Tamaris Healthcare (England) Limited

Elswick Hall Care Home

Inspection report

Gloucester Terrace
Elswick
Newcastle Upon Tyne
Tyne and Wear
NE4 6RH

Tel: 01912731772
Website: www.fshc.co.uk

Date of inspection visit:
28 April 2016

Date of publication:
26 July 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?	**Requires Improvement**
Is the service well-led?	**Good**

Summary of findings

Overall summary

This was an unannounced inspection which we carried out on 28 April 2016.

We last inspected Elswick Hall Care Home in September 2014. At that inspection we found the service was meeting the legal requirements in force at the time.

The home provides nursing care and support for up to 47 people, some of whom may have mental health needs or live with dementia and associated conditions. The 'neuro-disability' suite, located on the ground floor, provides nursing care to 18 people with various neurological conditions, as well as people with acquired brain injuries.

A registered manager was in place. 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.

People said they felt safe. We had concerns however that there were not enough staff on duty to provide timely and individual care to people. Care was provided with kindness and people's privacy and dignity were respected. However, we saw staff were busy and did not always have time to interact and talk with people except when they were carrying out care tasks.

People were protected as staff had received training about safeguarding and knew how to respond to any allegation of abuse. When new staff were appointed, thorough vetting checks were carried out to make sure they were suitable to work with people who needed care and support. Appropriate training was provided and staff were supervised and supported.

Elswick Hall Care Home was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). Staff had received training and had an understanding of the Mental Capacity Act 2005 and best interest decision making, when people were unable to make decisions themselves. People had access to health care professionals to make sure they received appropriate care and treatment. Systems were in place for people to receive their medicines in a safe way.

Communication was effective, ensuring people, their relatives and other relevant agencies were kept up to date about any changes in people's care and support needs and the running of the service.

Menus were varied and a choice was offered at each mealtime. Staff supported people who required help to eat and drink and special diets were catered for.

Limited activities were available for people and the activities and entertainment programme required expansion to ensure it met people's interests. We have made a recommendation about more activities

provision across the home.

The environment was mostly well-maintained but some bedrooms were showing signs of wear and tear.

A complaints procedure was available. People told us they would feel confident to speak to staff about any concerns if they needed to. People had the opportunity to give their views about the service. There was regular consultation with people or family members and their views were used to improve the service. The provider undertook a range of audits to check on the quality of care provided.

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

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

Not all aspects of the service were safe.

People told us they felt safe. However staffing levels were not sufficient to ensure people were looked after in a safe and timely way.

Staff were aware of different forms of abuse and they said they would report any concerns they may have to ensure people were protected.

People received their medicines in a safe manner.

Checks were carried out regularly to ensure the building was safe and fit for purpose.

Is the service effective?

Good

The service was effective.

Staff received the training they needed and regular supervision and appraisals.

People's rights were protected. Best interest decisions were made on behalf of people, when they were unable to give consent to their care and treatment.

Effective communication ensured the necessary information was passed between staff to make sure people received appropriate care. Staff liaised with General Practitioners and other professionals to make sure people's care and treatment needs were met.

People received food and drink to meet their needs and support was provided for people with specialist nutritional needs.

Is the service caring?

Good

The service was caring.

The staff team were caring and patient as they provided care and support.

Staff were aware of people's needs and met these in a sensitive way that respected people's privacy and dignity.

There was a system for people to use if they wanted the support of an advocate. Advocates can represent the views of people who are not able to express their wishes.

Is the service responsive?

Requires Improvement

The service was responsive.

There was good standard of record keeping. This meant people received support in the way they wanted and needed because staff had detailed guidance about how to deliver their care.

People were provided with some activities but the activities programme needed to be extended to ensure they were available to more people. People had the opportunity to access the local community. We have made a recommendation about activities provision across the home.

People had information to help them complain. Complaints and any action taken were recorded.

Is the service well-led?

