Croftwood Care Ltd

Golborne House Residential Care Home

Inspection report

Derby Road
Golborne
Cheshire
WA3 3JL
Tel: 01942273259

Date of inspection visit: 23 & 24 September 2015
Date of publication: 28/01/2016

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?	Good
Is the service well-led?	Requires improvement

Overall summary

This comprehensive inspection was unannounced and was conducted on 23 and 24 September 2015.

Golborne House is located in Golborne, Greater Manchester and is owned by the Minster Care Group. The home is registered with the Care Quality Commission (CQC) to provide care for up to 40 people. The home provides care to those with residential care needs, many of whom live with a diagnosis of dementia.

Golborne House is a two storey building and people's bedrooms are located on both the ground and first floors of the building. All rooms are of single occupancy. However, shared accommodation can be arranged, if required. There are two lounge areas on the ground floor and a dining room. On the second floor, there is a quiet lounge with a kitchen and a hairdressing room. There are

Summary of findings

seven toilet facilities on the ground floor, eight on the second and assisted bathing facilities on each floor. Car parking is available at the home, as well as in side streets close by.

At the time of our inspection 39 people were living at Golborne House. We last inspected this location on 07 July 2014, when we found the service to be compliant with all regulations we assessed at that time.

The registered manager was on duty when we visited Golborne House. 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 of the Health and Social Care Act and associated regulations about how the service is run.

During this inspection, we identified three breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014 in relation to Safe Care and Treatment, Good Governance and Staffing. We are considering our enforcement options at this stage.

You can see what action we told the provider to take at the back of the full version of this report.

People told us they felt safe living at Golborne House, but we found shortfalls in the management of slips and falls. Although incidents were reported and falls were reported robustly, no full action was documented and no plans were implemented to mitigate the risk of further incidents.

This was a breach of Regulation 12 (1)(2)(a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People, and their relatives, who we spoke with did not raise any concerns about their safety or that of their family member. However, people did raise concerns about staffing levels and that there was not enough staff to meet people's needs. We found there were not sufficient numbers of staff deployed at all times to meet people's needs. We were told by two healh professionals that there was a high proportion of people at the home with moisture lesions and skin tears. We also observed on the day of the inspection that people didn't have their teeth or hearing aids in which we felt was a consequence of staff being rushed as a result of the staffing level.

This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staff knew how to keep people safe and how to raise any concerns if they suspected someone was at risk of harm or abuse. Staff understood the risks people could face through everyday living and how they needed to ensure their safety.

The management of medications, in general promoted people's safety. Medication records were well maintained and detailed policies and procedures were in place.

New staff were suitably checked and vetted before they were employed. However, we found four staff that had worked at the home for a long time but there was no Disclosure and Barring (DBS) check record documented in there file. We were told that this was a historical issue with the previous provider holding these records. The registered manager promptly resolved this by requesting new DBS checks to be completed.

People had a choice of meals, snacks and drinks, which they told us they enjoyed. There was flexibility in what people might want to eat and when.

On the second day of the inspection there was a vibrant atmosphere in the home. A variety of activities were provided and staff demonstrated a good understanding of people's needs and adapted activies to reflect people's individual interests.

We observed people were treated with dignity and respect. Throughout the inspection we saw staff engaging with people in a positive and caring manner. Staff spoke to people in a respectful way and used language, pace and tone that was appropriate to the individual. Staff took time to listen to people and responded to comments and requests. People felt staff were kind and respectful to them.

Staff members were well trained and those we spoke with told us they had access to training programmes and provided us with some good examples of modules they had completed. We noted that there was a high attainment of vocational qualifications amongst staff. Staff also confirmed that regular supervision sessions were conducted, as well as annual appraisals and we saw documentation to substantiate this.

Summary of findings

The registered manager and staff were aware of their responsibilities around legislation regarding people's mental capacity. Staff described how they obtained people's consent before delivering care.

People knew how to make a complaint and these were responded to within the timescales of the provider's policy. Staff felt able to raise concerns or issues with the registered manager.

