Mrs H Haddow

Eridge House Rest 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?	Good
Is the service caring?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

Eridge House Rest Home is a residential home providing care for older people in Bexhill-on-Sea. People living at Eridge House required varying levels of care and support. Many were highly independent and just required some assistance with washing and dressing and others required assistance with all care needs.

Eridge House provides local authority and privately funded long and short term (respite) periods of care.

The service is registered to provide care for up to 43 people. At the time of the inspection there were 36 people living at the service.

This was an unannounced inspection which took place on 22 and 23 June 2015.

Everyone we spoke with during the inspection was able to tell us about their thoughts and feelings about living at Eridge House, what they enjoyed and how they chose to spend their time.

Eridge House had a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like

Summary of findings

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.

Care plans had been written and reviewed regularly by the manager. However, changes to care plans were not clear, or whether people had been involved in changes to the way their care was provided.

The provider could not demonstrate that people had received all medicines and topical cream applications in accordance with prescriptions by their GPs. A number of inconsistencies were seen in medicine documentation, including temperature checks and medicine administration records (MAR) charts.

Evacuation information for night time was not clear in the fire documentation.

Quality assurance checks were completed regularly by the manager and provider to ensure that the service provided good care and continued to improve. However some areas of auditing including medicines and care records needed to be improved.

Activities were provided regularly for people when they wished to access them with regular organised activities and people told us they accessed these when they wanted to. Many people spent their time going out independently and continued hobbies and activities they had prior to moving in to the service. A number of people were seen to go out independently or with visitors, and those who chose to stay in their rooms told us this was their choice.

People's weights were reviewed when needed, with referrals made to outside agencies when people had poor nutrition or had lost weight. People who required any help or assistance at meal times had this provided in a dignified manner.

People living in the service told us they felt safe at Eridge House and staff felt supported working at the service. The manager was a visual presence at the service on a daily basis and had an 'open door' policy for staff, people living in the service and visitors.

Staff and people living at Eridge House felt staffing levels were appropriate. Staffing levels had been regularly reviewed and extra staff provided when needed. Staff told us that they had a clear chain of management to report any concerns to as "the door was always open" and it was a positive open working environment. Staff told us the manager or owner was always around and available if they had any concerns.

A training schedule was in place. With a different training scheduled each month, which would be attended by all available staff. Staff had received appropriate training and were able to demonstrate a good knowledge around recognising and reporting safeguarding concerns. Staff told us that if they identified any new training which they felt would improve their knowledge to meet people's individual needs and his was supported and encouraged by the registered manager.

Environmental and individual risk assessments had been completed. There was an organisational recruitment policy and procedure to follow when recruiting new staff. This included an in house induction for new staff.

Equipment maintenance and servicing had taken place. With environmental and maintenance audits completed to ensure the building and equipment were maintained appropriately.

Staff felt supported by the manager and work colleagues .There was a programme for supervision and appraisals to take place, this included further 'ad hoc' meetings when required and policies and procedures were in place to support staff.

Staff involved people in daily decisions and gained consent from people before providing any care or assistance. Staff demonstrated an awareness around mental capacity, choice and restraint. The manager told us that they were aware how to make an application regarding Deprivations of Liberty Safeguards (DoLS) but had not needed to do this.

People we spoke with told us the meals were lovely and without exception we received positive feedback around food and drink provided. Meals seen were well presented, with three courses at lunch time. People had a choice of meal with alternatives available when people changed their minds.

People were seen to spend their time how they wished. During the inspection we saw many examples of positive communication and interaction between staff and people. Staff responded politely and positively when they sat with people for a chat or popped into their rooms.

Summary of findings

Staff showed a clear fondness for people and cared about their care and welfare. If people appeared upset or anxious staff responded in a calm manner. People knew staff and it was apparent in their body language they felt comfortable and trusted staff to look after them.

Staff told us they were part of a team, and felt that they all shared the same values to ensure people received the best care. Staff spoke positively about the manager, the culture within the service and told us they enjoyed being part of the team.

