought staff had appropriate skills. One person said, "They help me to my wheelchair and take me in the lift." A relative said, "You can't fault them [staff]."

Good

Is the service caring?

Our findings

People who used the service told us staff were kind and caring. They also said staff respected their privacy and dignity. Comments included, "It is alright here; staff are really good and everyone is friendly", "I've seen staff help people; they really take care of guests, as we are called", "I like it; I have my own room and carers are quite good", "I am content here." Other people said, "It is good; the carers come up and have a chat", "They are very good; we have a bit of banter and we have a laugh", "They're very pleasant and I think they listen" and "It is very quiet but that's a good thing." A relative said, "They are quite content here and happy with things. I can't fault them; the caring is just brilliant. Staff are polite."

Comments from health and social care professionals were positive about the staff team and their approach with people. Comments included, "Staff have been pleasant and approachable; extra measures have been put in place to aid communication for the patient I visit", "I have frequently observed staff promoting independence and choice, for example, choice over meal selection and clothing", "A patient was admitted with communication difficulties and all the staff did everything they could to allow the patient to communicate their needs", "Whilst assisting with my visits, carers have offered reassurance and maintained dignity" and "Staff have been very supportive and encouraging and helped service users to be as independent as possible. They also supported with family relationships."

We observed positive staff support during the inspection. Staff spoke with people in a kind and patient way, they stooped to an appropriate level so eye contact could be made and they were attentive to people's needs. One member of staff sat by a person with bowl of water and attempted to trim and clean their fingernails; this was only partially successful as the person asked them to stop which they did. Staff said they would try again later. We saw staff chatted to people throughout the day and asked them if they needed items such as tissues or a drink. The staff knew people well and we heard them ask about their relatives and what they wanted for lunch and the evening meal the next day; we observed staff were friendly and chatty. We saw staff used tongs and serviettes to serve biscuits to people instead of picking them up with their fingers.

People were provided with information and explanations so they could make informed decisions. We observed staff assisted a person from a chair into their wheelchair; they provided explanations of what they were going to do first. There were notice boards which contained information about menus, results of surveys and minutes of meetings. There were guides for people about the services on offer within the home.

In discussions with staff it was clear they knew how to promote people's privacy and dignity. They said, "We make sure curtains and doors are closed during personal care" and "We knock on doors before entering and make sure people are covered up." During the inspection, a pharmacist had visited to complete medication reviews; we heard staff ask people if they wanted to talk to the pharmacist and when they said yes, they asked if they wanted to speak with them privately.

We noted two toilets didn't have privacy locks and staff used a sign to let others know when they were occupied. The registered manager told us they would ensure privacy locks were fitted as soon as possible.

We saw people's care records were held securely in the dining room and staff personnel files were held in the registered manager's office. Computers were password protected and the provider was registered with the Information Commissioners Office, a requirement when computerised records were held. Staff were aware of the need for confidentiality when discussing people's care needs or making phone calls to health professionals.

Requires Improvement

Is the service responsive?

Our findings

When asked if staff were responsive to their needs and delivered care in line with their preferences people said, "It is sufficient", "Absolutely, I go to shops with carers for tonic water every two days", "My keyworker looks after me like a Mum", "They do enough; if you ask them, they do it", "I'm quite happy with the care" and "They meet my needs; it is good."

A health professional said, "Communication from all staff at Churchill House is very good."

The provision of activities was limited and records completed by staff indicated only a small number of people participated fully in them. There was no activity coordinator; care staff told us they completed activities each day in the afternoons. However, as care staff could be called away to provide other support to people, there was a risk this could affect activity provision. The registered manager confirmed there was no activity coordinator in post yet but recruitment was underway.

Some people spoken with said they were happy and preferred to remain in their bedrooms watching television, reading or completing quiz books. Other people said they would like to have more activities and at times they could be bored. Everyone said they enjoyed visits from their relatives. Comments included, "They asked me once if I wanted to do something but I didn't; I would like some though now", "My relatives take me out", "There are none; I do word searches to pass the time", "Sometimes there are dominoes or cards and we had an artist in the other day", "I watch television in my room", "I like to stay in own room; I have plenty to amuse myself", "There are none really; I like to watch television in bed and keep myself to myself" and "I've never seen any activities."

Care staff told us they had sing-a-longs, skittles and board games and had singers in occasionally; the last one was two weeks ago. They said the registered manager had plans to organise trips out but these hadn't occurred yet. We saw links had been made with a local woman's group who visited and brought in knitted items for people. We saw they had provided a doll with knitted clothes for one person living with dementia to use as part of their doll therapy; we saw this gave the person some comfort.

We recommend the provider and registered manager seeks advice from a reputable source regarding appropriate and meaningful activities for people living with dementia and to follow through with the recruitment of a designated activity coordinator.

We saw people had assessments of their needs, including risk assessments prior to admission, which enabled staff to plan care in ways the person preferred it to be delivered. The registered manager also received assessments completed by the local authority, which funded the placements and immediate discharge letters when people were admitted from hospital. We found there were five different assessments completed for people on admission to the service which duplicated information. We spoke with the registered manager about streamlining this system.

