Gemini Care Limited

Winchley Home

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

We carried out an inspection of Winchley Care Home on 19 April 2017. The inspection was unannounced.

Winchley Care Home is registered to provide accommodation and personal care for up to 41 older people, some of whom may be living with dementia. At the time of the inspection there were 36 people living at the home.

At our last inspection of this home, we judge the home to have on overall rating of "Good". At this inspection the expected standards had not been maintained and that improvements needed to be made. We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (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.

During this inspection people said they felt safe and that staff treated them well. Safeguarding adults' procedures were in place and staff understood how to protect people from the risk of abuse. Most risks to people's safety had been assessed however, actions had not always been taken to protect people from the risk of avoidable harm. Staff did not always provide support or monitoring of people's safety as identified in these plans.

There were sufficient staff numbers on duty to keep people safe and to meet people's needs. Robust staff recruitment procedures were in place which ensured only those staff deemed suitable to the role were in post.

Policies and procedures were in place to guide staff with the safe ordering, administration, storage and disposal of medicines. Medicines were managed, stored, given to people as prescribed and disposed of safely by trained staff.

Staff had completed an induction programme when they started work and they were up to date with the provider's mandatory training. The registered manager and staff completed training in the main principles of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and acted according to this legislation. However, not all people had assessments of their mental capacity completed where required. Review of some people's assessments did not take place regularly.

There were appropriate arrangements in place to support people to have a healthy diet, but there was limited choice and flexibility at mealtimes. People had access to a GP and other health care professionals when they needed them.

Records to monitor people who were at risk of not eating and drinking enough were not always completed accurately by staff. Changes in people's support needs were not always updated in all of the records provided for staff to use.

Staff provided people with care in a respectful, caring, kind and compassionate way, however people were not always provided with enough activity and stimulation on a daily basis.

Staff consulted people living in the home about their care needs and involved them in the care planning process. People were comfortable and relaxed with staff. Although staff knew what people liked, they did not always offer people choices.

The service had a complaints procedure available for people and their relatives to use and staff were aware of the procedure. The registered manager took action to address people's concerns and prevent any potential for recurrence. There was an open culture within the service and people were freely able to talk and raise any issues with the registered manager and staff team.

Systems were in place to monitor the quality of the service provided but they were not all effective in identifying issues around the home. Although regular checks were undertaken on all aspects of care provision, these did not always identify shortfalls in the quality of care provided to people.

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.

There were arrangements in place safeguard people from avoidable harm and abuse.

Risks to people were not always identified or managed with actions taken to reduce them.

There were enough staff available to support people in a timely way.

People were supported by staff to take their medicines safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Assessments of people's capacity to make decisions were not in place for all people in the home who needed them. Most staff asked people for their consent before completing a task but this did not always take place.

People who were at risk of not eating and drinking enough were not all being monitored effectively.

People had access to other healthcare facilities and were able to see health professionals when they needed to.

Is the service caring?

Good

The service was caring.

Staff had developed positive and caring relationships with people.

Staff ensured people's privacy and dignity were promoted.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People were not always provided with opportunities to engage in meaningful activity or conversation. Peoples own choices were not always sought by staff.

There was a complaints procedure in place.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Systems for monitoring, assessing and improving the quality and safety of the service were not operating effectively.

The registered manager was visible, people and staff felt that they were approachable.

There was a friendly, open and positive culture which encouraged good communication.

Winchley 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 unannounced inspection took place on 19 April 2017 and was carried out by two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using a service or caring for someone who uses this type of care service.

Before our inspection, we looked at information we held about the service including notifications. A notification is information about important events, which the provider is required to tell us about by law. We also spoke with professionals from the local authority and clinical commissioning groups who had regular contact with the home.

During the inspection, we spoke with four people living in the home, three relatives, the registered manager, the care manager, three care staff and the homes cook. We also spoke with the managing director of the provider.

Some people living in the home were unable to provide us with feedback about the care they received. We therefore used the Short Observational Framework for Inspection (SOFI) which is a way of observing care to help us understand the experience of these people.

We looked at five people's care records, staff meeting minutes and medication administration records and audits. We checked records in relation to the management of the service such as health and safety audits and staff training records.

Requires Improvement

Is the service safe?

Our findings

At our last inspection of this home, we rated this key question as "Good". At this inspection we found that these expected standards had not been maintained and that improvements needed to be made.