There were no current complaints investigations in progress. Past complaints had been dealt with following the organisations complaints procedure. People told us they knew how to raise concerns if they needed to.

We found some breaches of Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what actions we told the provider to take at the back of the full version of the report.

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?

Requires improvement

The service was not consistently safe.

Although people told us they felt very safe living at Eridge House. They had not been protected against all risks associated with the unsafe management and administration of medicines.

Fire risk assessments and evacuation plans needed to be made clearer for staff especially for night time, to ensure safe evacuation of people living at the service if required.

Staffing levels were regularly reviewed with extra staff provided when required. Staff and people living at Eridge House felt staffing levels were appropriate.

Staff had received safeguarding training and understood their responsibility to report concerns.

Recruitment procedures were in place to ensure new staff were suitable to provide care.

Is the service effective?

Good

The service was effective.

Staff felt supported and received regular supervision.

A programme of staff training took place monthly.

Staff gained consent from people, and displayed awareness around mental capacity, choice and restraint.

People were very complimentary about the standard of meals and felt meal choices were varied. People's individual dietary needs were met.

Is the service caring?

Good

The service was caring.

Everyone we spoke with told us that staff were caring and supportive.

Staff knew people well and were able to tell us about their lives before they moved to Eridge House. People received care in the way that supported their preferences.

Staff spoke to people with kindness and people felt comfortable and supported by staff.

People were offered choices and involved in day to day decisions; people's independence was supported and encouraged.

People were encouraged to maintain relationships and visitors felt welcome to the service at any time.

Summary of findings

Is the service responsive?

Requires improvement 

The service was not consistently responsive.

Care plans were not in place for all care needs. Care plans in place had not been appropriately updated to ensure care was provided in a clear and consistent way.

Activities were provided and were well attended by people living at the service.

There were no on-going complaints. The manager had an 'open door' policy. Staff and visitors felt able to discuss any complaints they would be happy to raise these with the registered manager.

Is the service well-led?

Requires improvement 

The service was not consistently well led.

Auditing had identified issues with medicine administration; however direct action had not been taken to improve this.

Audits had not identified issues with care documentation which needed to be improvement.

Staff felt supported and valued as part of the team.

Staff meetings took place and feedback was being sought from people and their relatives to ensure they continued to meet people's needs.

There was an open and transparent culture, staff and management were clear about their responsibilities and the values of the service.

Eridge House Rest 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 which took place on 22 and 23 June 2015 and was unannounced.

The inspection team consisted of one inspector and an expert by experience who has experience of older people's care services. 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 looked at information provided by the local authority including contracts and purchasing (quality monitoring team). We reviewed records held by the CQC including notifications. A notification is information about important events which the provider is required by law to tell us about. We also looked at information we hold about the service including previous reports, safeguarding notifications and investigations, and any other information that has been shared with us.

A Provider Information Return (PIR) had not been requested as this inspection had been bought forward due to information received. The PIR 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.

People living in the service were able to tell us about their experiences and what it was like to live at Eridge House. We spoke with 16 people using the service and nine staff. This included the registered manager, care staff, administration, kitchen, housekeeping and other staff members involved in the day to day running of the service and one visiting professional.

We carried out observations in communal areas, looked at care documentation for four people and daily records, risk assessments and associated daily records and charts. All Medicine Administration Records (MAR) charts and medicine records were checked. We read diary entries and handover information completed by staff, policies and procedures, accidents, incidents, quality assurance records, staff and resident meeting minutes, maintenance and emergency plans. Recruitment files were reviewed for three staff and records of staff training, supervision and appraisals.

Requires improvement

Is the service safe?

Our findings

Everyone we spoke with told us they felt safe living at Eridge House. We were told, "Although I miss my own home, I know this is the best place for me where I am safe and my family do not have to worry about me". And, "When I have a bath, there is always a carer nearby to make sure I am safe." One relatives told us "I spend a lot of time away, but I know my mother is in safe hands and do not have to worry". Although people told us they felt safe we found some areas that were not consistently safe.

