Mr & Mrs M S Sadek

Westwood Care Home

Inspection report

9 Knoyle Road
Brighton
East Sussex
BN1 6RB

Tel: 01273553077

Date of inspection visit:
18 October 2016

Date of publication:
20 December 2016

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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We inspected Westwood Care Home on 18 October 2016. The inspection was unannounced. The home provides residential care for up to 29 people. At the time of the inspection 22 people were living at the home. The home is a large property, over three floors, situated in Brighton. There is a communal lounge and dining room and well maintained gardens. The home is the sole location owned and run by Mr & Mrs M S Sadek.

As part of this inspection we checked what action had been taken to address the breaches of legal requirements we had identified at our last inspection on 24 March 2015. After our last inspection, the provider wrote to us to say what they would do to meet legal requirements and sent us an action plan detailing how they intended to ensure they met the requirements of the law. At this inspection we found improvements had been made and sustained and all the breaches previously identified were addressed.

During this inspection we found risks to people's safety had not always been assessed. Identified risks were not always followed by appropriate risk assessment and management plans. As a result, the provider was unable to ensure people received care that kept them safe.

Staff had knowledge of the MCA and were observed to be working in a way that enabled people to make their own choices and were delivering support to people in their preferred way. However, we found that the provider was not using the Mental Capacity Act (MCA) to care for people who may lack the capacity to make their own decisions. The provider had not submitted Deprivation of Liberty Safeguards (DoLS) applications to the supervisory body, the local authority, that could lead to people being deprived of their liberty unlawfully.

People's respect and dignity was not always considered. They did not always receive care from staff that indicated respect for the person or acknowledged their needs. We observed a person's bedroom where there was no curtain or blind cover to two small side windows of a dormer type top floor window.

The provider failed to notify us of deaths within the home. It is a legal requirement for these notifications to be received from the registered person.

Although staff we spoke to told us they felt supported, records showed that, outside of the daily staff handover, regular staff meetings were not held. This meant opportunities that could be used to help share learning and best practice and ensure staff understood what was expected of them at all levels was not in place.

People and their relatives were not given opportunities to participate in a survey or similar process to provide feedback on the quality of service. As a result, opportunities to influence and improve the quality and safety of the service were missed.

People were protected from harm and abuse. They said they felt safe and there were sufficient staff to

support them. One person told us, "If I want any help I ring my buzzer and they come at once. At night they put the bell near me so I feel safe". Staff were knowledgeable and trained in safeguarding and what action they should take if they suspected abuse was taking place. Staff had received essential training. When staff were recruited, their employment history was checked and references obtained. Checks were also undertaken to ensure new staff were safe to work within the care sector.

Medicines were managed safely and in accordance with current regulations and guidance. There were systems in place to ensure that medicines had been stored, administered, audited and reviewed appropriately.

People were supported to eat and drink well. There was a choice in what people ate and drank. One person told us, "The food is good and we have a choice". People's weight was monitored, with their permission, to look for patterns of weight loss or gain.

People's health needs were assessed and met by staff who made referrals to external healthcare professionals when required. A health care professional told us, "People have access to all professionals. When a person moves into the home, [the provider] will contact us if the need arises to ask advice if they want to know what additional support they need."

There were quality assurance processes in place to enable the registered person to have oversight of the home and to ensure that people were receiving the quality of service they had a right to expect. People, relatives and staff were complimentary about the leadership and management of the home. One member of staff told us, "I'd recommend this home, it's small so everyone gets attention. Any problems are easily dealt with, we work as a team and the boss [the provider] is here every day."

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 always safe.

Identified risks were not always assessed by appropriate risk assessments.

Staff were able to explain indicators of abuse and the action they would take to ensure people's safety was maintained.

Medicines were managed and administered safely.

The provider used safe recruitment practices.

There were enough skilled and experienced staff to ensure people were safe and cared for.

Is the service effective?

Requires Improvement

The service was not always effective.