Risks associated with people's care needs had been assessed however, these assessments did not always include enough detail about the risk or the actions that needed to be taken to reduce them. We also found that risks that staff were able to tell us about, were not always included in the persons plan. For example, we were told that one person had a history of putting tissues in their mouth, which presented a choking risk. We observed that staff gave the person tissues, although this presented a risk to them. This information was not detailed in the persons care plan. Staff also explained to us that another person required the use of a pressure relieving cushion when they were sitting. Neither of these risks were identified in their care plan. We saw that one person who had guardrails on the side of their bed to prevent them from falling out, had a significant gap at the end of the rail, which presented an entrapment risk. The last risk assessment that took place in December 2016 detailed that there was no gap and therefore no risk. We brought this to the attention of the registered manager who assured us that they would review this immediately.

One care plan we reviewed did not contain a risk assessment for the person's safe moving and handling whilst using a hoist. Staff supporting this person were not aware if the sling they were using was the appropriate size, but stated that this was the allocated sling for that person. The markings that would identify the slings size and serial number were not present. This meant that staff could not be sure that they were using equipment that was safe and appropriate for that person.

Where people were at risk of not eating or drinking enough, this had been identified and they were monitored. People were weighed monthly, and a universal screening tool was completed so that any trends could be identified and actions taken if required. However, we saw that the screening tool for two people was not always calculated, or calculated correctly. This meant that the correct actions could not be taken as the information to indicate this was incorrect.

We saw that in people's bedrooms, unsecured tubs and bottles of prescribed creams and lotions were accessible. This presented a risk to people living with dementia in case of accidental ingestion. The registered manager told us that this had been covered in a risk assessment for people's toiletries, however this risk assessment was not specific and did not consider other people living in the home entering the room.

We saw regular checks and audits had been completed in relation to fire, health and safety and infection control. However, we found that these audits had not identified some potential health and safety issues. This included the hot tap in the visitor and staff toilet not working, meaning that users could not wash their hands effectively.

We also saw that a kitchenette and servery area adjacent to a dining room had cluttered and dirty work surfaces, as well as a refrigerator that had out of date food stored within. The registered manager told us

that this was an area that was only used by the staff, but agreed that the area needed to be cleaned and tidied. However, we observed during our lunchtime observation that the area had been in use for the serving of meals to people living in the home. The registered manager told us that this room was not checked as part of the homes regular audit schedule, and was unaware that staff had begun to use it when supporting people at mealtimes. They agreed to address this, and include all areas of the home within their audit process.

This meant that some identified risks to people, and the planned actions to help mitigate them, were not adhered to or adequately monitored by the registered manager or staff. We concluded that systems for managing and minimising risks did not properly contribute to people receiving safe care and treatment.

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

General risk assessments had been carried out to assess risks associated with the home environment. These covered such areas as fire safety, the use of equipment, infection control and the management of hazardous substances. The risk assessments were reviewed on an annual basis unless there was a change of circumstance. We saw there were plans in place to respond to any emergencies that might arise and these were understood by staff. We saw that all people had a personal emergency evacuation plan, which detailed the assistance they would need in the event of an urgent evacuation of the building. This helped to reduce risks to people living in the home from hazards associated with the premises.

We saw records were kept in relation to any accidents or incidents that had occurred at the service, including falls. All accident and incident records were checked and investigated by the registered manager to make sure that responses were effective. They identified if any changes could be made to prevent incidents happening again. The registered manager had made referrals as appropriate, for example to the falls team or the persons GP. They also carried out a monthly analysis of accidents involving falls in order to identify any patterns or trends.

All of the people we spoke with told us they felt safe and secure in the home. One person said, "The staff are thoughtful, friendly and helpful, I feel safe here." Relatives visiting the home supported these comments. One relative told us, "They are safe here."

The provider had taken suitable steps to ensure staff knew how to keep people safe and protect them from the risk of abuse. There was an appropriate policy and procedure in place which included the relevant contact details for the local authority. The procedure was designed to ensure that any safeguarding concerns were dealt with openly and people were protected from possible harm. The registered manager was aware of their responsibility to report issues relating to safeguarding to the local authority and the Care Quality Commission.

Staff understood their role in safeguarding people from harm. They were able to describe the different types of abuse and actions they would take if they became aware of any incidents. All staff spoken with said they would report any incidences of abuse and were confident the registered manager would act on their concerns. Staff were also aware they could take concerns to organisations outside the service if they felt they were not being dealt with. Staff said they had completed safeguarding training and we saw records confirming this.