People had not been protected against the risks associated with the unsafe management of medicines. There were medicine policies in place however staff did not follow these when completing documentation or ensuring medicines were taken by people before they were signed for. Staff had received medicine training, however we did not see any evidence that spot checks had taken place to regularly assess competency. During the morning of the inspection one person found a tablet on the floor in their bedroom, which was later identified by staff as an antibiotic prescribed to that person. It was unclear when this tablet had been administered and why staff had not ensured it had been taken before leaving the room. MAR charts for this medicine had been signed to say it had been administered. Where people were prescribed topical medicines such as creams, records were incomplete. People told us they were unsure when their creams should be applied and that they, 'left it to the staff to sort out.' On MAR charts where creams had been prescribed by the GP to be applied four times a day, there were days when the MAR chart had not been completed at all and others with one or two signed entries to show that the creams had been applied. Staff could not demonstrate people's skin conditions had been treated as prescribed. This meant that some people had not received their medicines and topical creams as prescribed which could leave them at risk of prolonged or untreated conditions.

MAR charts for medicines also showed staff had not always recorded whether tablets and eye drops had been taken as prescribed. For example, one person had two different types of eye drops, both prescribed four times a day. We found multiple occasions when both of these had not been documented to identify whether they had been administered in accordance with the GPs prescription. This person was unsure if they had their eye drops in every day as the staff did this. This placed this person at risk of not receiving medicines appropriately and did not ensure that medicines were given in a safe and consistent way.

Medicine fridge and room temperatures were meant to be checked and logged daily. However documentation did not evidence this had been done every day in accordance with requirements to ensure that medicines are stored at appropriate temperatures. On days when the temperature was not recorded there was no evidence that this had been raised with staff. On occasions when the temperature had been recorded and was not within the temperature range expected there was no evidence of actions taken. Failure to ensure medicines are stored at appropriate temperatures could impact on the effectiveness of a medicine.

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

There was however other areas of medicine procedures that showed best practice was being followed. Medicines were stored securely in a key pad entry room. There were processes in place for ordering and disposal of medicines. Medicines were seen to be labelled, dated on opening and stored tidily within the cupboard and trolleys. There were systems in place to ensure administration of specific medicines was done with a second person checking and signing. Medicines were administered from medicine trolleys which were locked when left unattended.

Some medicines were 'as required' (PRN) medicines. People took these medicines only if they needed them, for example if they were experiencing pain. There was clear PRN guidance in peoples MAR charts about the maximum daily dose people could take in a 24 hour period and what these medicines had been prescribed for. Staff had documented when and why PRN medicines had been given.

Fire emergency plan and risk assessment had been completed by an external organisation in February 2015. The fire action for staff included a separate daytime and night-time routine. However, this did not give clear evacuation guidance for staff at night. We were told by the manager and staff rotas confirmed that two staff worked at night. The night-time fire evacuation routine stated that two staff should stay together at all times. Whereas the fire risk assessment and emergency plan stated one member

Requires improvement

Is the service safe?

of staff to take documentation and wait at the door for the fire service. Therefore there would not be two staff together to commence evacuation. This was an area that required to be improved to ensure information was clear and consistent for staff in the event of a night time evacuation.

Personal emergency evacuation plans (PEEP's) information including mobility. Some people would require the assistance of at least one staff member to evacuate due to their mobility; others would be independent and would only require verbal reassurance. Emergency evacuation information had also been included in peoples individual care files. There were contingency plans in place in the event of an emergency evacuation. Fire safety and evacuation information was seen displayed around the building. Fire alarm bells, lighting and equipment checks had been inspected and tested regularly. All staff had completed fire safety training in the last 12 months. When people were going out they informed staff and signed themselves out, so that people were aware where they were.