People who potentially lacked capacity to consent to care had not been assessed using the Mental Capacity Act 2005. The provider had not submitted Deprivation of Liberty Safeguards (DoLS) applications to the supervisory body.

People were able to choose what they had to eat and drink and had a positive dining experience. We have made a recommendation about the provision for healthy eating.

People had access to healthcare services to maintain their health and well-being.

Is the service caring?

Requires Improvement

The service was not always caring.

People's respect and dignity was not always promoted.

Care was provided for people in the way they wanted.

People were offered choices in relation to their care.

Is the service responsive?

Good

The service was responsive.

Staff were knowledgeable about people's care needs and preferences in order to provide a personalised service.

There were activities on offer that met people's needs for stimulation.

People's needs were reviewed on a regular basis.

People were aware of the complaints procedure and were given information on how to make a complaint.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider failed to notify us of deaths within the home.

Regular staff meetings were not held and there was little evidence of people's views on the home being sought.

Staff were supported and listened to by management and understood what was expected of them.

Westwood 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.

We visited the home on the 18 October 2016. We previously carried out a comprehensive inspection at Westwood Care Home on 24 March 2015, where we identified areas of practice that needed improvement in relation to the maintenance of some of areas of the home and the management of some medicines.

This was an unannounced inspection. The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

During the inspection, we spoke with six people who lived at the home and four relatives or visitors. We talked with three care staff, the deputy manager and registered person. Some people were unable to speak with us. Therefore, we used other methods to help us understand their experiences. We used the Short Observational Framework for Inspection (SOFI) during the morning in the lounge area. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Before our inspection, we reviewed the information we held about the home. We considered information which had been shared with us by the local authority, looked at safeguarding concerns that had been raised and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. A Provider Information Return (PIR) was not requested prior to the inspection. A PIR asks the provider to give some key information about the service, what the service does well and any improvements they plan to make.

During the inspection we reviewed the records of the home. These included staff training records and procedures, audits and four staff files along with information about the upkeep of the premises. We looked at four care plans and risk assessments along with other relevant documentation to support our findings.

Requires Improvement

Is the service safe?

Our findings

Previously, we found the provider had not made suitable arrangements to protect people against the risks associated with unsafe or unsuitable premises because of inadequate maintenance. This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found the provider had followed their action plan and this breach had been addressed with the improvements had been sustained.

At our last inspection, we found the maintenance of some of areas, such as walls and items of furniture had not been maintained to a high enough standard to prevent risks to people. At this inspection we found the provider had taken action to ensure that, as far as possible, people were protected from the risk associated with unsafe or unsuitable premises because of inadequate maintenance. This was because the areas of water damage on the walls of the home identified at the last inspection had been repaired and made good and furnishings that were worn were being replaced.

At our last inspection, the provider had not made suitable arrangements to protect against unsafe practice in the proper and safe management of medicines. This was a breach of Regulation 13 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. At this inspection, we found the provider had followed their action plan, medicines were handled appropriately and their administration was accurately recorded. This breach had been addressed with the improvements and had been sustained.

People's consent was gained and they were supported to take their medicine in their preferred way. We looked at the management of medicines. Each person had a medicine administration record (MAR) which contained information on their medicines and included other information such as any known allergies. The MAR contained guidance for staff to follow for the administration of medicines. Medicines were correctly recorded and there was a safe system in place for recording the disposal of medicines.

Some people were prescribed medicines that they could take as and when they required them. The process for administering 'when required' medicines was included in the homes medicines policy. The process followed for this medicine included recording the reason for giving 'when required' medicine. The provider ensured good practice was followed by ensuring that the temperature of the medicine cabinet was monitored and recorded. Medicines could be less effective or harmful if they were out of date. Some liquid medicines and creams have a limited shelf life once opened, observations showed that the date when these medicines were begun was recorded.

