Kahanah Care

Dene Court Residential Care Home

Inspection report

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Date of inspection visit: 27 January and 6 and 10 February 2015
Date of publication: 08/05/2015

Ratings

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

Overall summary

This inspection took place on 27 January 2015, 6 and 10 February 2015. The inspection was unannounced. The inspection was carried out by two inspectors, one of whom is a pharmacist inspector. We previously carried out an inspection on 23 September 2013 when we found the home was fully compliant with all regulations covered in the inspection.

Dene Court is registered to provide accommodation with personal care for up to 28 older people. There is a registered manager in post. 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. The

Summary of findings

registered manager was on holiday at the time of this inspection. Therefore we spoke with the provider, assistant manager and a team leader about the management of the home.

Records did not show how people had been consulted and involved in planning or reviewing their care. Most care plans provided good detail about each area of people's needs, although we also found some areas where important information had been missed, or did not provide sufficient detail. Although staff were fully aware of current risks to people's health and welfare and knew what actions they should take to reduce those risks the records did not provide evidence that the risks had been formally reviewed on a timely or regular basis. Some significant risks had not been reviewed in the previous year.

There was a happy and stable staff team, many of whom had worked in the home for several years. Staff knew each person well and understood their needs. We were given verbal reassurance that safe recruitment procedures had been followed and saw evidence that satisfactory checks and references had been obtained for each applicant. However, some records did not show dates of employment or references and therefore it was not always possible to check the references and checks had been completed before new staff began working unsupervised in the home.

Staff had received training on the Mental Capacity Act (MCA) and understood the principles of seeking consent. However, records did not provide formal evidence to show how consent had been sought for important tasks relating to people's health and personal care needs. Staff were unaware of recent changes in the Deprivation of Liberty Safeguards (DoLS) legislation. One application had been submitted but more people living in the home may also be deprived of their liberty and therefore further assessments may be necessary. This meant the provider had not properly trained and prepared their staff in understanding the requirements of the Mental Capacity Act in general, and (where relevant) the specific requirements of the DoLS.

There were some monitoring and quality assurance procedures in place. These included systems to check all areas of the home were kept clean. Areas for redecoration and improvements had been identified and there was a plan in place to address these. However, there were no formal systems such as regular residents meetings, or questionnaires to gather the views of people who lived in the home, their friends and relatives or people involved in their care. There were no formal systems to monitor the completion of medicine administration records, or to review any medicine administration errors that may have occurred. There was no system in place to review all of the information received and held in the home, such as complaints, accidents and incidents, care needs, staffing levels and staff competence to help the provider consider the overall quality of the services provided, or to help them identify where further improvements could be made.

People told us they were happy with all aspects of the care and support. Comments included "It's lovely," and "I agree – it's a nice place." Health and social care professionals we spoke with told us they were confident people received good care. Comments included "I have no concerns. They provide very good care," and "I have no qualms about Dene Court at all. The home is always nice. There are enough staff around. The staff seem very capable." We saw staff supporting people in a friendly, caring and respectful manner.

There was a programme of activities provided on a daily basis and people told us there were plenty of things to do. There were three lounges and people could choose if they wanted to watch television, listen to music, sit and talk to people, or sit on their own quietly.

Staffing levels were adequate to meet people's needs. Call bells were answered promptly and staff gave each person the time they needed, for example when assisting people to move. The staff were well trained and fully understood each person's needs. Most staff held a relevant qualification and several were in the process of obtaining higher qualifications. A training assessor told us "Staff training is always high on the agenda and staff attendance is always good. Staff are always interested in topics taught and keen to learn."

Medicines were stored and administered safely. Staff were all able explain each person's needs in relation to management of their medicines, although there was no consistent guidance for them to follow.

Staff told us they were well supported and supervised. There were good systems of communication including daily handover sessions, and they could seek advice and

Summary of findings

support at any time. They told us they received regular supervision but were unsure how often this took place. Records of supervision were showed formal supervision was given irregularly. There were no policies and procedures in place to make sure staff received consistent and regular formal supervision.

There were breaches of regulation 9 Care and welfare of service users, 10: Assessing and monitoring the quality of service provision, and 18: Consent to care and treatment.

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

Some aspects of the service were not safe. People told us they felt safe. Risks to people's health and welfare had been assessed, and staff fully understood the risks and actions they should take. However the records did not provide evidence to show some risks had been regularly reviewed.