There was an organisational recruitment policy and procedure. Staff files included application forms, identification, although we found this did not include photographic identification to ensure that people's identity had been confirmed. This was an area that required to be improved. All staff files included two written references with one being the most recent employment. Interview notes had been completed, and each staff member had a Disclosure and Barring Service (DBS) check completed prior to commencing employment. These checks identified if prospective staff had a criminal record or were barred from working with children or people at risk. All files included a job description and contract of employment to ensure all staff were aware of their roles and responsibilities.

Staff and people living at Eridge House felt staffing levels were appropriate. Staff told us that they felt safe and well supported working at Eridge House with a number of staff having worked at the service for a number of years. They felt they had good access to training and the training provided met their needs. There were first aid training sessions taking place on the first day of the inspection, with further planned training sessions booked each month. Staff told us that they had a clear chain of management to report any concerns to as "the door was always open" and felt that it was a positive open working environment. A whistleblowing policy was in place. Staff told us the manager or owner was 'always around and available' if they had any concerns. Staff felt able to speak to the registered manager and that they would be listened to and supported.

Staffing levels were reviewed regularly. All staff told us that if people became unwell or their care needs increased they spoke to the registered manager and extra staff were allocated whilst this was needed. We saw that this had also been documented in minutes of meetings when staff had reported that specific times of the day were busier and an extra member of staff had been put in place to cover this time period. Staff told us that agency staff were rarely needed as they all covered for each other and swapped shifts if someone needed a specific day off. This meant people living at Eridge House had continuity with regular staff proving care. Staff felt this worked well, and were happy to be flexible. We saw this was evident when staff came in early or changed their shifts to ensure they were available to assist people when they had appointments to attend. Throughout the inspection we saw that people received care in a timely manner. Communication between people and staff was relaxed and easy going. This showed that people knew and trusted staff. One person told us that a certain staff member 'had been at the service as long as they had and they got on really well.'

Staff had received safeguarding training and were able to demonstrate good knowledge around recognising concerns appropriately. They told us they would raise concerns with the registered manager or owner but understood their responsibility to raise concerns with outside organisations if appropriate. It was discussed with the registered manager that staff told us they would raise a safeguarding concern with The Care Quality Commission (CQC) rather than directly with the local authority. This is not in accordance with current requirements; however the registered manager and owner were aware how to raise a safeguarding concern correctly, directly with the local authority. The registered manager told us staff would be reminded of this. Safeguarding policies and procedures were in place and were up to date and appropriate.

Accident, incident and falls audits had been completed monthly to identify trends and analysis of falls. With actions completed if any identified, for example for one person actions had been put in place to prevent re-occurrence of falls.

Requires improvement

Is the service safe?

The chance to live as independently as possible should be supported and encouraged for older people in residential care services. Eridge House supported people to maintain their independence. People who were living at the service went out alone, one person who was staying at Eridge House for a period of respite told us they went out every day just like they did when they lived in their own home. The registered manager enabled people to take day to day risks whilst ensuring measures were in place to reduce the likelihood of any harm. Throughout the inspection, we saw people freely coming and going from the home alone or with visitors.

Environmental and individual risk assessments had been completed for all identified risks, including going outside the home. These had been reviewed regularly. People had signed to say whether they wished to be checked at night or declined assistance at night unless they requested it. Moving and handling, outside activities and self-administration of medicines had also been risk assessed to ensure people's safety around the service was maintained.

Appropriate equipment maintenance and servicing had taken place. Certificates were seen for water checks, personal appliance testing as well as equipment servicing and maintenance documentation. Corridors and communal rooms were large and uncluttered which provided ease of access for people to move around unrestricted.

Good

Is the service effective?

Our findings

People received care from staff who were well trained and supported. Everyone told us that the food was very good with comments like, “Food is first class.” And, “The meals are lovely, you can have what you fancy, but I cannot fault any of the meals I have had here, especially the puddings, wonderful.”

Inductions had been completed by all staff. Staff told us they felt inductions were important and told us it gave staff the information and support they needed to provide care for people living in the service. Recruitment files for newly employed staff members included information regarding the ‘in house’ induction and confirmed this was in progress. Reviews took place weekly for the first month of employment, with further reviews scheduled until completion.