There were policies and procedures to manage some risks. Care documentation and individual risk assessments were reviewed and updated to provide guidance and support and there were emergency plans in place to ensure people's safety. However, we identified risks associated with individuals care and support were not always identified and addressed. For example, the kitchen was off the lounge and people occasionally liked to go into the kitchen area. We saw entries in records and heard about times when staff

had asked people to leave the kitchen because of the dangers they perceived the person to be in by being in the area. We asked if all people were at risk by being in the kitchen and were told that some people were safe to be in the area with staff support. Those people not at risk and who may be able safely access the kitchen were not identified. The location and individual specific risks had not been considered and recorded. This meant people's individual risk of harm was not safely assessed and steps that could be taken to minimise the risks and maintain the person's safety not considered. This, in turn, affected their freedom and choices they were able to exercise safely. We have identified this as an area of practice that needs improvement.

Risks associated with the fire safety of the environment were managed appropriately. The provider ensured there were adequate and appropriate fire safety measures in place to minimise the risk in the event of a fire. There were risk assessments that included the individual needs of those who may be at risk. They considered how the risk could be reduced and managed to protect the person. Staff were equipped with all the skills needed to observe procedures they needed to follow.

Staff had a good understanding of safeguarding adults, they had undertaken relevant training and could identify different types of abuse and knew what to do if they were to witness any concerning incident. There were policies to ensure staff had guidance on protecting people from abuse. These were accessible to staff and they were aware of how to raise concerns regarding people's safety and well-being. Records confirmed staff had received safeguarding training as part of their essential training at induction and that this was refreshed. Staff described different types of abuse and what action they would take if they suspected abuse had taken place. A staff member said, "I have done the safeguarding training and we have talked it over and I would report anything straight away."

There were sufficient staff to ensure that people were safe and cared for. Staffing levels were reassessed when the needs of people changed, to ensure people's safety. People we spoke with told us staff were available to provide care and support. Staff were available to respond to people's requests and needs. Individual bedrooms were fitted with call buttons and staff responded in good time to people's call bells. One person said, "If I want any help I ring my buzzer and they come at once. At night they put the bell near me so I feel safe". Another person told us, "I try to do things on my own but if I didn't feel safe, I could ring the bell and they come in a flash". This meant that people did not have to wait too long for staff to provide assistance. Staff had time to speak with people and to check that people across all areas of the home were safe. Staff told us they checked in with people who preferred to spend more time in their bedroom and we saw that no one was left alone for long periods of time. The relative of one person commented, "I come in at different times and there is always someone around." One member of staff said, "The day-to-day provision of staff is sufficient."

The provider had effective systems in place for the safe recruitment of staff. Records showed that recruitment checks were in place to ensure staff were suitable to work at the home. Prior to their employment starting there were security checks completed and employment history was gained. Disclosure and Barring Service (DBS) checks were carried out for all the staff. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with vulnerable groups of people.

Requires Improvement

Is the service effective?

Our findings

People and visiting relatives spoke positively of the home and of staff members. One person told us, "They're looking after me properly." However, we found Westwood Care Home did not consistently provide care that was effective.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the provider was working within the principles of the MCA and whether any conditions on authorisation to deprive a person of their liberty were being met.

People were empowered through the provision of choice and support was delivered in a way they liked. This was seen during our observations and by how staff described their work with people. From talking to staff, it was clear staff knew that some people could make some decisions. For example, what to eat, what to wear or what to do. People were provided with the information in a way they understood and were given time to make the decision. However, the provider did not always understand the principles of the MCA and their responsibilities in accordance with the MCA code of practice. It was not always determined if a person had capacity. Only for people with no capacity can decisions be made for them in their best interests. The process to determine a person's capacity and then make decisions for them in their best interests had not always been followed. This meant appropriate consent had not been recorded for people who lack capacity.