There were sufficient numbers of competent staff employed to meet people's needs.

We were given verbal reassurance that safe recruitment procedures were followed. Records showed references and checks had been carried out to ensure new staff were suitable. However, incomplete records meant evidence of safe recruitment procedures could not always be demonstrated.

People could be confident their medicines were stored and administered safely. Staff demonstrated a good understanding of each person's medicines and how they should be administered, but records did not provide adequate guidance on some areas of medicine administration such as prescribed variable doses of pain relieving medicines.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective. Staff received supervision, but records showed this was not provided on a regular or planned basis. Staff told us they were well supported and there were good communication systems in place. There was a stable staff team and good team work and co-operation between staff.

Staff had received training on the Mental Capacity Act (MCA) and understood the principles of seeking consent. However, records did not provide formal evidence to show how consent had been sought for important tasks relating to people's health and personal care needs. Staff were unaware of recent changes in the Deprivation of Liberty Safeguards (DoLS) legislation. One application had been submitted but more people living in the home may also be deprived of their liberty and therefore further DoLS assessments may be necessary. This meant the provider had not properly trained and prepared their staff in understanding the requirements of the Mental Capacity Act in general, and (where relevant) the specific requirements of the DoLS.

Staff were well trained and qualified. Staff training was treated as a high priority. Staff demonstrated a good understanding of each person's needs and how their needs should be met.

Summary of findings

Is the service caring?

Requires Improvement

Some aspects of the service were not caring. People told us the staff were always kind. Comments included “They are all kind,” “They look after us very well,” and “I wouldn’t want to be anywhere else. We have wonderful treatment.” We saw staff supporting people in a caring and respectful manner.

People told us they felt involved and consulted. However there was no evidence to show how this had been achieved. There were no formal systems such as resident’s meetings to seek people’s views on daily routines in the home.

People received the care and support they needed and had requested at the end of their lives.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive. Staff knew each person well and they were able to explain how they met people’s care needs. Care plans were in place for each person setting out information covering most areas of their needs. However, there were no records showing how people had been involved or consulted about their care plan. Most care plans contained a good level of detail but we also noted some omissions and areas where there was insufficient detail.

There was a programme of activities each day including quizzes and games. People told us they were happy with the level of activities provided.

People told us they were confident they could raise any concerns and complaints with the staff, managers or provider and these would be addressed.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well led. The managers were not pro-active in keeping up to date with changes in legislation, for example changes in the Mental Health Act and Deprivation of Liberty Safeguards. We were, however, reassured that managers sought advice and guidance from relevant professionals appropriately when people’s needs changed and they followed advice on current best practice.

People told us they had confidence in the managers and providers to make sure the home ran smoothly. Management arrangements were effective and ensured competent staff were in charge when the manager or assistant manager were absent.

Systems to monitor and review the quality of care were incomplete. Some checks were carried out on important routines such as cleaning routines to make sure people were safe and routines ran smoothly. However, there were no systems in place to seek the views of people who used the service, their relatives and others involved in their care. Some monitoring systems were not fully effective, for example staff supervision, medicine administration records, care plan and risk assessment reviews, or recruitment procedures.

Dene Court Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.'

The inspection took place on 27 January 2015, 6 and 10 February 2015. The inspection was unannounced. The inspection was carried out by two inspectors, one of whom is a pharmacist inspector.

Before our inspection we looked at all the information we had received about the home since our last inspection, including notifications and complaints. The provider 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. This information helped us plan our inspection.

During our inspection we spoke with the provider, the assistant manager, five staff, eight people who lived in the home and a training assessor who was visiting the home. We sat with people in each of the lounges and observed staff supporting people throughout the day. We were unable to speak with the registered manager as they were on holiday. After the inspection we contacted seven health and social care professionals for their views on the service.

During our visits we looked at medication storage and administration processes. We looked care plan files and daily records relating to four people and tracked the care they received. Other records we looked at included staff recruitment, induction, supervision and training records, staff rotas, menus, accident records, fire log book, maintenance records, and quality monitoring records.

Requires Improvement

Is the service safe?