Staff received on-going support and professional development. A supervision and appraisal schedule was in place and staff confirmed they received regular supervision and appreciated the opportunity to discuss their concerns. Staff told us that they used supervision to request specific training and that this had been discussed and actioned by the registered manager. All staff told us that the manager had an ‘open door’ policy, and they could speak to them at any time if they had a concern. We saw that during the inspection staff regularly accessed the registered manager’s office.

The registered manager was seen spending time with people around the home assisting staff and interacting with people/visitors and staff throughout the day. People told us that sometimes college students are employed in the evening and weekend to help with odd jobs. Many of the staff had been working at the service for many years and knew people very well. This meant that communication was effective and people greeted staff and volunteers positively and felt comfortable chatting to them.

A training schedule was in place. Different training was scheduled to take place each month. This was done by visiting training organisation and took place at the service, with all available staff attending over the course of the day. On the first day of the inspection first aid training was taking place. We saw that many staff had come in to specifically attend the training, so this had not impacted on the number of staff available during the morning or afternoon shift. We saw that newly appointed staff completed an in house induction, and attended training.

Staff told us that they felt they had the skills and understanding to provide care appropriately to people. We were told, “The training is brilliant and it’s not just the regular training, I asked for training regarding a specific health need and the manager has organised this.” More than one staff member confirmed that they had requested training to enhance their knowledge in a particular health related area, and the registered manager had sourced and arranged this.” This had helped them to understand specific health conditions which could be shared with other staff. This meant that staff were continually developing their skills to meet the changing needs of people living in the service.

Many people had their own telephones in their rooms, and told us that if they wanted to contact someone or speak to their doctor they would do this themselves. Others told us they preferred to speak to staff and ask them to arrange appointments and visits and arrangements would be made for people to see a doctor or dentist if needed. People told us they could either go unaccompanied or accompanied by a member of staff if they wished. One visitor told us she had visited her relative and they appeared to be unwell with a high temperature. When she told her relative she would ask for the doctor to call she replied “the staff noticed I wasn’t very well and have already called the doctor.” Staff were aware of changes in people’s health and were responding appropriately. Relatives told us they were always notified of any change in a relative’s condition, or if they had a fall or became unwell.

People’s care plans included risk assessments and reviews. People’s weights were reviewed when needed with referrals made to appropriate outside organisations if needed. Records showed that people had regular access to healthcare professionals, such as GPs, district nurses and chiropodists. Documentation showed that people and had attended regular appointments for their health needs. We saw future appointments were written into a diary and discussed with the individual. Keyworkers ensured people knew when appointments were received or dates changed.

Good

Is the service effective?

The diary included messages for staff so they were aware of any appointments or visits booked for that day. Staff shared information with each other and during handover and told us they worked well as a team.

Care staff informed us how they gained consent from people, and displayed awareness around mental capacity, choice and restraint. We saw people being offered choices and involved in decisions throughout the inspection. If people did not have capacity to consent to decisions staff were aware to involve family and/or next of kin (NoK) in decisions. The manager told us that they were aware how to make an application regarding Deprivations of Liberty Safeguards (DoLS) but had not needed to do this. Where people had a Do Not Attempt Resuscitation (DNAR) in place it had been documented that they had been involved in this decision.

The dining room was located on the ground floor. Dining tables were nicely set, with condiments and napkins. People told us they normally sat at the same tables and this was their choice. A lot of people came to the dining room for lunch. Those who did not ate in their rooms, this was their choice and meals were taken up to them by staff. Meals were nicely presented and all feedback we received was extremely positive. At lunchtime there were three courses starting with a soup. The cook told us that people were asked in the morning or evening before what they wanted for lunch the following day. If people changed their minds, which happened regularly, this was not an issue as extra of each meal choice was made, and staff would just let them know what extra was needed. For people with allergies or special dietary requirements the kitchen staff were aware of this and meals were provided to meet these needs. We spoke to one person who told us they did not fancy a big lunch that day so had asked for two bowls of soup instead, and this had been provided. Tea, coffee and other cold drinks were offered throughout the day. When people requested snacks and drinks these were provided.