The Care Quality Commission is required by law to monitor and use the Deprivation of Liberty Safeguards (DoLS). People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. DoLS are applied for when people lack capacity and the care they require to keep them safe amounts to continuous supervision and control. At the time of the inspection, only one person was subject to a DoLS order. The lack of understanding and knowledge about what DoLS could lead to a person being deprived of their liberty unlawfully. The provider had not submitted applications to the supervisory body, the local authority. They were uncertain if DoLS may be applicable to any other people living in the home. They agreed to seek advice from the local authority and submit applications where necessary. However, people's rights were potentially restricted pending the outcome of future applications. Additionally, the lack of system to identify and make necessary referrals meant there was a lack of clear processes to ensure that people's rights were protected when consent was sought for their care.

This was a breach of Regulation 11 (Need for consent) of The Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

People told us that they were involved in making choices about the food they ate. We observed the lunchtime meal and saw people were supported to make more informed choices about their meal. We observed staff working in a person centred way with people, for example, by checking people's preferences for a particular dish or beverage. Some people chose to eat at the dining room tables or while seated in the nearby chairs with their meal on a side table. It was a calm and peaceful environment and people were at ease in their surroundings. People had a choice of food and we were told people could also order an alternative if they didn't like what was on offer. Staff were observed to be kind and considerate towards people and we saw that people were supplied with hot and cold drinks and snacks throughout the day.

We asked staff how people's individual preferences were supported. They told us that people were asked what they would like each day. We were told there was a variety of options available. Staff told us preferences and special diets were recorded in the care plan. We were shown a sheet in the kitchen which indicated the quantity of the food people preferred, whether full or half portions and who required a soft diet. We asked people what they thought of the food on offer. One person told us, "The food is good and we have a choice." Another person said, "I have no complaints over the food. The quality and quantity is excellent." The cook told us that fresh vegetables were served with the traditional Sunday lunch. However, what we were told and what we observed of stocks of fresh vegetables confirmed that frozen or processed vegetables were otherwise used. We recommend that the provider current guidance about the provision and promotion of healthy eating, including the provision of fresh vegetables, based on current best practice.

Staff understood the importance of monitoring people's food and drink intake and monitored for any signs of dehydration or weight loss. People's weight was taken on a regular basis and where necessary, referrals were made to the dietician or speech and language therapist. Records confirmed that people had received visits from healthcare professionals including the dietician and their GP. The provider said that they had good links with the doctors and district nursing service. Staff attended planned hospital appointments with people when they were unwell to ensure they were supported. People were supported to maintain good health and received on-going healthcare support. People commented they regularly saw the GP and visiting relatives felt staff were effective in responding to people's changing needs. One relative told us, "[My relative] had an infection that was picked up quickly." Staff recognised that people's health needs could change rapidly and that not everyone was able to communicate that they may be feeling unwell. They commented that if people's presentation did change they considered if they had an underlying health problem which may be a factor, such as a urinary tract infection (UTI). The provider and staff sought the advice of the GP and district nursing team if they suspected someone had a UTI. Where staff had concerns they took prompt action to gain input from healthcare professionals. The home had a daily diary that recorded any input, advice or guidance from visiting healthcare professionals.

People and their relatives told us they thought the staff were trained to meet their needs. One person told us, "They are all quite experienced and know what they are doing. They use a [standing] frame to help me move into the chair and it feels very safe". Staff commented they felt supported and received sufficient training that enabled them to provide effective care to people. Training schedules confirmed staff received an on-going programme of essential training that was updated regularly. Staff attended training provided by the provider or by the local authority. One staff member told us, "The training is informative and helpful."

Systems to support and develop staff were in place through regular individual meetings with the provider and deputy manager. These meetings gave staff the opportunity to discuss their own developmental needs as well as any concerns or issues they may have. Therefore, mechanisms were in place for supporting staff in relation to their roles and responsibilities. Staff commented that if they had any worries they could

approach the provider or deputy manager for advice or guidance. One member of staff said, "It is better to bring things up as they occur. For example, I saw [the provider] about the strain of laundry duties on care staff and as a result he had added some laundry responsibilities to the cleaner role, which had made a big difference."

Requires Improvement

Is the service caring?