Our findings

People said they felt safe. They were confident if they had any worries or concerns they knew who to speak with. Comments included "Yes I feel safe." One person described an incident which had caused them concern. They said they pressed the call bell and staff came straight away and dealt with the problem immediately. From our observations of people being supported by staff, and from our discussions with staff we were satisfied people received safe care. However, safe systems could not be fully evidenced in the records, particularly in relation to assessment and review of risks.

People's needs and risks had been assessed and staff were able to explain clearly the care and support people needed to support them safely. For example, staff had noted that a person was at risk of choking and had sought specialist advice promptly. As an interim measure they had given the person individual support with all food and drinks. Food was pureed and staff had assisted the person to eat slowly. The person was visited by a Speech and Language Therapist on the third day of our inspection. Staff were given information, training and advice on prevention of choking and they were able to demonstrate a good understanding of the risks and the actions they needed to take.

Some risks had not been regularly reviewed. A letter from a community psychiatric nurse in 2012 for a person who had a history of mental illness gave guidance on actions to reduce risks of harm or self-injury. Staff understood the risks and they explained the actions they took, including reassurance when the person was in a low mood. Although this reassured us that the staff understood the person's current needs, the care records did not provide full evidence that the risks had been fully or regularly reviewed. The risk assessment had not been reviewed within the previous year. There was no evidence to show how the person had been consulted about their care plan or whether they had agreed to the measures taken to reduce the risks. The assistant manager explained the actions the staff took each day to reduce the risks. However, these had not been formally agreed with the person, recorded or reviewed.

We also saw examples where the risk of pressure sores had not been reviewed on a regular basis, with some risks not reviewed in the previous nine months.

This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were unable to confirm from a review of the records that staff were recruited safely, although we received verbal reassurance that safe procedures were always followed. We looked at the records of three staff records recruited since our last inspection. They contained evidence of references and checks carried out to make sure the staff were suitable for the job they had applied for. The assistant manager assured us no staff provided unsupervised care to people until all checks and references had been received and they were confident the staff were suitable. However the dates new staff began working in the home had not been recorded and some references were undated. This meant the records did not provide clear evidence to support the verbal reassurances we had been given that safe recruitment procedures had been followed. No interview records had been retained and therefore there was no evidence of how the applicant's suitability for the job had been explored during the interview process. We also noted that references were not always requested from the applicant's current or most recent employer.

Accidents and incidents were reported and recorded promptly. Records showed that, where people had fallen, staff had taken prompt action to review the risks, seek specialist advice, and put a range of measures in place to reduce the risk of injury. For example, pressure mats, crash mats, and nursing beds which could be lowered were used where people were at risk of falling when getting out of bed. Where bed rails were used the risks had been formally assessed and the person concerned had agreed to their use.

Personal Emergency Evacuation Plans (PEEPS) had been completed for some people, but not for every person. These had been filed in their individual care plans. This meant staff did not have quick access to each person's evacuation needs in the case of an emergency. The assistant manager told us they had started to use some forms that had been too complicated. They showed us some other forms that were clear and easy to use and they said they would complete a PEEP for every person using these forms. All forms would be made available to staff in an emergency.

Requires Improvement

Is the service safe?

Staff had received training on safeguarding and understood how to recognise signs of abuse. Where people were unable to express concerns verbally due to illness such as dementia staff explained how they looked for signs such as changes in behaviour. Staff understood the actions they should take, and who to contact if they had concerns people may be at risk of abuse. They were very confident the management team would take appropriate action immediately concerns were reported to them.

Professionals who visited the home regularly told us they were confident people received safe care. Comments included "We have no concerns. The staff report issues promptly, they seek advice and follow our advice correctly."

People told us they felt there were enough staff to meet their needs. Comments included "There are enough staff. They come quickly if I press the bell." They told us staff gave them assistance with daily routines such as washing and dressing at times to suit them. A training assessor told us staffing levels were always sufficient to meet people's needs whenever they visited and staff never appeared rushed.

During our inspection there were four care staff, a team leader, a chef, a kitchen assistant, a domestic and a handyman on duty in the mornings. In the afternoons and evenings the number of care staff reduced to three. At night there were two care staff on duty. Staff rotas showed this was the normal level of staff planned. On the second day of our inspection the manager and assistant manager were both unavoidably absent and instead the provider was present. During our visits staff were attentive to people's needs and had time to assist people at their own pace without appearing rushed. Routines were carried out in a timely way. Call bells, telephones and doorbells were answered promptly, cheerfully and efficiently.