The building was open and light with wide stairways; stair lifts and a large passenger lift to enable people to access all areas of the building. There was easy access to the garden area, and a smoking area used by people living in the service. People told us they liked the freedom of being able to move around the service autonomously and for those who smoked they felt that they were able to do this independently.

Good

Is the service caring?

Our findings

Everyone we spoke to was consistently positive about living at Eridge House and the way staff supported them in a caring manner. We were told, "The carers are very kind, helpful and caring. They treat me like an auntie." And, "Staff are super; they are always popping in to check we are alright." Relatives told us, "When I come in sometimes one of the staff are in the room holding her hand and talking to her. That means a lot to me." A person visiting a friend told us, "I am amazed at this home. What a lovely group of kind and caring staff. Until I started visiting here, which I do every week, I didn't realise homes like this existed."

Information in care files gave staff background information about people. When we spoke with the registered manager and staff they were able to tell us about people before they moved to Eridge House. Some people had lived there for many years and had built up a close bond with staff. People were encouraged to bring in personal items and furniture. For people who were living at Eridge House for a period of respite staff had got to know them well. One person who was living there for a couple of months until they were able to return home had their own curtains and duvet put in their room to make them feel at home.

We spoke to people about how they spent their day. We saw in daily records that people's routine varied and people confirmed that they made their own choices and decisions. Everyone told us they chose what time they liked to get up, and this varied day to day. Others told us they liked to be up early and had told staff when they needed assistance with this. One person told us they liked to stay up late and catch up on the television in peace, they told us they went to bed when they were ready, and would just let staff know if they needed any help, another liked to be up in the communal lounge until they were ready to go to bed. Staff knew people very well and were able to tell us about their individual needs, for example how they liked to have care provided, or individual preferences including a glass of sherry before lunch. People told us they liked and trusted staff to look after them well.

People sat in the lounge, dining area and their own rooms. During the inspection we saw many examples of positive communication and interaction between staff and people. Staff stopped to chat to people, and It was clear that people enjoyed this interaction. They took the opportunity to check people had everything they needed and did not need a drink or any assistance. Staff popped into people's rooms to discuss appointments and make sure people knew what was happening around the home that day. For example, reminding people what was for lunch, and what activities were planned for that day. We saw examples of staff chatting to people about visitors, family members and recent events.

People responded to staff and it was apparent they felt comfortable and trusted staff to look after them. If people were distressed or anxious, staff responded swiftly showing empathy and support. One person told us, "I am fairly new here and sometimes do not sleep well and get anxious during the night. I then ring for a Carer who comes to reassure me and makes me a cup of Horlicks which settles me down. They are so good here." Staff told us that they knew how to respond when people became anxious or upset, as they knew the people well. We saw during the inspection staff sat and spoke with people ensuring they were content and did not need anything. When one person showed signs of distress staff responded kindly and took time to find out what was wrong.

People expressed to us that they particularly enjoyed chatting with younger people, and told us the college students that helped out at times were, "Lovely caring, respectful young people," and were, "a joy to have around." Staff and volunteers assisted people in communal areas offering drinks, participating in activities, supporting and chatting to people.

People were encouraged to maintain their independence whenever possible. A number of people were independent and went out alone. We saw that staff ensured people had everything they needed and that mobility scooter batteries were charged before people went out. The service helped to maintain people's independence and allowed people to be as independent as possible within acceptable parameters of risk.

People were encouraged to maintain relationships with family and friends. Outings with family were encouraged and supported by staff and the provider. Relatives were seen to visit throughout the day and told us they were always welcome at any time to pop in if they wished and felt welcomed and involved by staff. People and relatives/ visitors felt able to speak to the registered manager or owner and it was clear that this 'open door' policy was the norm, with visitors visiting the service during the inspection.