Our findings

People were complimentary about the care they received. We asked people if they thought the home was a caring environment. One person said, "They are all very caring. They look after you very well. I have the same lady help me with a bath once a week just as I like it, she is very nice". Another person told us, "They are very nice and friendly. I like to have my door open and they often call and say 'hi' as they pass by". A third person said, "They treat you like a guest, nothing is too much trouble". However, we found Westwood Care Home was not consistently caring.

During the inspection, we spent time observing staff and people who used the service. There was a calm and relaxed atmosphere. The level and quality of staff interaction with people was, for the most part, caring and friendly. Staff were attentive, respectful and patient with people. Observation of the staff showed that they knew people well and could anticipate their needs. For example, sometimes people were in need of reassurance and this was provided for people in a person centred way, which meant it was how the person wanted and liked to be supported. Staff took time to talk and listen to people.

Some people who had difficulty with communication. When one person wanted to stand up and move around the lounge, staff knew the person no longer had the ability to stand without support and they intervened to help the person understand this but also to reassure them. We observed good interaction between people and staff who consistently took care to ask permission before intervening or assisting. We observed instances of staff engaging in positive caring relationships with people. For example, one person came out of their room disorientated to time and place. The member of staff took their hand and led them to their room and suggested they help them get ready for lunch in a polite, reassuring and friendly way.

However, not all staff displayed such a caring attitude. We observed one person became agitated during lunchtime because they thought they had to be somewhere else. When the person tried to stand up a staff member said, "Sit down" and "Stay there," and did not respond to their obvious anxiety. This was fed back to the registered person who expressed disappointment at the interaction. They looked into the incident and provided further context. They told us the member of staff was carrying a tray of hot soup and the person could not see them. As they were hard of hearing the member of staff had to raise their voice and ask them to sit down. However, the exchange was accepted and it was agreed that there was no attempt to address the person again after the exchange. A short while later the person became anxious again and another member of care staff approached and engaged the person in conversation and the person responded with laughter and became more relaxed.

Staff told us how they worked in a way that protected people's privacy and dignity. For example, they told us about the importance of knocking on people's doors and asking permission to come in before opening the door. A staff member told us "We always ask people what they want to happen, anything at all we can do, we will." Another member of staff told us, "We always knock on people's door before we go in, we respect that. We help everyone to keep their independence as much as they can." However, respect for people's privacy and dignity was not always upheld. We observed a person's bedroom where there was no curtain or blind cover to two small side windows of a dormer type top floor window. The provider had

tacked material, what appeared to be pillow cases, to the windows as a temporary measure. The occupant of the room had not voiced any concern to the provider about the arrangement but the measure did not indicate respect for the person. When we raised the issue with the provider they undertook to remedy the situation and subsequently informed us that new curtains had been fitted in the room. We have identified this as an area of practice that needs improvement.

People told us staff always treated them with respect especially when providing personal care. A relative said that staff ensured their family member was always clean and dressed in accordance with their preferences. Staff told us they protected people's dignity by ensuring they kept them covered when providing personal care and by waiting to be called in when they knocked on their door. One staff member said, "We are in their home." They explained that it was important to respect people and their property. We saw that staff supported people in a discreet manner. People and their relatives told us staff were kind and caring. When asked their opinion of living at the home and one person told us, "Yes I like it here." They explained that staff were attentive to their needs. A relative told us, "They [Staff] look after them the best they can. Care is explained to people, it's care with a human face."

Staff had formed positive relationships with people. One person said, "Staff are lovely and always willing to have a chat about something." Another person told us, "We have a chat and a bit of a joke." Relatives we spoke with found staff welcoming. One relative said, "As soon as we come in they [staff] ask us if we want a drink." Another relative told us they liked how staff spoke about their family member in a positive manner. Staff were positive about their caring role and the people they supported. One staff member told us they enjoyed their job and liked getting to know people.