Although there were systems to assess the quality of the service provided in the home, we found that these were not always effective. The systems had not ensured that people were protected against risks. We found that the audit system had not identified the risk to people around slips and falls, or picked up that there were gaps in the documentation and that there were insufficient staff deployed to meet people's care needs.

This was in breach of regulation 17(1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 safe.

There were not always enough staff on duty to meet the needs of people who lived at the home.

The staff had completed risk assessments but they were not accurate, up to date and did not manage the risks to people.

People's medicines were managed in a safe way.

Is the service effective?

Good

The service was effective.

The registered manager and staff were knowledgeable about mental capacity and deprivation of liberty. Staff explained how they sought people's consent before delivering care.

People were given choices of suitable and nutritious food and drink to protect them from the risks of inadequate nutrition and dehydration. The service worked together with health professionals to ensure people received care appropriate to their needs.

Staff had regular supervision and appraisals. People received care from staff that were skilled and trained to deliver care.

Is the service caring?

Good

The service was caring.

People and their relatives were enthusiastic about the care provided. People told us that staff were caring and respected their privacy and dignity.

People were supported to maintain important relationships. Relatives told us there were no restrictions in place when visiting the service and they were always made to feel welcome.

The service was caring. Staff had developed positive relationships with people and had a good understanding of their needs. Each person had a named keyworker who was responsible for overseeing the care they received.

Is the service responsive?

Good

People had access to activities that were important to them. These were designed to meet people's individual needs, hobbies and interests, which promoted their wellbeing. Staff were creative in finding ways to support people to live as full a life as possible.

People's concerns and complaints were investigated, responded to promptly and used to improve the quality of the service.

Summary of findings

Is the service well-led?

This service was not consistently well-led.

The registered manager had been in post for many years and the turnover of staff was very low. This helped to provide continuity in the management structure of the home and consistency in the staff team.

There were a wide range of systems in place for assessing and monitoring the quality of service provided. However, we found these were not always thorough enough to identify and address potential risks to the health, safety and welfare of those who lived at Golborne House.

The home worked in partnership with other agencies, such as a variety of community professionals, who were involved in the care and treatment of the people who lived at Golborne House.

Requires improvement

Golborne House Residential Care Home

Detailed findings

Requires improvement

Is the service safe?

Our findings

People told us they felt safe. Relatives told us they didn't have concerns for their family member's safety. One relative said,"I have no concerns regarding mum's safety. She is very frail but they are on the ball around mobility. There is always somebody behind her. Another relative told us, "I definitely feel my mum is safe, though she wouldn't know what the buzzer was for."

On the day of our inspection, we did not find safe practices were consistently demonstrated in the home. Risks were not always accurately assessed and risk assessments were not updated to reflect changes in risks.We identified the systems in place for falls monitoring were not satisfactory. The registered manager was effective in incident reporting and was able to demonstrate the frequency that falls occurred. However, there were serious shortfalls in how falls were managed and delays in the time taken to make referrals to health care professionals. The registered manager completed a monthly falls audit, which indicated the number of falls or slips a person had had each month. The registered manager maintained robust records in relation to slips and falls. However, we found the care plan had not been updated to demonstrate an increase in the risks and systems had not been implemented to mitigate the risk of further slips or falls.

We saw that one person had been hospitalised in April following a fall that required stitches to their face. The person had three falls and four slips between April and July when a referral was then made for a falls assessment. The registered manager told us that there had been a delay in making the referral because the person had capacity to make decisions and initially refused a referral to the falls clinic. The registered manager told us that discussions had been ongoing throughout this time with the person and their relative before they had agreed to the referral. We looked at the person's care file and there was no documentation in the daily progress records to demonstrate these discussions had occurred. The registered manager explained that informal discussions had occurred regularly when the person's relative had visited. The registered manager acknowledged that they had not documented the conversations.

This person's risk assessment described them as being a very independent person that didn't like to bother staff. We asked the registered manager how frequently care staff were required to make an entry in people's progress records. We were told daily. We looked at the person's progress records, handover records and care assistant observation check list from 23 August to 23 September and found there were seven gaps in the documentation which suggested that this person had not been observed or supported on these occasions. This gave rise to our concerns that this person may not be safe in regards to the management of their falls and as a result we made a safeguarding referral to the local authority.