We looked at how the provider managed the deployment of staff. People told us there was sufficient staff on duty. One person told us, "There always seem to be enough staff here." Another person told us, "If I need to

talk to someone, there's normally someone available." Staff we spoke with felt that there were enough staff on duty and that they could respond to call bells quickly. People living in the home, and our own observations confirmed this. We observed that people's requests for support were responded to in a timely manner, and that staff were usually present within the communal areas.

The home had a rota which indicated which staff were on duty during the day and night. We noted this was updated and changed in response to staff absence. We saw evidence to demonstrate the registered manager continually reviewed the level of staff using an assessment tool based on people's level of dependency. In addition to the care staff, there were also ancillary staff including a cook, maintenance and cleaning staff. We found that there was enough staff on duty to keep people safe and meet their needs.

We looked at the recruitment records of three staff members and spoke with a member of staff about their recruitment experiences. The recruitment process included a written application form and a face-to-face interview. The applicants were asked a series of questions at the interview which were designed to assess their knowledge and suitability for the post. We also saw two written references and an enhanced criminal records check had been obtained before staff started work in the home. This meant the provider only employed staff after all the required and essential recruitment checks had been completed.

During the inspection, we looked at how information in medication administration records and care notes for people living in the service supported the safe handling of their medicines. When we asked people and their relatives about their medicines, they told us that they received them on time. Medicines prescribed were stored safely for the protection of people who used the service and at correct temperatures. Supporting information was available to assist staff when giving medicines to individual people. There was personal identification information on each person's record to help ensure medicines were administered to the right people and information about how they preferred to take their medicines.

When people were prescribed medicines on an 'as and when required' (PRN) basis, there was written information available to show staff how and when to give them these medicines consistently and appropriately. Records showed that people living at the service were receiving their medicines as prescribed. Frequent internal audits were in place to check records and monitor and account for medicines. These were overseen regularly by the registered manager.

Medicines were stored securely in a locked cupboard and there were appropriate processes in place to ensure medicines were ordered, administered, stored and disposed of safely. Staff authorised to handle and administer people their medicines had received training and had been assessed as competent to undertake medicine-related tasks.

Requires Improvement

Is the service effective?

Our findings

At our last inspection of this home, we rated this key question as "Good". At this inspection we found that these expected standards had not been maintained and that improvements needed to be made.

The Mental Capacity Act (MCA) 2005 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 2005. 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 2005, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the provider had policies and procedures on the MCA and staff had received training in this topic.

However, staff we spoke with had varying degrees of knowledge and understanding of the principles of the Act. They understood how to support people to make certain decisions, for example showing them clothes to wear so that they could make a choice. However, where people did not have capacity to make decisions, staff where unable to describe how they should support a person in their best interests.

We saw in people's care plans that assessments of people's capacity had been completed. However, not all of these had been reviewed or updated. In one instance, the assessment had been completed in 2013 and not updated since. Staff told us that some people living at the home had fluctuating capacity, however this was not detailed in these people's care plans or MCA assessment.

Staff told us they asked for people's consent before providing care, explaining the reasons behind this and giving people enough time to think about their decision before taking action. However, we observed that staff did not always ask people for consent before performing certain tasks and did not always offer choice. Some staff practice we saw demonstrated that staff may have assumed the person could not consent. This was because we observed some of them making decisions for people without asking them or supporting them to make a decision. For example, we saw a person being taken through the main dining area to another area of the home to eat their meal. They were not asked if this was their choice. Staff told us that the person's capacity to make decisions fluctuated, meaning that sometimes they could make their own decisions and therefore should be given choices. Another person had a tabard placed over them at lunchtime without being asked if that was what they wanted.

We concluded that staff did not always seek peoples consent before providing them with support. Although staff had undertaken training in the principals of the MCA, their knowledge was not sufficient to ensure that these principals were always followed.

The registered manager understood when an application for a DoLS authorisation should be made and how to submit one. This ensured that people were not unlawfully being deprived of their liberty.

The people and their relatives we spoke with told us they felt staff were appropriately trained and had the necessary skills and abilities to meet their needs.

We looked at how the registered manager trained and supported their staff. We found all staff completed induction training when they commenced work in the home. This included an initial orientation induction, training in the organisation's policies and procedures and mandatory training. The registered manager told us that they had not yet started assessing new staff to complete the Care Certificate but that they had plans in place to do this. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life.