People told us they were involved in decisions, for example, about their care and to maintain important relationships. One person told us, "Staff know how I want my care and when." Relatives we spoke with told us they were involved in decisions about their loved one's care and kept informed of any changes as required. The provider told us when people first moved in they spoke to them, their family and representatives and they kept up this level of contact. A health care professional told us that relatives had told them they found the provider supportive and caring not just to the person but to them also. We saw that people were offered choice and were listened to. For example, staff asked one person if they wanted to go to the dining able for lunch and they said they wanted lunch in their armchair. Their decision was respected and lunch was served to them in their preferred location.

Good

Is the service responsive?

Our findings

People told us they were pleased with the care and support provided by staff. One person said, "I like being here. I know the staff and they know how to meet my needs." A health care professional told us, "People have access to all professionals. When a person moves into the home, [the provider] will contact us if the need arises to ask advice if they want know what additional support they need."

People's health and care needs were assessed before they moved into the home. Pre-admission assessments were in place and the provider used them as a basis to develop care plans. The care plans described the person, their preferences and how they wanted to be cared for. People's care files were organised so that they could be followed. The details were reviewed on a regular basis. For example, one person's care plan summary told us, 'This page is intended to show what a usual day would look like', and the document matched the person we saw in the home. The description of care they wanted and required was detailed enough to reflect care needs. For example, in the section on personal care it recorded that this person had arranged to receive a strip wash in light of their expressed refusal to receive baths or showers. Their 'long term plan' of support was re-written in July 2016 and reviewed again in August 2016 and covered their mobility, special needs, personal care, skin care, diet, communication, oral care, foot care and sleeping.

People's care plans were person-centred and provided clear guidance for staff on how to support them in areas of their daily lives including methods of communication, support with personal care, eating and drinking, and mobility needs. Care files included people's ethnicity, religion, life histories, the name they preferred to be called and their former occupations. Care files were reviewed monthly or more frequently if required. Daily progress notes were maintained to record the care and support delivered to people to ensure people's individual needs were met.

We asked people if they thought the care they received was responsive to their needs. While not all people we talked with could recall being involved in the process of contributing to their plan of care, all were satisfied that the staff knew what care people needed. For example, a person told us, "We play cards, every day after lunch. I have always enjoyed playing cards and this is taken note of." Relatives told us people received personalised care that was responsive to their needs. One relative told us, "I've never had any concerns because I am always consulted." Some people preferred to spend most of their time in their rooms and people's bedrooms were personalised to their own taste. One staff member said, "The majority of people come down, but if they don't want to then that is fine. We do encourage them, but sometimes they might just not want to come down. We respect what they want."

People were supported by staff to participate in the activities they liked and some that were new to them. We spoke with people and staff about the provision of meaningful occupations and activities at the home. All the people we spoke to were happy with the options available and said that they were able to choose to join in. One person said, "There are things going on but I don't mix easily so I choose not to join in." Another person told us, "They bring me up to my room and I can watch my own TV as I don't always like what they

have on downstairs". Some people told us about events happening in the home. One person said, "There is a nice woman who gives a slideshow and a talk. We had one on Chelsea Flower Show and one on Wimbledon. They were very good."

When people needed to attend hospital, the provider made sure they received consistent individual care. In these cases, people were accompanied and had their health care file summary already prepared to take. These contained all the relevant information required by health professionals, including people's current medicines and preferences for care.

We asked about how the home listened and responded to complaints and concerns. All of the relatives and representatives we spoke to said they knew how to raise concerns and their opinions were listened to. One person told us, "I would speak to any of the staff and the owner. I feel I could talk to them anytime". Another person said, "I would have a word with the manager first and they will help out." People told us there were no organised residents meetings, one person said "There are no meetings but there is a suggestion box in the hall, but I haven't needed to use it." There were procedures displayed at the home for people to see how to raise a complaint. There were no complaints recorded for 2016.

Requires Improvement

Is the service well-led?