Good

The service was well-led.

A registered manager was in place.

Staff and relatives told us the manager was supportive and could be approached for advice and information.

The home had a quality assurance system to check on the quality of care provided.

Elswick Hall 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 28 April 2016 and was unannounced. The inspection team consisted of an inspector 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 for older people.

Before the inspection we reviewed the information we held about the service prior to our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send CQC within required timescales. We contacted commissioners from the local authorities and the local safeguarding teams. We received no information of concern from these agencies.

During this inspection we carried out observations using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not communicate with us.

We undertook general observations in communal areas and during mealtimes.

During the inspection we spoke with 11 people who lived at Elswick Hall, two relatives, the registered manager, two registered nurses, six support workers, one domestic worker, the activities organiser and two members of catering staff. We observed care and support in communal areas and looked in the kitchen, bathrooms, lavatories and some bedrooms after obtaining people's permission. We reviewed a range of records about people's care and how the home was managed. We looked at care records for six people, recruitment, training and induction records for four staff, four people's medicines records, staffing rosters, staff meeting minutes, meeting minutes for people who used the service and relatives, the maintenance book, maintenance contracts and quality assurance audits the manager had completed.

Requires Improvement

Is the service safe?

Our findings

The service provides care and support to people with neurological needs and associated physical conditions, including some behaviours that challenged. We had concerns there were insufficient numbers of staff available to care for people in a safe, consistent and timely way although some people had commented that they felt safe. Due to some people's complex needs we were not able to gather their views. Other people said they felt safe and they could speak to staff. Peoples' comments included, "Yes, I do feel safe with staff around," "Staff help me when I need it," It's alright living here sometimes," " Yes, I feel safe," "I don't always feel safe, as staff make me hurry in the shower," "The staff are always busy," "The staff work very hard, but I don't think they are happy," "They're not nearly enough staff," and, "Everything is okay."

At the time of our inspection there were 40 people who lived at the home. Each floor provided a nurse and three support workers to support people. Across the home we saw staff were particularly busy because of the personal care needs of the people. We had concerns on the ground floor that there were insufficient staff to provide support to people due to their specialist neuro disability needs which included their physical support requirements. On the top floor 21 people were supported by one nurse and three support workers. We were told nine people also required two members of staff for their moving and assisting needs. We observed people had to wait for assistance as staff were busy. Some people who spent time in their room did not see staff except at mealtimes as staff did not call in to see them. A number of people had distressed behaviour and needed consistent care and support to help maintain their equilibrium.

We were told 14 of the 19 people accommodated on the ground floor required two members of staff for their moving and assisting needs and 12 people required total assistance for all their care and support. Six people displayed distressed behaviour and their care plans stated they needed reassurance and supervision from two members of staff because of their anxiety. The nurse on each floor was not available to provide direct care and support as they had other duties to carry out to ensure people's health care needs were met. This meant whilst one person was assisted by two staff other people had to wait for help as only one member of support staff was available to provide supervision and support. Peoples' comments included, "I'm late getting up as they're short of staff, it varies I'd usually have been up earlier. I haven't had breakfast and now it's too late as it's nearly lunchtime," and, "I often have to wait for support, especially at night."

We noted the safeguarding log included a number of safeguarding alerts raised by visitors to the service about the lack of quality care and support to people as staff were so busy. Staff members comments included, "We don't have time to spend constructively with people as we used to," "We could do with more staff," "Mornings are particularly busy," "Downstairs there are only three of four people who don't need two staff members to support them for moving and assisting," and, "There used to be four members of support staff downstairs then it reduced to three." This meant staffing levels were not sufficient to assist people in a timely way and to provide person centred care. The registered manager told us a dependency tool was used to calculate the required staffing levels for the home, however we considered due to people's needs and physical care requirements there were not sufficient support staff to provide person centred care to people in a timely way.