The registered manager did contact the person's GP on the day of the inspection to request a visit but the GP surgery was closed .The registered manager placed the person on observations to mitigate the risks of the person mobilising without staff support. The registered manager also contacted the contact centre to escalate the requirement for the falls risk assessment.

On the day of the inspection, a person was returning from hospital following a serious incident that had resulted in the person fracturing their hip. Again we found that this person had several incidents prior to this injury occurring; a seizure which had resulted in a fall, they were found on the floor, three slips from their bed and a fall from overbalancing. No referral had been made for a falls assessment or occupational therapist assessment. The person's risk assessments indicated that there was no change to the risks and systems had not been implemented to reduce the risk prior to this incident. This person did not have capacity but the registered manager had made a referral for an Independent Mental Capacity Advocate (IMCA). Despite this, no discussion had occurred with the IMCA regarding the person's care and the management of slips and falls. A referral had not been made to the falls clinic for assessment prior to the person fracturing their hip. On the day of the inspection, the registered manager did place an order for a pressure mat transmitter which would raise an alarm when the person got out of bed so that staff could respond and support the person when mobilising.

This was a breach of Regulation 12 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On arrival at the service on the second day of the inspection, we found that the registered manager had further responded to our concerns around falls and had updated the two people's risk assessments. The area

Requires improvement

Is the service safe?

manager had also devised and implemented a falls flow chart, which was displayed in the care team leader office and highlighted steps that should be taken. The registered manager had also implemented a Falls Risk Assessment Tool (FRAT). The FRAT was to be completed on all residents who experienced a fall and had guidance notes attached for staff detailing what action to take.

We discussed staffing levels with people's relatives, visiting professionals and care staff. We were told there was not enough care staff to meet people's needs. One visiting health professional told us, "The staff are friendly but there is not enough of them. In a morning, I've seen three care staff which is not enough to get 40 people up." A relative told us, "No I don't feel that there is enough staff but it isn't the fault of the girls. They are run off their feet. People with dementia can be demanding. The girls do their best but they can't keep on top of it." However, another relative told us, "I don't feel that people are left on their own, staff are always passing and the doors are propped open. I've never felt people are just dumped." Comments from care staff included, "It is challenging but I like my job", "We definitely could do with another person on shift because of the double ups", "I don't think there are enough of us, nobody is able to monitor wanderers", "There isn't enough of us and we miss things through rushing, not putting people's glasses on, teeth in, seating them and they've not got their Zimmer frame."

The registered manager told us they used a formal method to calculate staffing levels, based upon people's level of dependency. The registered manager had updated the dependency tool on the day of our inspection to reflect people's needs. We asked the area manager to show us how the care hours were calculated from the dependency tool and following this calculation, we found that there was a discrepancy in the care hours being provided and the care hours required. The service required 15 more care hours than were currently being provided. The area manager told us they had been working on dependency level assessments with the registered manager and intended to use the dependency tool to review staffing levels further.

The deployment of staff meant that people's needs were not always being met and sometimes they were at risk because of this. We spoke to two health care professionals who told us that 30 of the residents at Golborne House were known to them. The majority of these referrals were made as a result of moisture lesions or trauma wounds, for example; skin tears. It was acknowledged that the home was effective in making referrals but concerns were expressed in regards to the management of people's continence needs. We were told that the home was particularly effective at managing pressure relief and that that it was rare for anybody to be referred with a pressure ulcer.

This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at four personnel files and found evidence that Disclosure and Barring (DBS) checks had been carried out in three of the four staff personnel files. We asked the registered manager who told us that historic information relating to recruitment checks was likely to have been held centrally by the previous provider. The registered manager told us that they had identified there was missing DBS records for four long standing care staff and they had approached the previous provider to ascertain this information. These checks identify if prospective staff have a criminal record or are barred from working with people at risk. The four care staff had signed a declaration to say that they had no convictions and following our inspection the registered manager re-applied for a DBS check for the four care staff.