Our findings

People, their relatives and staff spoke positively about the provider. One relative told us, "I often drop into [the providers] office and catch up with matters around mums care. They are an open and easy person with whom to discuss things. Mum tells me he is around every day to have a conversation with."

As part of gathering intelligence for the inspection, we noted that we had not received any statutory notifications relating to people who had died in the home. It is a legal requirement for these notifications to be received from the registered person. During the inspection, we spoke with the provider and they told us they had not sent these notifications to us.

This was a breach of Regulation 18 (2) (e), (4B) (Notification of other incidents), Regulation 16 (Notification of deaths), of The Care Quality Commission (Registration) Regulations 2009.

Staff attended daily handover meetings at the beginning of every shift so they were kept up to date with any changes to people's care and welfare. However, outside of the handover, regular staff meetings were not held so that opportunities for seeking and acting on feedback were missed. This meant opportunities that could be used to help share learning and best practice and ensure staff understood what was expected of them at all levels was not in place. Staff felt they could express their views at handover, however the meeting was short, the handover we observed lasted a matter of minutes and did not provide the forum for in-depth discussion of issues surrounding, for example care and management of the home. One staff member told us, "A staff meeting would be good, I cannot remember the last staff meeting but I'm sure if there was a problem we'd have one." Another member of staff described the position of mutual respect between the staff team and the provider and told us the provider had been personally supportive. They described how this encouraged them to feel personally committed to help the home continue to work well. However, they told us, "But we need a proper staff meeting, we haven't had one for two years." We have identified this as an area of practice that needs improvement.

Opportunities to seek and act on peoples or relatives opinions on aspects of care and management of the home were not available. For example, surveys were not used to obtain feedback. We did not find people were encouraged to raise issues and make suggestions in the form of a survey response or through either one-to-one or group meetings. This meant that the provider missed opportunities to get results, possibly both positive and negative. We asked the provider about 'resident and relatives' meetings. They told us there were no organised meetings but preferred to have an, "Open door" policy so that people could raise issues and comments at any time. One relative told us, "We see the owner most times. When we pass the door he says 'come in, come in'. If we have a problem, like last week the TV was playing up, we mentioned it to the owner and the next day it had been fixed". We have identified the lack of formal mechanisms to receive and collect feedback, for example, from surveys and meetings, as an area of practice that needs improvement.

There were processes in place to monitor the quality of the existing service. Records demonstrated regular audits were carried out to identify any issues or shortfall, for example in medicines. The provider was able to

identify the issues including the safe management of medicines, medicine risk assessments and completion of records.

Staff understood their responsibilities to share any concerns about the care provided at the service. They described a culture where they felt able to speak out if they were worried about quality or safety. One member of staff said, "I'd recommend this home, it's small so everyone gets attention. Any problems are easily dealt with, we work as a team and the boss [the provider] is here every day."

Throughout the course of the inspection it was clear from people, their visitors, staff and provider that the ethos of the home was to provide a safe and happy environment, as well as promote people's independence and wellbeing. Staff we spoke to told us they enjoyed caring for people. One staff member we spoke with told us, "I love caring for the people who live here, it's like we are family."

Staff told us they were happy working in the home and felt supported by the management in the home. They spoke positively about the leadership being receptive to staff input when it was offered. They told us the provider operated an open door policy and they could go and speak to them at any time. One staff member said, "I have confidence in [the provider] he is a good boss, he is sympathetic. He is genuinely interested in the home and in us."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 Registration Regulations 2009 Notification of death of a person who uses services Regulation 16 Registration Regulations 2009 Notification of death of service user. The provider was not notifying the CQC of incidents. Regulation 16 (1) (a) (Notification of death of service user) HCSA 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Regulation 11 HCSA 2008 (Regulated Activities) Regulations 2014 Need for Consent The provider failed to ensure that the people were given the opportunity to consent to care at all times. Regulation 11 (1) (2) (3) (4) (Need for Consent) HCSA 2008 (Regulated Activities) Regulations 2014