Staff told us they were confident they could arrange additional staff cover if they were concerned they were unable to meet people's needs. Staff rotas showed that in the afternoons and evening there was usually three care staff on duty and two care staff at night (both awake – no sleeping-in staff used).

There was a programme of maintenance, decoration and improvement in progress. A new front door had recently been fitted to improve the entrance to the home. New co-ordinating bedding and curtains had recently been purchased. Some areas had been improved in recent months, although we noted the improvements were incomplete. For example, a ground floor bathroom had been improved by providing a new bath and bath hoist. Some of the items previously cluttering the room had been removed. However, the flooring was patched and the room was still used for storing some equipment such as laundry trolleys. This affected the overall appearance of the room. The provider told us they were in process of redecorating many areas including corridors, stairways and bedrooms. They were aware of those areas that needed further attention and planned to address these in the near future. After the inspection they provided evidence showing the action will be completed within the next three months.

New commercial laundry equipment had recently been provided. However, when the machines had been installed the flooring had not been replaced. Some areas of the flooring was patched or damaged which may prevent the floor from being kept clean and hygienic. We also saw clean washing folded on top of the washing machines instead of being placed in individual laundry baskets. The assistant manager said they were planning to change the layout of the laundry and create more shelving which will enable staff to use the individual laundry baskets effectively in future.

All areas of the home were warm and comfortable. Thermometers on the walls in communal areas showed that all areas of the home were warm despite very cold weather outside.

All areas of the home were fresh and well aired. We spoke with a professional who specialised in continence after our inspection. They told us there were never any unpleasant odours when they visited the home.

A training assessor who was visiting the home told us they were confident they could raise any concerns about the safety of the environment and these would be addressed promptly. For example on one visit they noticed the steps up to the home were wobbly. They mentioned this to staff and the steps were mended promptly.

Arrangements had been made to support people with particular medical conditions getting their medicines at the times they needed them to prevent the breakthrough of symptoms of their diagnosed conditions. The members of staff carrying out these tasks were all able explain how they managed the differing times of administration and the assessments that needed to be made. However we found

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Is the service safe?

that there was no consistent guidance for them to follow. This was particularly the case for people prescribed variable doses of pain relieving medicines which could mean that different members of staff may make a different assessment of need.

Good records were made of the administration and removal of pain relieving patches and also of those medicines that required regular but infrequent administration.

There was clear information in people's care plans around the administration of medicines in particular circumstances and the actions to be taken in response to particular patient condition monitoring results.

Requires Improvement

Is the service effective?

Our findings

People were supported to have a well-balanced diet. People told us they enjoyed the meals. Staff went around each day to let people know the choice of meals being offered each day and their preferences were recorded. Most people we spoke with told us they were offered a choice of meals and they could always ask for an alternative. However, one person said they did not think they were able to ask for an alternative if they did not like the main meal on offer. There were no menus were displayed around the home showing the alternatives. We spoke with the assistant manager who immediately took action to display the menus in the dining rooms. We were also assured by the cook that people were always offered a choice, and if they did not like the alternatives offered on the menu there was always plenty of other things they could choose, for example salads, soup or sandwiches. They said they always made sure people were happy with the meals they were given. They assured us staff were always willing and able to accommodate last minute changes of meal choices.

The cook was aware of each person's likes and dislikes and dietary needs, including diabetics and people at risk of weight loss or choking. The cook and staff explained who required pureed or soft foods, and how they had followed specialist advice to ensure people were safe. The assistant manager had recently attended training on nutrition and planned to provide training to other staff on this topic in the future. Care plans listed people's dietary needs, likes and dislikes.

The staff team were well trained and competent. Staff turnover was low and many of the staff had worked in the home for a number of years. 25 permanent staff were employed. Of these, 20 staff held a relevant qualification such as a National Vocational Qualification (NVQ) or equivalent to at least level 2. A number of staff held, or were in the process of achieving a higher level of qualification. They had also received regular training and updates on essential health and safety related topics such as first aid, moving and handling, food hygiene and safeguarding. Topics such as dementia training and diabetes were covered on a regular basis. A training assessor told us "Staff training is always high on the agenda and staff attendance is always good. Staff are always interested in topics taught and keen to learn."