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

The registered manager understood their role and responsibilities with regard to safeguarding and notifying the Care Quality Commission (CQC) of notifiable incidents. They had ensured that notifiable incidents were reported to the appropriate authorities and independent investigations were carried out if necessary. We viewed the safeguarding records and found concerns had been logged appropriately by the manager. 17 safeguarding alerts had been raised since April 2015. They had been investigated by the provider where required and the necessary action had been taken by the provider to address the concerns. The information had been shared with other agencies for example, the local authority safeguarding team.

Staff had an understanding of safeguarding and knew how to report any concerns. They were able to describe various types of abuse and tell us how they would respond to any allegations or incidents of abuse and knew the lines of reporting within the organisation. One staff member told us, "New safeguarding training is coming out." Staff told us they would report any concerns to the registered manager. One support worker told us, "I'd report any concerns to the nurse on shift straight away." Nursing staff spoken with showed a good understanding of peoples' individual needs and their vulnerabilities, and the need to provide a safe environment. They said they regularly reminded care staff of the safeguarding process.

Records showed if there were any concerns about a change in a person's behaviour a referral would be made to the department of psychiatry or the community mental health team. Staff told us two people were currently involved with the behavioural team. They followed the instructions and guidance of the behavioural team for example to complete behavioural charts if a person displayed distressed behaviour. The team also talked them through the guidance that was available in the specialist care plan for the person that was devised by the team. This specialist advice, combined with the staff's knowledge of the person, helped reduce the anxiety and distress of the person because the cause of distress was then known. One staff member told us, "We've had training about [Name]'s distressed behaviour from the behavioural team. [Name] can be fine one moment but then after a lie down the behaviour can be changed."

Medicines were given as prescribed. We observed a medicines round. We saw staff who were responsible for administering medicines checked people's medicines on the medicine administration records (MAR) and medicine labels to ensure people were receiving the correct medicine. Staff who administered the medicines explained to people what medicine they were taking and why. People were offered a drink to take with their tablets and the staff remained with the person to ensure they had swallowed their medicines. Medicines records were accurate and supported the safe administration of medicines. There were no gaps in signatures and all medicines were signed for after administration.

Systems were in place to ensure that all medicines had been ordered, administered safely and audited. Medicines were stored securely within the medicines trollies and treatment room. Records showed temperatures were recorded daily. Medicines which required cool storage were kept in a fridge within the locked treatment room. Records showed current temperatures relating to refrigeration were recorded daily and were within the required range for the storage of refrigerated medicines. Appropriate arrangements were in place for the administration, storage and disposal of controlled drugs, which are medicines which may be at risk of misuse.

Staff were trained in handling medicines and a process was in place to make sure each worker's competency was assessed. Staff told us they were provided with the necessary training and felt they were sufficiently skilled to help people safely with their medicines.

Risk assessments were in place that were reviewed and evaluated in order to ensure they remained relevant, reduced risk and to keep people safe. They included risks specific to the person such as for falls, pressure area care and nutrition. Records contained information for staff on how to reduce identified risks, whilst avoiding undue restrictions. For example, a falls risk assessment included measures to minimise the risk of falls.

A personal emergency evacuation plan (PEEP) was available for each person taking into account their mobility and moving and assisting needs. It also included their mental capacity to understand. The plan was reviewed monthly to ensure it was up to date. This was for if the building needed to be evacuated in an emergency. However, we noted some records on the top floor such as the PEEP assessments, the bedroom fire risk assessments and the long term falls risk assessments that were in place were not all dated to show when they were initially carried out. The registered manager told us that this would be addressed.

We spoke with members of staff and looked at personnel files to make sure staff had been appropriately recruited. We saw relevant references and a result from the Disclosure and Barring Service (DBS) which checks if people have any criminal convictions, had been obtained before applicants were offered their job. Records of checks with the Nursing and Midwifery Council to check nurses' registration status were also available and up to date. Application forms included full employment histories. Applicants had signed their application forms to confirm they did not have any previous convictions which would make them unsuitable to work with vulnerable people.