We checked to see if medication was handled safely within the home and saw that medication was administered by care team leaders (CTL's). When we checked the training matrix, we saw the CTL's had obtained a level 2 in medication training. One CTL told us their training had been nearly two years ago and they were unaware of any recent update. The medication was stored in secure trolleys. We reviewed records in relation to medication. Medication Administration Records (MAR) were kept for each person but there was no warning on the MAR alerting CTL's when people had the same surname. The CTL observed dispensing medication was aware of this and did check before dispensing to ensure that she was giving people the correct medication. The MAR was signed appropriately with no gaps. Medication audits were carried out by the manager quarterly and an external pharmacy annually which had been completed in August. We saw action plans had been completed to address issues.

During our inspection, we checked to see how the service protected vulnerable people against abuse. We found

Requires improvement

Is the service safe?

suitable safeguarding procedures in place, which were designed to protect vulnerable people from abuse and the risk of abuse. We found that all the staff had completed training in safeguarding vulnerable adults, which we verified by looking at the training matrix. The registered manager had also scheduled a team meeting to update staff on changes to the policy.

We spoke to six staff members. All the staff spoken with told us they had received appropriate safeguarding training and they were all able to describe what action they would take if they witnessed or suspected any abusive or neglectful practice. One member of staff told us "See something, say something." We also saw there were posters prominently displayed on the notice board displaying this message. This provided staff with guidance about how to report suspected abuse appropriately.

Good

Is the service effective?

Our findings

We looked at the training and professional development staff received to ensure they were fully supported and qualified to undertake their roles. The registered manager told us that staff completed a three day induction, which covered moving and handling, policies and procedures, reporting of injuries, control of substances that are hazardous to health (COSHH), practical sessions and competency based questions. We looked at the training matrix, which confirmed all staff had received the induction prior to working at the home. We asked four staff members if they had received an induction which they confirmed they had. One staff member said, "The induction was very good and the training and support I have received is very good."

From our discussions with staff and from looking at training records, we found all staff received a range of appropriate training applicable to their role. This gave them the necessary knowledge and skills to look after people properly. We looked at the training matrix, which showed staff had access to training such as: infection control, moving and handling, fire safety, first aid, safeguarding, dementia awareness and medication. Staff training was maintained and there were clear records to indicate when refresher training was scheduled to enable staff to maintain their knowledge and skills. Staff had not received an annual safeguarding update but the registered manager showed us correspondence with the local authority to arrange this. The registered manager also showed us that a team meeting had been scheduled to discuss changes in the safeguarding policy.

The registered manager expressed a commitment to staff training. Additional training had been sought and all care staff had obtained a National Vocational Qualification (NVQ) Level 2. Eight staff had gained Level 3 NVQ and a further five staff were working towards this. All the members of staff we spoke with told us they were satisfied with the training and support they had available to them. One member of staff said, "I have good, regular training. I have also just completed my NVQ." Another member of staff told us, "We have annual training and the registered manager does competency checks."

Staff told us they felt supported and were provided with regular supervision and had an annual appraisal of their work performance. We looked at the supervision matrix, which recorded that all staff had received supervision quarterly and received an annual appraisal and personal development plan. We selected three personnel files at random and saw that supervision had been conducted. The supervision was positively written and focused on achievements and areas for growth. This enabled the registered manager to assess the development needs of their staff and we saw evidence that the registered manager had scheduled training based on these discussions.

The Care Quality Commission has a duty to monitor activity under the Deprivation of Liberty Safeguards (DoLS). This legislation protects people who lack capacity and ensures decisions taken on their behalf are made in the person's best interests and with the least restrictive option to the person's rights and freedoms. Service providers are required to make an application to the local authority when it is in a person's best interests to deprive them of their liberty in order to keep them safe from harm. The registered manager demonstrated a good understanding of the Mental Capacity Act (2005) and eight people residing at the home were subject to DoLs and five people were awaiting authorisation by the local authority. One person had an IMCA following a referral made by the registered manager.

Staff had not received mental capacity and DoLS training but the registered manager showed us evidence of correspondence with the local authority to schedule the training. The registered manager also showed us team meeting minutes and supervision records were mental capacity and DoLS had been discussed. Staff spoke with demonstrated some understanding of the Mental Capacity Act and provided examples of what could constitute a deprivation. One care assistant told us, "I have not had training in MCA or DoLS but the registered manager has talked to us about it and I know one lady has an advocate because she doesn't have any family."