Staff newly recruited to the home initially shadowed more experienced staff to enable them to learn and develop their role. All new staff completed a probationary period of six months during which their work performance was reviewed at regular intervals. Staff we spoke to told us that they felt their initial training when employed was very useful to them in completing their role. One staff member also told us that they did not feel ready to work unsupervised. In response to this, they said the registered manager had arranged additional support and supervision for them until they were confident to work on their own.

There was a programme of on-going training available for all staff, which included, safeguarding, moving people, safe handling of medicines, health and safety, Mental Capacity Act (MCA) 2005, person centred planning and proactive approaches to conflict. We looked at the staff training records and noted staff completed their training in a timely manner. The variety of training offered meant that staff were supported to have the correct knowledge to provide effective care to people. All staff spoken with told us the training was beneficial to their role.

All staff spoken with told us they were provided with regular supervision and we saw records that confirmed this. The supervision sessions provided opportunities for staff to discuss their performance, development and training needs. As part of the supervision process, the registered manager carried out regular observations of staff providing direct care. The registered manager also carried out an annual appraisal of each member of staff's work performance, and staff received regular support and feedback to enable them to carry out their roles. However, we observed some shortfalls in staffs practice, for example asking people for their consent, meaning that this support was not consistently effective.

We looked at how staff supported people with eating and drinking. People told us they enjoyed the meals provided. One person said, "I like the food, its good and there is plenty. I like to have meals in my room, on one occasion I didn't like what was on offer, I forget what it was but I didn't fancy it, the carer offered me a sandwich which was fine." We observed that refreshments and snacks were offered throughout the day. These consisted of hot and cold drinks and a variety of cakes and biscuits. People who required support to eat their meal were offered and provided this. Staff interacted with people throughout the meal and we saw them supporting people sensitively.

Weekly menus were planned and rotated every four weeks. On the day that we visited, there was only one choice of meal provided at lunchtime. We were told that this was because the home was using up supplies in the kitchen. We asked the registered manager about this who told us that this only took place on a small number of occasions through the year, and that an alternative could be provided on request. We observed lunch and saw that the dining tables were set with place settings and condiments.

People's weight and nutritional intake was recorded where it had been identified as being needed to do so. We noted risk assessments had been carried out to assess and identify people at risk of malnutrition and dehydration. However, we saw that the monitoring of people's intakes was not always completed consistently. For example, some staff recorded people's intake of fluid by the number of teaspoons taken, whereas others recorded the amount of millilitres drank. Targets for people whose fluid intake was monitored had not been set, meaning that staff did not have a benchmark identified as to whether a person was not drinking enough.

People using the service and their relatives confirmed that health care from health professionals, such as the GP or dentist could be accessed as and when required. One relative told us, "If [relative] needs to see someone like an optician or dentist, the manager will organise it." Records showed people were registered with a GP and received care and support from other professionals, such as the chiropodist and the district nursing team, as necessary.

Good

Is the service caring?

Our findings

At our last inspection of this home, we rated this key question as "Good". At this inspection we found that these expected standards had been maintained.

People told us the staff treated them with respect and kindness. One person said, "If you're not happy here, you won't be anywhere." Another person commented, "The care is very good, they are kind, considerate and caring, and I like it here." Relatives gave us positive feedback about the staff team. One relative said, "I think they look after [relative] really well." Relatives spoken with said they were made to feel welcome in the home.

We observed that most staff interacted in a caring and respectful manner with people living in the home. For example, one person who was new to the home and had a visual impairment, was guided by a carer who explained their surroundings to them. Staff also acted appropriately to maintain people's privacy when discussing confidential matters or supporting people with personal care. We observed appropriate humour and warmth from staff towards people using the service. People appeared comfortable in the company of staff and had developed positive relationships with them. We saw staff dancing with people who wanted to, or sitting and holding their hand, talking quietly to them. On one occasion, staff noticed that one person appeared to be getting cold, so they asked them if they would like a blanket. The overall atmosphere in the home appeared calm, friendly, warm and welcoming.

Staff spoken with understood their role in providing people with compassionate care and support. Staff told us that they enjoyed working at the home because of the caring and compassionate relationships staff had with people living there. We saw instances of people's independence being valued and upheld. Staff spoken with gave examples of how they promoted people's independence and choices, such as supporting and encouraging people to maintain and build their mobility. People said they made choices throughout the day regarding the time they got up, went to bed, whether they stayed in their rooms, where they ate and what they ate. For example, one person told us, "I choose when I get up and take myself to bed, and I can look after most things myself, I put new batteries in my hearing aid."