Good

Is the service caring?

When staff assisted people with personal care doors were closed and staff were seen to knock before entering people's rooms. Staff were also observed speaking with people discretely about their personal care needs. Policies and procedures were in place to support staff and ensure they were aware of their responsibility to treat people with dignity and respect at all times. People felt their belongings were looked after and staff respected the way they liked things to be done, and their personal preferences. For example one person had a daily routine which they had always followed. This was detailed in their care documentation and we saw this took place during the inspection. Everyone confirmed that they felt well cared for, and treated with dignity and respect at all times.

Requires improvement

Is the service responsive?

Our findings

People told us that they felt that the service was responsive. We were told, "I had difficulty getting out of my chair and so they provided this chair for me which tilts to help me up, it has made life so much easier." And one person told us they had their own telephone in their room and they were able to speak to their family who lived abroad whenever they wished. This meant they did not feel so isolated. We spoke to a married couple who told us that they had their own seating area to watch television together and their rooms felt like their own living space.

Care plans were in place with pre assessments completed. Although some information was provided, this was not in a clear and consistent way. For example, we saw in one person's pre-assessment that this person had a mental health concern and may become distressed. However, there was no specific support plan in place for this to inform staff how to respond if they became distressed or anxious, what may trigger this and management tactics appropriate for this individual. It was clear from observations that staff responded in a timely manner, however not all staff responded in the same way.

Care documentation included a number of changes, with care information crossed out and hand written additions included. Some care plans had a high number of changes and it was not clear when these had taken place. This meant it was difficult to get a picture of people's needs and whether they had been involved in the changes. We saw one care plan had been changed from the person wanting baths to showers. Despite looking back in their care plan and daily records over a number of weeks it was not apparent when or why this change had occurred. Personal care had been provided, however the documentation did not show this had been this persons choice.

Daily records identified when accidents or incidents had occurred and accident forms had been completed. However, when injuries had occurred these had not been documented on body maps. This meant that current injuries or wounds were not clear in care documentation. These were reported to the district nurses and GPs appropriately, but staff were not aware of wounds by reading peoples care plans as this information had not always been updated or included. Staff were therefore reliant on this information being shared during handover.

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

Private information kept about people was securely stored in the manager's office. All care staff had access to this. Further newly implemented folders and charts used to document people's daily care were either kept in folders or in the office to allow staff to complete them when needed.

There were a number of organised activities which people told us they enjoyed. Bingo was particularly popular and we saw this was very well attended in the afternoon. This was supported by staff and volunteers. A programme of visiting entertainers was on-going. People were happy with the activities on offer and did not think more was needed as many people went out or had their own things to do. Feedback was gained from people and they were involved in planning future activities and trips out. Due to peoples level of independence many people were reading, knitting, listening to music and watching television as they chose. There was a religious service once a month, and people who wished to attend services outside the home were supported to do so. For people who chose to stay in their rooms, staff and volunteers visited them in their rooms and they were encouraged to attend organised activities but if they declined their wishes were listened to. One relative told us, "My mother loves going to the musical afternoons and she seems to come to life then. The Carers never forget to take her along for that."

A complaints policy and procedure was in place. This was displayed in the main entrance area, and was available for people to access. There were no current complaints investigations in progress. The registered manager told us that when people had small concerns they would come and speak to them, therefore any small niggles could be sorted immediately before they became a formal complaint. People we spoke with confirmed that if they raised any issues with the registered manager they felt these would be responded to immediately.

Requires improvement

Is the service well-led?

Our findings

People told us the manager was, "Very nice, and always around if you need anything." And, "They are lovely, just lovely." Relatives spoke positively about the staff and manager and were seen to speak to the registered manager when they visited, popping into the office for a chat during the inspection. Staff told us, "The manager is great, if we need anything she will sort it" "The manager is really approachable." And, "The manager and owner are around most days and we can call them if we need to when they are not here."