We looked at how people were protected from poor nutrition and supported with eating and drinking. A relative told us, "[person's name] has not lost weight; they keep a good check on her. [person's name] eats hardly anything but she never has and the care staff spend time encouraging her." Where people were at risk of poor

Good

Is the service effective?

nutrition, they had been referred to a dietician and appropriate food supplements were prescribed and offered. Regular checks were made on people's weight, either monthly or weekly depending on the assessed risk.

We observed breakfast and the lunchtime meal and saw people were offered sufficient amounts to eat and drink. A choice of meal was offered. We saw the food was nicely presented and the meal was not rushed. The meal was a relaxed and sociable time with staff and residents engaged in conversation. We saw some people required assistance eating their meal and this was done in a discreet and sensitive manner. People told us the food was good and it was warm when they received it. We saw staff remained present during breakfast and lunch and they monitored people eating their food and offered encouragement.

Staff spoken with demonstrated a good understanding of people's nutritional needs. One member of staff told us, "Some people don't eat as well and we support them with fortified food and fluids. There is one person that has difficulty swallowing and she has her food pureed. This person doesn't like fish so they don't have that."

We saw the home worked closely with other professionals and agencies in order to meet people's health needs.

Involvement with these services was recorded in people's care plans and included Chiropodists, District Nurses and Doctors. A health care professional visited the home on the day of our inspection and confirmed that they were responding to a referral that had been made by the registered manager.

We looked around and found the home was clean and free from offensive odours. We saw on the downstairs corridor people's art work was displayed on the walls from projects that people had engaged with. On the upstairs corridor there was a quiet lounge and dining area with a small kitchen that people and visitors could use to spend time together. The registered manager told us the lounge had been decorated at Christmas and families used the area to have Christmas dinner with their relative. We saw letters from relatives thanking the registered manager for arranging this. The home was clean and had been recently decorated but we didn't regard the upstairs to be 'dementia friendly' as the walls were bland and there was no signage to differentiate between corridors and bedroom doors looked exactly the same and did not clearly stand out.

Good

Is the service caring?

Our findings

One relative spoken with told us, “I am extremely happy with the care my relative receives, the staff work together and are so willing to help.” They told us their relative was out of bed when they visited and was wearing coordinated clothes. We saw that people were well groomed and well presented.

People told us, “The carers are marvellous”, “The staff are very good to you here.” Relatives told us, “All the girls are wonderful”, “The people’s faces light up when they see the carers”, “The staff are very caring. I’m been totally warmed by them. They always show respect to people.”

We observed how people were supported by staff. Staff responded swiftly and efficiently when people needed assistance. We observed people requesting a drink or wanting to go to the toilet having their needs met quickly. People were not left on their own for any length of time. We noted people appeared relaxed and comfortable in the company of staff.

We heard polite and friendly interactions between people living at the home, staff and relatives. There was a relaxed atmosphere in the home and staff were knowledgeable on people’s past histories and present likes and dislikes. There was a genuine fondness shown for the people they cared for. There was a rapport and banter which people enjoyed. We observed staff instigate social conversations sharing mutual knowledge of people who lived in the local area. Staff were seen laughing and joking with people in a positive way. One member of staff told us, “Sometimes after I’ve finished my shift, I stay on and spend time chatting with people.”

Staff spoke about the people they looked after with affection. Staff told us they had worked at the service for a long time and worked well together. One staff member said; “We don’t use bank staff, we have really good staff and everybody is always in good spirits.”

We saw staff provide explanations when assisting people. For example, when a staff member was supporting a person to eat, they sat next to the person and explained what food they were offering on the spoon and asked if the person was ready to receive another mouthful. Staff worked at the pace of the individual and did not rush the activity which gave people the opportunity to enjoy their meal.

Staff treated people with respect and called them their preferred names. A member of staff described how they protected people’s privacy and dignity. They ensured doors and curtains were closed and were respectful when assisting people with personal care tasks. They showed understanding of people’s feelings and commitment to maintaining their privacy and dignity when they talked with us about their work.