We saw from records that the provider had arrangements in place for the on-going maintenance of the building and a maintenance person was employed. Routine safety checks and repairs were carried out, such as checking the fire alarm and water temperatures. External contractors carried out regular inspections and servicing of, for example, fire safety equipment, electrical installations and gas appliances. There were records in place to report any repairs that were required and this showed that these were dealt with. We also saw records to show that equipment used at the home was regularly checked and serviced, for example, the passenger lift, hoists and specialist baths.

Good

Is the service effective?

Our findings

Staff had opportunities for training to understand people's care and support needs and they were supported in their role. Support staff said they received regular supervision from one of the home's management team every three months and nurses received supervision from the registered manager. Staff comments included, "The registered manager does my supervision," "At supervision I'm asked how I'm getting on, how I'm enjoying the job and if there is anything I'd change," "I feel supported," and, "Nurses supervise support staff." Staff also received an annual appraisal to evaluate their work performance and to jointly identify any personal development and training needs. A staff member commented, "I have an appraisal annually."

Staff members were able to describe their role and responsibilities. Some staff told us when they began work at the service they completed an induction programme and they had the opportunity to shadow a more experienced member of staff. This ensured they had the basic knowledge needed to begin work. Staff member's comments included, "Staff do induction with the help of the manager," and, "When I started I did some training on line and had an induction book and file to complete for three months." The registered manager told us new staff members had the opportunity to study for the Care Certificate in health and social care as part of their induction training.

Staff told us and training records showed they were kept up-to-date with safe working practices. Staff members comments included, "I do loads of training," "There's enough training," "We've done training about dignity," and, "There are opportunities for training." The registered manager told us there was an on-going training programme in place to make sure staff had the skills and knowledge to support people. Staff training courses included equality and diversity, basic life support, allergen awareness in care, mental capacity, dignity, challenging behaviour, catheter care, urinary tract infections and deprivation of liberty safeguards.

A weekly clinic took place at the home. The clinic was run by the General Practitioner (GP) from a local surgery, a specialist nurse and was supported by a nurse from the home. The clinic was held to review people's health needs and their medicines and make sure they were treated promptly. It was also to help prevent people's unnecessary admission to hospital. We were told relatives also had the opportunity to attend the clinic to support their relative.

People were supported to maintain their healthcare needs. People's care records showed they had regular input from a range of health professionals. Staff received advice and guidance when needed from specialists such as, a dietician, a psychiatrist, the behavioural team and General Practitioners (GPs). Records were kept of visits and any changes and advice was reflected in people's care plans. For example, the behavioural team had become involved when a person had extreme distressed behaviour.

Staff told us communication was effective. We were told a handover session took place, to discuss people's needs when staff changed duty, at the beginning and end of each shift. This was to ensure staff were aware of the current state of health and well-being of the person. We saw handover records contained information

about the care provision and the state of well-being for each person over the previous 12 hours. Written information was also referred to with regard to any concerns with people's dietary needs and any personal care issues.

Staff told us the diary and communication book also provided them with information as well as daily care entries in people's individual records. Staff members' comments included, "Communication is good," "Communication is rubbish," "If you've been off you sometimes just get information filtered through the staff," "It's okay," and, "We usually get told all we need to know." We discussed with the manager the negative comment about communication and we were satisfied with their response. Records showed relatives were kept informed by the staff about their family member's health and the care they received.