Staff told us they were part of a team, and felt that they all shared the same values to ensure people received the best care. Policies clearly supported the 'ethos of the service' encouraging and supporting transparency and support between the registered manager and staff. Staff felt that if they had any concerns about people's practice they would challenge this and raise this with the registered manager and it would be dealt with promptly.

Audits are an integral part of the provider's quality assurance framework. Quality assurance means raising standards and driving improvement whilst promoting better outcomes for people. On a monthly basis, the registered manager completed checks of care plans. Despite monthly checks made, these had not identified concerns with inconsistent documentation or whether changes made to care plans had taken place with the involvement of the individual. This was an area that required to be improved.

Medicine audits had identified that staff were not following policies and procedures but no direct action was seen as a result of this. Competency assessments had not taken place for staff administering medicines or further training taken place. This was an area that required to be improved.

Further areas of auditing were being completed effectively; these included daily checks of domestic cleaning schedules. A maintenance plan including redecoration and refurbishment was seen, including a second laundry room being built. Staff reported maintenance issues via a book which was signed by maintenance staff when actioned.

There were a number of monthly quality assurance systems in place. Including falls, incidents, wounds, safeguarding, complaints, accidents, cleaning and falls. Incidents were looked at and analysed with regards to the number of incidents, falls or hospital admissions. Regular provider checks took place, the most recent one been completed in May 2015. Information following quality assurance checks was used to aid learning and drive quality across the service.

There were policies in place for management values including an 'Ethos of management' policy. We discussed this with the registered manager who told us this included information about the culture and values of the service. How this should be open and transparent to ensure people felt empowered to speak out if they had any concerns and to involve people and staff in the continuing development of the service. People told us they were very happy with the way the service was run. Staff told us they felt supported and that the manager had a clear picture and overview of the service and what was going on as they spent time each day on the 'shop floor' assisting staff and speaking to people and visitors.

Due to peoples level of independence and the fact that most people were able to communicate their needs, staff and registered manager felt they got valuable feedback from people. Further to this the service sought feedback from people and relatives through meetings and surveys to ensure that people's views were heard and changes taken forward to improve the service. Staff and resident meetings minutes were seen. It was noted that when issues had been identified in meetings actions had been taken to follow these up in a timely manner. Any actions taken were also documented. For example suggested places for days out had taken place or been planned. A food questionnaire was given to people every three months to gain feedback. Visiting professionals had also been asked to complete satisfaction questionnaires and people living at the service for a period of respite had been asked for their views and feedback. When questionnaires were returned, they were analysed and evaluated.

People were involved in the continued improvement of the service and their views were sought and listened to. The registered manager documented feedback from people regarding activities. Activities were evaluated with an analysis of all findings and new activities planned or preferred activities increased, for example extra bingo.

Staff told us they were part of a team, and felt that they all shared the same values to ensure people received the best care. Policies clearly supported the 'ethos of the service' encouraging and supporting transparency and support

Requires improvement

Is the service well-led?

between the registered manager and staff. Staff felt that if they had any concerns about people's practice they would challenge this and raise this with the registered manager and it would be dealt with promptly.

Staff were aware of their responsibilities during each shift and told us they helped each other out whenever they needed to. Staff spoke positively of the culture and how they all worked together as a team to support each other. A number of staff had worked at the service for a number of years. We were told, "I stay because I love it here." And we are a team." Staff were aware of the values within the service and how these influenced care provision. Staff felt that the atmosphere within the home was generally very positive and that they were listened to and felt valued as part of the team. The manager told that they always emphasised the importance of being open and honest to ensure the service was open and transparent.

The managers engaged with people on a daily basis and were open to challenge and suggestions which could improve the day to day running of the service. The manager took an active role within the running of the home and had good knowledge of the staff and the people. There were clear lines of responsibility and accountability for management and staff. The service had notified the Care Quality Commission (CQC) of all significant events in accordance with their requirements.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17(2)(c)** **Records had not been updated to show care people required, or that they had been involved in decisions.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Medicines had not always been stored or administered safely.** **Regulation 12(2)(g)**