People we spoke with told us that they were able to receive visitors whenever they wanted. Relatives told us, “The manager told us at the beginning, you can visit whenever you want, any time of day and I know I can. I am always welcomed. Another relative said, “Nothing is ever too much trouble. My sister travels a long way and they always offer her a lunch. That’s the extra mile.” People were able to spend time privately with their visitors if they wished either in their own room or in the quiet lounge which was predominantly used for visitors. The lounge area promoted people’s independence as it had a kitchen area which enabled people to make their visitor a drink or offer them a biscuit.

Good

Is the service responsive?

Our findings

We saw that people's care files contained detailed information about the person. This included information about their likes and dislikes, personal preferences and hobbies. There was attention to detail and one relative told us, "Before mum moved in, I was asked to write down as much information as I could about her; jobs, holiday's, things to start a conversation with. My mum doesn't always remember and she looks to me but at least the team try."

The home employed two activities coordinators who arranged games, social events and leisure type activities within the home. These included arts and crafts, pet therapy, musicians, movies, singing, fetes, trips, baking, arm chair exercises, dominoes, cards and bingo. People's art work was displayed throughout the home. On the wall there was a project named "if I was a flower" and there were folders scattered throughout the home with clippings of news events. The home's pet cat wandered around the home and we saw people took an interest in the cat when he entered communal areas.

On the second day of the inspection, there was a vibrant atmosphere in the home. The activities coordinator had arranged arm chair exercises and we observed 22 people of varying ability engaged in the activity. We spoke to the activities coordinator and they told us how they had developed the activity programme to meet different people's needs and hobbies. The activities coordinator had an excellent knowledge of each person's interests and told us different ways in which they had engaged people. For example, the activity coordinator told us that one gentleman enjoyed golf so she would inform him when golf was on the television and engage him in conversation about the sport. Another lady enjoyed flower arranging so the activity coordinator would pick up materials to enable the person to engage in this activity. One person told us that they supported Liverpool football club and for their 'special' birthday the activity coordinator had arranged for Ian Rush to visit them and they had received a card from Steven Gerard.

We heard people talking about the bingo that was scheduled for that evening and one person told us, "I'm looking forward to bingo, I enjoy it." Relatives told us, "[person's name loves listening to music and singing. The activities coordinator sits and plays dominoes with her."

Another relative told us, "The staff encourage people to get involved quite a lot. There was a gentleman playing the guitar and [person's name] was reluctant to go but they encouraged her and she really enjoyed it."

Each person had a key worker. This was a member of staff who met regularly with the person to make sure their care was given in ways that suited them and their needs were met. One relative told us, "I really like it that [person's name] has one designated carer. She has got used to them. They wash [person's name] and she says they are a darling." Another person told us "[person's name doesn't like showers and is scared of the bath. She was the same with me. They listened to what I said and they top and tail her. They apply her cream. That's lovely." Staff knew people well. People could choose when to get up and go to bed and breakfast was flexible to accommodate this. People told us they could have a drink when they wanted and some people told us they liked a whiskey before bed some days and this was accommodated.

The home had a number of communal rooms that people who lived there could use. This included a quiet lounge with a kitchen. There was a garden area that people could access when they wanted and plans in place for there to be a vegetable garden.

Some people had complex needs and required their care to be reviewed from other visiting health professionals. One health professional we spoke with told us, "I am very happy with the care being offered here. I have no concerns. I feel feedback is taken on board." However another health professional told us that they didn't feel there was enough staff and this impacted on how frequently they could toilet people. The health care professional also told us," There are things they do very well. There's drinks being offered frequently and through summer people were offered ice cream and lollies regularly."

People and relatives had information about how to make a complaint and this was displayed in the front entrance. People told us they knew how and who to raise any concerns or complaints too. One relative told us, "I haven't been unhappy about much but when I have, they've responded." Another relative told us, "Some of my mum's clothing had gone missing but I reported it to the registered manager and she went straight out and replaced them."

There were effective systems in place to investigate and respond to people's complaints. The home had a concerns

Good

Is the service responsive?

and complaints policy, which gave clear guidance and timescales to staff on how to deal with complaints. We saw the complaints process displayed in communal areas and by the door. The registered manager discussed with us the process they would use to investigate complaints and we found that they had a thorough understanding of the complaints procedure.