Care plans were developed from the information and a care needs summary completed to give staff a quick

'at a glance' list of important care issues. The care plans described people's care in an individualised way. For example, one person had communication difficulties and the care plan explained how staff were to manage this and who to contact as an interpreter. Some people's care plans were more comprehensive than others and the registered manager told us they had audited them and had started the process of re-writing them in a more detailed way. This would ensure staff have up to date and full written information about how to deliver care to people.

In discussions with staff, it was clear they knew people's needs very well. This was confirmed in observations we completed throughout the day. Staff had worked in a very person-centred way to improve communication with two people who had difficulties in this area. For one person, staff had developed prompt cards to aid communication and had an 'app' on their mobile phones to assist with language translation when required. A health professional visited daily to speak with the person and their family was very involved.

Bedrooms were nicely personalised and all had call bells and leads present so people could request assistance when required. The majority of bedroom doors had photos of the occupant and their name on it to help people living with dementia find their room.

The provider had a complaints policy and procedure which detailed timescales for investigation and outcome. The complaints procedure was included in information provided to people who used the service. People told us they were able to make complaints and knew these would be addressed. They said, "I would tell any of staff but I've never had to [complain]" and "I would ask for the boss; I've never had to." Every person spoken with told us they did not have any concerns or complaints.

Requires Improvement

Is the service well-led?

Our findings

People who used the service told us they were happy with the way it was managed. Comments included, "Definitely yes [well-managed]; I can't think of anything to improve" and "Yes, I'm perfectly happy." A relative said, "From what I see, all is okay."

Health and social care professionals said, "Feedback to me via the district nurse team is positive", "The manager is excellent at keeping in touch with myself about any issues" and "The manager is very visible around the home. They communicate well with our team and ensure any advice we have given is followed."

An annual quality monitoring system had been implemented and consisted of audits, questionnaires and meetings so people could express their views. Audits were carried out on specific topics every four months. We saw results of audits for the period between February and May 2017 for staff training, personal care, laundry, health care, medicines and care plans. The outcomes were scored in percentages. The registered manager provided an action plan which was the culmination of the previous quarter's audits; this indicated the shortfalls identified, what action was needed, who was responsible and the date it was completed; most of the actions had been completed. In light of issues found during this inspection, there needs to be a more thorough and regular check made of the environment to analyse potential risk areas. The provider had developed a refurbishment plan for the following year.

Surveys had been completed between February and May 2017 and the results were pinned to the notice board in a 'You said, we did' format. Comments from people referred to a request for more activities/entertainment and refurbishment. We saw during the inspection this has partially been actioned. For example, two new light fittings have been installed and new carpets laid in the sitting room, entrance, stairs, corridors and upstairs landing. Non-slip flooring had also been laid in the dining area and new dining tables and chairs provided. However, the provision of a full activity programme had not been completed yet. Some people who used the service were unaware surveys took place. A relative said, "I have attended a meeting; the last one was last year to inform us of changes and refurbishment. I've filled in a survey but can't say if there are any changes from it. One thing I will say is that the place is very clean."

There was refurbishment and redecoration plan for the service. The work was extensive and covered all communal areas, bedrooms and specific rooms, such as the provision of a sluice and an upgrade of the laundry. It is recognised the refurbishment and redecoration plan will be undertaken over the next 12 months to upgrade the building and will provide an enhanced environment for people when completed.

We recommend the provider follows through with the refurbishment plan to improve the quality of the environment for people and develops a more robust system to analyse environmental risks.

We spoke with the registered manager about the culture of the organisation and their management style. They told us the provider was very accessible, kept in contact, completed regular, fortnightly visits to the service and held meetings with the staff team; the last one was in August 2017. We saw that action had been taken when staff reported they were struggling in the evenings so the provider agreed to an additional

person to work 4-10pm. During visits the provider spoke with the registered manager, staff and people who used the service and checked the environment. This showed us the provider was interested in what happened at the service and had general oversight.

The registered manager was aware of their responsibilities in informing the Care Quality Commission and other agencies of accidents and incidents which affected the safety and welfare of people who used the service. We received notifications in a timely way. There were very few accidents or incidents that occurred in the service and these were managed appropriately.

Staff told us they felt supported by the registered manager. Comments included, "Its lovely working here; the staff team is good and morale is good", "They [registered manager] are very approachable and supportive" and "We have staff meetings frequently."

The provider's statement of purpose focussed on the provision of quality care and support to people and listening and including them so they could influence how the service was delivered. Improving the environment and an investment in staff was also highlighted. The registered manager said, "It really is a good company. They are very interested in the care side and listen to me when I say I need something", "We are in the process of making a garden space for people, fencing it off and making it secure" and "I believe in an open-door policy; if staff are struggling, they come and get me to help." During the inspection, we saw this happened in practice when the registered manager gave medicines to people at lunchtime as the senior care staff were busy.

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 11 HSCA RA Regulations 2014 Need for consent The provider had not consistently acted in accordance with the Mental Capacity Act 2005 in relation to when people were unable to give consent because they lacked capacity. They had also not consulted with the local authority when there was the possibility some people met the criteria for a Deprivation of Liberty Safeguard.