Staff told us they received supervision on a regular basis, although they were unsure of the actual frequency. Some staff thought they received formal supervision every three months while other staff said they thought it was every six months. All staff said they received informal supervision on a daily basis and they could ask for a formal supervision session at any time. They said they felt well supported. Supervision records were held in each staff member's file but there was no central record of supervision dates. This meant there was no way of checking if staff had received regular supervision, or if some staff had missed supervision sessions. The provider did not have a policy on staff supervision which specified the frequency of supervision or the topics which should be covered. We spoke with the provider and they told us they will implement a staff supervision policy and put in place procedures to check the supervision policy is being followed.

All staff had received training on the Mental Capacity Act 2005 (MCA) and understood the importance of supporting people to make their own decisions. They told us the topic had also been covered in their NVQ qualifications. They explained how they offered people choices, and the importance of gaining consent before carrying out personal care tasks. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. However, although we received reassurance staff understood the importance of gaining consent there were no records to evidence how consent had been gained. For example, there was no evidence that people had been given the choice to hold and administer their own medicines, or if they consented to their medicines being stored and administered by the staff.

A Deprivation of Liberty Safeguards (DoLS) application had been made for one person and was waiting formal assessment. This showed there was an awareness of DoLS and how it supported people's rights. However, the assistant manager was unaware of recent changes in the legislation than meant DoLS applications may be necessary for other people living in the home. For example, the front door was kept locked at all times to prevent people leaving the home because some people were at risk of accident or becoming lost if they left the home unescorted. This meant the provider had not properly trained and prepared their staff in understanding the

Requires Improvement

Is the service effective?

requirements of the Mental Capacity Act in general, and (where relevant) the specific requirements of the DoLS. The assistant manager said they would seek further information and guidance on current DoLS legislation and make further applications where necessary.

This was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People with memory loss received positive and understanding support from the staff team. Staff had received training every year on dementia and told us a recent session with a specialist trainer had been excellent and they had learnt a great deal. Around the home signs had been placed on doors to help people with memory loss find their way around. However, we also saw notice boards in one lounge that had been intended as orientation aids had not been kept up-to-date. A wipe board had a message saying 'Merry Christmas' and a blackboard had an incorrect list of activities for the week. A member of staff told us they had accidentally used the wrong pen to write 'Merry Christmas' and the message could not be removed. On the third day of our inspection the assistant manager told us both boards had been removed. They said they would consider alternative ways of giving people information about the day, such as a poster setting out the planned activities. After the inspection they told us they purchased two large clocks for the lounge areas with the day, month and year to help orientate people to the date and time.

Handover sessions were held between each shift to make sure staff were aware of any changes to people's health and care needs. Daily reports were completed for each person which provided good information about their daily health and wellbeing and the care they received.

A community care worker specialising in care of older people with memory loss said the staff were competent and provided effective support for people with dementia, including those with complex needs. They commented that they coped well with people who required a high level of support and understanding. They added the managers were realistic about the range of needs they could meet and sought professional guidance when necessary.

Requires Improvement

Is the service caring?

Our findings

People said they felt involved and consulted about their care, and about daily routines in the home. They said there were residents meetings and staff asked people what they wanted. However, when we asked the assistant manager for copies of the resident's meeting minutes they told us they had not held meetings in the home for some time. They said they had decided not to hold meetings any more and instead to go around and speak with people individually. However, there were no records of their discussions with people and therefore no formal evidence to show how people had been involved and consulted.

People told us the staff were always caring. Comments included "They are all kind," "They look after us very well," and "Yes, they are nice." They told us staff were never bossy. They always offered to help but never insisted if people refused. They told us there were lots of smiles and laughter in the home. One person said "We are all friendly." Another person said "I wouldn't want to be anywhere else. We have wonderful treatment."

We observed staff offering people gentle and caring support to help them join in organised activities. For example, on the second day of our inspection a professional activities organiser visited the home to provide an arts and crafts session. During the session people made collages with a valentines theme which were then displayed on the walls in the dining room. The session was well attended and people were smiling, laughing and chatting together during the session. One person initially said they did not want to join in and the staff member accepted their decision. A little while later the staff member asked the person again if they wanted to join in and this time the person agreed. The member of staff walked with them to the table where the activities were taking place, chatting to them in a warm and friendly way, and helped them get settled, staying with them until they were happily participating in the activity. The person enjoyed the session and was clearly pleased with the card they created.