The staff were knowledgeable about people's individual needs, backgrounds and personalities and were familiar with the content of people's care records. Most people that we spoke to were not aware of their care plan, or had no desire to be involved in the development of it. One person told us, "I leave that to the carers." People were also able to express their views by means of daily conversations, satisfaction surveys and residents' meetings. The registered manager told us that people were encouraged to attend these meetings, however most people chose not to, and that this was respected.

The registered manager and staff were considerate of people's feelings and welfare. The staff we observed and spoke with knew people well. They understood the way people communicated and this helped them to meet people's individual needs. People told us that staff were available to talk to and they felt that staff were interested in their well-being. People were supported to be comfortable in their surroundings. People told us they were happy with their bedrooms, which they were able to personalise with their own belongings

and possessions. This helped to ensure and promote a sense of comfort and familiarity.

Some people chose to spend time alone in their room and this choice was respected by the staff. We observed staff knocking on doors and waiting to enter during the inspection. There were policies and procedures for staff about caring for people in a dignified way. This helped to make sure staff understood how they should respect people's privacy, dignity and confidentiality in a care setting.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection of this home, we rated this key question as "Good". At this inspection we found that these expected standards had not been maintained and that improvements needed to be made.

The home had staff that had dedicated time within their role to organise and provide activities. External entertainers visited the home and included musicians and singing acts, people told us that they enjoyed this and looked forward to it. Most people we spoke told us that staff found the time to sit and talk with them, but that the activities provided could be improved. One person told us, "There's not a lot on offer." Another person told us that they sometimes became bored.

During our observation on the morning of the day we visited, we saw that there were no activities, and that staff interaction with people was limited. However, during the afternoon a game of skittles had been arranged which people engaged happily with. Some staff engaged in conversation with people, or took the time to sit and look at a magazine with a person.

We saw that there was a weekly programme of activities arranged, which was displayed on a notice board. However this programme was not followed, and activities were arranged on an ad hoc basis. The registered manager told us that the activities co-ordinators had received training in reminiscence therapy, which had been specifically designed for supporting people living with dementia. They went on to tell us that activities were arranged on the day of the event, and that it was dependent on factors such as weather, and the mood of the people living in the home. The registered manager acknowledged that this could lead to confusion. We concluded that the opportunities for people to engage in conversation or activities were varied and reliant upon the actions of individual members of staff rather than an ingrained and organised approach.

An assessment of people's needs was made before they came to live at the home. These assessments helped to inform care plans for the person and records showed that people and their relatives were encouraged to be part of this process. People's preferences, their personal history and any specific health or care needs they had were documented. For example, we saw that peoples preferred times of getting up in the morning or going to bed in the evening were detailed. We also saw that people were asked for their preferred gender of care staff to support them with personal care, and how often they wished to take a bath or shower.

Although people's preferences had been assessed, we found that people were not always able to exercise choice and control in their daily living. For example, we saw that some people were not able to leave the dining room when they had finished their meal because the exit door had a key code lock to which they did not have the code. A staff member asked people to wait for a short amount of time as they were helping another person take their medicines. Care plans did not show that staff had assessed if people could uses the code themselves, or that there was a risk to them to be given access to the code and leave the room unescorted. We spoke with the registered manager about this who agreed that there was no reason for the door to be closed.

During the lunchtime meal, we saw that people could not access the dining room until a staff member let them in. One person told a member of staff they were hungry but were told they would have to wait until the cook was ready to bring the meal through. Another person also told us that they were very hungry and was having to wait. As soon as the cook was ready, the staff member told people and they all stood and ascended into the dining room at the same time. People were not given the option of when they wanted to eat as there was one serving time available for lunch and the same for the evening meal. We saw that the evening meal choice had been advertised on the notice board as 'resident's choice'. We asked the registered manager what this meant, they told us that people could have whatever they wanted. However, we saw that people were not asked what they wanted for their evening meal, and that once sat in the dining room, were offered two types of sandwiches that had already been made. During the lunchtime meal, only one choice was on offer, and people were not asked if they would like an alternative. Meals came to the table already plated, and had gravy added to them with asking the person whether they would like this or not. We concluded that some people were not always able to have full choice and control in their daily lives and were sometimes restricted by the routines and timings in place.