We looked at the complaints received and noted that there had been one complaint recorded in the last year. Issues raised had been dealt with and records maintained. The manager said that if there were any concerns, they discussed the issues and dealt with them as and when they arose. There were a number of compliments made about the home.

Requires improvement

Is the service well-led?

Our findings

There was 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 staffing structure in place made sure there were clear lines of accountability and responsibility. At the time of our inspection the registered manager was on duty.

On arrival at the home we asked for a variety of documents to be made accessible to us during our inspection. These were provided promptly. We found all the records we looked at were organised in a structured way which made information accessible and easy to find.

The registered manager was visible throughout the inspection and one person told us, "I like the manager, she tells the truth." Another person told us, "The manager is lovely; she always has time for us." Relatives told us they could speak with the registered manager or staff if they had any concerns and these were responded to. All of the people we spoke with, and their relatives, told us that they would be happy to raise concerns about the service provided. Each person knew who the registered manager was and said they were approachable. One relative told us, "The registered manager always has her door open. I've seen when somebody is upset, she goes and sits with them and comforts them quietly."

Staff told us they felt well supported by the management and were able to raise concerns or make suggestions about how to improve the service. One care worker said, "What we do is hard work but I leave here and think I've done a good job. We've got a good set of girls and a really good manager that picks things up too." We were told there was no agency staff use. The registered manager told us, "The staff are very good, they will cover each other if that is needed." It was clear to us that the management team were proud of the staff that were employed at the home.

We saw a staff meeting took place in January and June and there was another scheduled for the end of September. We saw that the registered manager had encouraged staff to share best practice and their experience of things working well to drive change within the home. However, staffing levels were discussed at the January meeting and consideration given to the deployment of staff but nothing had been done to address this and it was evident at the inspection that there was not sufficient staff on duty at certain times to meet people's needs.

We reviewed documentation of residents' meetings, which were held biannually. The meeting minutes were person centred and focused on people's suggestions for improving the home. There were associated action plans in place. The fire brigade had attended the meeting and discussed health and safety issues and spoken to people about what to do in the event of a fire. This allowed people to talk about things they felt were important to them in an open forum and to make suggestions, as well as provide feedback about the services and facilities available.

We looked at five people's care plans which were called, 'getting ready for the day' to establish people's preferred personal care arrangements. We looked at the personal care records which were completed by staff when the person's personal care needs had been met. The personal care records had large gaps in the five records that we looked at. For example, one person's care plan identified they took pride in their personal appearance and had a body wash because they were unable to have a bath due to their leg dressings. We looked at the personal care record and found that the last three entries for attending to this person's personal care were 30 May, 11 June, 26 July and no further entries had been made. We raised this with the registered manager who told us that the person's personal care needs had been met but that staff were not consistently reporting this in the documentation to reflect that it had occurred.

This was in breach of regulation 17(1)(2)(c)of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The area manager, registered manager and staff undertook a large number of audits covering all aspects of the service. However, the internal quality monitoring system had failed to identify some of the safety concerns recognized at the time of our inspection and reported on within the relevant section. During this inspection we identified risks were not always accurately assessed and risk assessments were not updated to reflect changes in risks. The provider took action following our inspection to mitigate some of these risks.

Requires improvement

Is the service well-led?

This was in breach of regulation 17(1)(2)(a)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager demonstrated a commitment to address any issues identified in a planned and structured way. Following our inspection visit the registered manager gave us feedback on how she had started to address areas of concerns we identified during the visit, these included specific actions such as implementing a new assessment to assess falls, updating records and staff training.

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 How the regulation was not being met: Appropriate systems were not in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. A record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided was not documented. Regulation 17 (1)(2)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: There were insufficient staffing levels at the home to look after people safely. Regulation 18 (1)

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: The provider was not assessing the risks to the health and safety of service users of receiving the care or treatment and doing all that is reasonably practicable to mitigate any such risks. Regulation 12(1)9")(a)(b).

The enforcement action we took:
We issued a warning notice. The provider is required to comply with the warning notice by 01February 2016.