Staff sat with people who were unable to join in without assistance. They understood people's individual abilities and encouraged people to do as much as possible for themselves. For example a member of staff asked a person "Where do you want to stick this piece?" Staff were friendly, understanding and respectful to each person.

Staff understood the importance of respecting privacy and dignity when providing personal care. They gave examples of locking doors and closing curtains when assisting people with personal care tasks such as bathing. They told us when medical professionals such as community nurses visited the home people always received treatment in the privacy of their bedroom or in the medical room.

One person had a stained blouse. The assistant manager said the person had suddenly developed a health problem which meant they were unable to eat their food easily, resulting in some food spills on their clothing. During our inspection we saw that staff reacted promptly to the person's illness and took a range of actions including seeking medical attention. They recognised the person needed assistance with their meals until their health improved and allocated a member of staff to sit with the person to assist with their meals. We were given assurance that staff always discreetly checked every person after meals to make sure their clothing was clean, and offered assistance where necessary.

People received care from competent and caring staff at the end of their lives. Staff had received training on end of life care. They understood each person's wishes for the care they wanted at the end of their lives. Care files contained documents called Treatment Escalation Plans (TEP) for most people which had been completed by a medical professional. These provided information for ambulance and hospital staff about the person's wishes regarding resuscitation in an emergency. The assistant manager said she was unhappy with the way some TEPs had been completed and they were in the process of asking GP's to complete new forms which clearly showed they had discussed the decision with the person, their next of kin or their Lasting Power of Attorney.

Requires Improvement

Is the service responsive?

Our findings

Four people told us they had been fully consulted about their care needs. One person said "They sit down and agree with me what I want help with." Staff told us they discussed the care plans between them to make sure they contained sufficient information about each person's needs. They also said they sat down and discussed the care plan with those people who were able to be involved. However, there was no evidence in the care plans to show how or when people had been consulted. The care plans were not signed or dated by people to show they had agreed the content, and the staff had not provided evidence to show how they had consulted with those people who were unable to sign their care plans. Staff also told us families were also consulted and involved in drawing up and reviewing care plans, but this was not documented clearly in the care plans.

Most care plans contained information about individual preferences regarding their care. For example, one care plan said the person "Likes to go to bed at 8pm. He wears his boxers with a nightshirt with one button done up. He likes his call bell and a hankie under his pillow." This level of detail showed staff knew the person well and understood the things that were important to them, including the small details that made them feel comfortable. It also meant the person could be confident they would receive consistent support from the staff. We spoke with the person who said they were entirely satisfied with the care they received.

While the level of detail in most care plans was adequate or good, there were also some areas where information could have been expanded or was missing. For example, in one care plan the section on likes and dislikes had not been completed. A member of staff was able to describe the person's likes and dislikes, but this information was not available in the care plan to ensure the person received consistent care. Some information had been archived instead of transferring to new care plan files. This meant some important information had not been readily available to staff. Therefore, while we were assured staff knew each person well and understood their individual needs and preferences, the care plans did not always provide evidence to support this.

This was in breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they were happy with the level of activities provided and said there was always something to do. Some of the activities they regularly enjoyed included singing, bingo, games and quizzes. There was a display unit in one lounge with a selection of books and games people could choose from. A blackboard in one of the lounges gave a list of the group activities planned for each day. There were three lounges and people could choose where they wanted to sit. In one lounge a large screen television was on, although no-one appeared to be watching it during our inspection. The assistant manager said that people had decided they wanted the television in one lounge, music or activities in another lounge, and the third lounge had no music or television so that people could sit and talk, or sit quietly. They assured us people chose which programme they wanted to watch, and often enjoyed watching films in the afternoons.

People told us they were confident they could raise any concerns and complaints with the staff, managers or provider and these would be addressed. There were records of four complaints since the last inspection. These had been taken seriously, investigated, recorded and responded to formally. Where the investigations found the complaints had been upheld we saw appropriate actions had been taken to reduce the risk of the problems recurring. However, a few actions had not been fully completed. For example, a relative had complained that toilet rolls were not always provided in each toilet. In response to their complaint the provider had agreed to install toilet roll dispensers in every toilet to prevent some people from removing toilet rolls. We found some toilets still did not have toilet rolls provided. The assistant manager told us they had not purchased sufficient toilet roll holders of the right type for each toilet and therefore they needed to make further purchases. They agreed to consider alternative actions they could take in the meantime to ensure toilet rolls were available in every toilet.