We saw that each person had a care plan in place however, these were brief in nature and formed more of a monthly update of a person's welfare rather than a detailed plan of care. This meant that it was difficult to identify what level of care a person required, and how this should be provided. We saw that each care plan contained an assessment of peoples physical and mobility support needs. However, we found that these assessments did not accurately reflect what was contained in other sections of people's care plans. For example, we saw for one person that it stated they used a hoist for transfers, but in other sections, it stated that they could transfer using a walking frame. We saw that another's persons care plan stated that they needed to be prompted to put in there hearing aids. We saw that this person was not wearing them on the day of our inspection. Staff told us that the person did not wear them because they did not like them and would throw them on the floor. The person's care plan did not reflect this, or detail how to support them with their hearing loss. The registered manager acknowledged that these plans were not up to date and could cause confusion to new staff not familiar with the person, and agreed to address this.

The provider's complaints policy was displayed in the entrance to the home. We saw any concerns or complaints were investigated and actions from these were implemented. Records showed recent concerns or complaints had been addressed. The registered provider monitored all complaints and concerns reported. They worked closely with the registered manager to ensure the appropriate management of these.

Staff were encouraged to have a proactive approach to dealing with concerns before they became complaints. Staff welcomed visitors in a warm and friendly way and relatives felt able to express their views or concerns and knew that these would be acted upon effectively.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection of this home, we rated this key question as "Good". At this inspection we found that these expected standards had not been maintained and that improvements needed to be made.

We looked at the arrangements in place for quality assurance and governance. Quality assurance and governance processes are systems that help registered providers to assess the safety and quality of their services. We saw that there were systems in place to monitor the quality of the service, and quality audits were undertaken. However, these had not been effective at identifying the shortfalls in the service that were identified during our inspection. We found that record keeping processes needed improvement. Care records were not always kept up to date with changes in people's care need. Records did not always accurately reflect the care that people had received.

Risks were not always managed effectively, this included areas such as choking hazards, food safety and the safe use of equipment. Monitoring of people's intake of food and drink was incorrectly assessed and care records did not always contain enough information to enable staff to support people effective. For people who lacked the capacity to be able to make decisions, this had not always been assessed or identified in their care plan. Assessments of people's capacity that had been undertaken, were not regularly reviewed. Oversight of staff performance by the registered manger did not ensure that their practice promoted people's choice and control over their daily lives. We spoke with the registered manager about this who agreed that a more robust and comprehensive system needed to be implemented to ensure these shortfalls were addressed.

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

People and their relatives told us they were satisfied with the service provided at the home and the way it was managed. They said that the manager was very approachable and visible. One relative told us, "I usually visit four times a week, and I see the manager just about every visit." Another relative we spoke with told us, "I have recommended this home to a number of people now, I would have no hesitation."

The service was led by a manager who is registered with the Care Quality Commission. The registered manager had responsibility for the day to day operation of the service and was visible and active within the home. People were relaxed in the company of the registered manager and it was clear they had built a good rapport with them. During the inspection, we spoke with the registered manager about the daily operation of the home. They were able to answer all of our questions about the care provided to people showing that they had a good overview of what was happening with staff and people who used the service.

The staff members spoken with said communication with the registered manager and senior staff was good and they felt supported to carry out their roles in caring for people. One member of staff told us, "We get a lot of support from [registered manager], she is brilliant. We have a good team spirit and work well together, its really great working here." Staff told us they were part of a strong team, who supported each other. We

found there to be a strong culture of good team work, and morale amongst staff was positive.

There was a clear management structure. Staff were aware of the lines of accountability and who to contact in the event of any emergency or concerns. If the registered manager was not present, there was always a senior member of staff on duty with designated responsibilities. Staff told us that the provider's managing director visited regularly, and spent time with staff and people living at the home to ask for their views and opinions. They said that he was approachable and interested in the welfare of everyone living or working at the home.

We saw that people and their relatives were regularly asked for their views on the service. As part of this, people were invited to complete a satisfaction questionnaire. We looked at the evaluation and analysis of results and noted people had indicated they were satisfied with the service. We noted several people had made positive comments about the care they received.

We saw there were organisational policies and procedures which set out what was expected of staff when caring for people. Staff had access to these and they were knowledgeable about key policies. The provider's whistleblowing policy supported staff to question practice and assured protection for individual members of staff should they need to raise concerns regarding the practice of others. Staff confirmed they would report any concerns and felt confident the registered manager would take appropriate action. This demonstrated an open and inclusive culture within the service.

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 12 HSCA RA Regulations 2014 Safe care and treatment Risk to people's safety had not always been assessed or action taken to mitigate these risks. Regulation 12 (1) (2) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems for monitoring and improving the quality and safety of the service and having regard to the accuracy of records were not operating effectively. Regulation 17 (1) and 17 (2) (a), (b) and (c)