Requires Improvement

Is the service well-led?

Our findings

People told us the home was well managed. Comments included "Everything runs smoothly here – it is well managed." They told us they liked the managers and providers and said they could speak with the managers or providers at any time if they had any concerns, comments or queries.

Staff told us the home was well managed and routines ran smoothly. One staff said "We work as a team here. We are a very close team." Another member of staff said "I love it here."

A training assessor told us the home was well managed "The managers are 'on the floor' much of the time so they very much keep staff 'on their toes'." They told us when they visited the home they heard laughter and friendly support between the staff. They described how the management team supported and encouraged the staff to learn new skills and gain qualifications. They said the managers were always approachable.

Despite reassurance that routines ran smoothly, monitoring systems did not cover all aspects of routine management tasks. For example, there were no policies or procedures setting out the provider's expectations for staff supervision, and there were no systems in place to make sure these were carried out in accordance with the provider's expectations. Recruitment checks had been carried out, but there were no systems in place to make sure all documentary evidence was in place before new staff worked unsupervised in the home.

Risk assessments on people's health and welfare had not been checked to ensure they had been reviewed regularly. Care plans had not been checked regularly to make sure all essential information had been completed, and there were no systems in place to check people had been involved and consulted in their care.

There were no formal systems available in the home to monitor the completion of medicine administration records and there was no formal feedback system in the event of any errors occurring.

There were systems in place to make sure equipment and the buildings were regularly maintained. The fire log book showed fire equipment had been regularly checked and maintained. Staff received regular training on fire precautions.

The management team sought professional advice promptly and made sure the advice was followed. However, there was no evidence to show how they kept up to date with changes in legislation. For example, they had been unaware of recent changes to the Mental Capacity Act 2005 and the specific requirements of the DoLS.

There were no formal systems in place to review all of the information they received about people's care on a regular basis. People's views on the management of the home had not been sought. No resident's meetings were held and no questionnaires were completed by people living in the home, their relatives or people involved in their care. After our inspection the registered manager told us they planned to hold residents' meetings and staff meetings every three months in future. They also planned to send out regular newsletters keeping people informed about daily life in the home, special events and future plans.

We were assured that accidents and incidents were reported promptly and actions taken to reduce the risk of recurrence, but there were no formal systems to review all accidents and incidents over a period of time to consider any trends, or areas where further preventative action may be necessary. Complaints had been investigated on an individual basis but there were no systems in place to consider how the complaints procedure could be improved, or where people could be encouraged to give further ideas or suggestions how the service could be further improved.

This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some monitoring systems were in place and were effective. These included a training matrix which provided evidence of training and qualifications staff had completed, and where further training or updates were needed. Personnel audits were carried out which covered staff absences, disciplinary procedures, induction and recruitment . The audits showed these areas had been discussed between

Requires Improvement

Is the service well-led?

the registered manager and provider. Where improvements had been identified, for example improvements to the decoration or furnishings were necessary, actions had been taken. We also saw evidence of induction checklists which showed new staff had completed all areas of their induction.

Daily cleaning schedules were in place to provide evidence that all routine cleaning tasks had been completed.

The registered manager and assistant manager were both temporarily absent for part of the inspection. In their absence team leaders were in charge. They were knowledgeable, confident and competent and were able to demonstrate a good understanding of management systems in the home. This showed there were suitable management arrangements in the home at all times.

The providers and managers met on a regular basis to discuss the home and agree any improvements needed. The provider told us this had resulted in an agreement to put in place a plan to redecorate all areas, and they had identified a number of areas they intended to improve and upgrade in the next three months. They told us about actions already in hand, including new carpets and flooring that had been ordered, and quotes were being gathered for improvements to the lighting.

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 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 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them. The provider was not fully complying with the requirements of the Mental Capacity Act 2005. This was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The registered person has failed to protect each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe, because measures to review potential risks to people have not been carried out effectively. Effective procedures were not in place for dealing with emergencies which may arise. This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers The registered person did not adequately protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, because effective systems were not in place to regularly assess and monitor the quality of the services. This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records People were not fully protected against the risks of unsafe or inappropriate care and treatment because there was a lack of proper information about them relating to their assessed care and treatment needs. This was in breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.