We checked how people's nutritional needs were met. Care plans were in place that recorded people's food likes and dislikes and any support required to help them eat. We spoke with the chef who was aware of people's different nutritional needs and special diets were catered for. The chef told us they received information from nursing staff when people required a specialised diet. For example, diabetic and soft or pureed diets. Preferences related to people's culture of beliefs were also catered for, such as a vegetarian diet. The chef explained about how people who needed to increase weight and to be strengthened would be offered a fortified diet and they explained how they would be offered milkshakes, butter, cream and full fat milk as part of their diet. We looked around the kitchen and saw it was well stocked with fresh, frozen, home baked and tinned produce. We saw food was well presented and meals looked appetising. People told us they had a choice at meal times. They were positive about the food saying they had enough to eat and received good food. People's comments included, "The food is good," "I enjoy a cooked breakfast," and, "The food is above average." Hot and cold drinks were available throughout the day.

There were systems to ensure people identified as being at risk of poor nutrition were supported to maintain their nutritional needs. This included monitoring people's weight and recording any incidence of weight loss. Referrals were also made to relevant health care professionals, such as dieticians and speech and language therapists for advice and guidance to help identify the cause. Records were up to date and showed people with nursing needs were routinely assessed monthly against the risk of poor nutrition using a recognised nutritional screening tool. Information from people's nutritional assessments were transferred to a care plans where necessary. Nutritional care plans also recorded people's food likes and dislikes and any support required to help them eat. For example, "Where people had been identified as at risk of poor nutrition staff completed daily 'food and fluid' balance charts to record the amount of food and drink a person was taking each day.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and be the least restrictive possible.

Records contained information about people's mental health and the correct 'best interest' decision making process, as required by the Mental Capacity Act 2005. Best interest decision making is required to make sure people's human rights are protected when they do not have mental capacity to make their own decisions or indicate their wishes. Peoples' care records showed when 'best interest' decisions may need to be made. For people who did not have the capacity to make these decisions, their family members and health and social care professionals involved in their care made decisions for them in their 'best interests'. For example, a care plan recorded, "All best interest decisions should be made in consultation with family, other health professionals, social care professionals or an IMHCA." (Independent Mental Health Care Advocate.)

People can only be deprived of their liberty so that they can 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. Staff were aware of and had received training in the MCA and the related Deprivation of Liberty Safeguards (DoLS). They had a good understanding of the MCA and best interest decision making, when people were unable to make decisions themselves. One staff member told us, "I'm doing the MCA training again as I've just come back to work." The registered manager and staff were aware of the deprivation of liberty safeguards and they knew the processes to follow if they considered a person's normal freedoms and rights were being significantly restricted. The manager told us 17 applications had been authorised and other applications were in the process of being completed for people. One person was appealing with the relevant authority against the DoLS that was in place for them.

We looked around some of the premises and observed some bedrooms, although personalised they were showing signs of wear and tear as bedroom walls were marked. One person commented, "Could I just have my room decorated, I'd love some wallpaper to make it brighter." We were aware refurbishment work was in progress and decorating had taken place in communal areas and hallways and some bedrooms. We identified with the manager the rooms we had observed where work still needed to be carried out. We also discussed the televisions in communal areas and some peoples' bedrooms that had a poor quality television picture. The registered manager told us there had been a problem with the outside television aerial which had been adjusted but this would be followed up to make sure all the televisions were tuned to provide a better reception.

Good

Is the service caring?

Our findings

People who used the service we spoke with were positive about the care and support provided. Peoples' comments included, "It's alright living here," "I am quite happy," "Staff are helpful," "Most staff respect me," and, "Staff are kind and caring." A relative commented, "Staff are alright." Staff were observed to be respectful in their approach with people. They called people by their preferred name. Staff we spoke with were able to clearly explain how they would preserve people's privacy, for example when providing personal care.

People were supported by staff who were kind, caring and considerate. Staff engaged with people in a calm and quiet way. They bent down when they carried out tasks with the person and as they talked to people so they were at eye level. They asked the person's permission before they carried out any intervention. For example, "Can I help you stand up.?" The interactions we observed between staff and people who used the service were friendly, supportive and encouraging. Staff explained what they were doing as they supported people, for example, one staff member said as they assisted someone to eat, "I'll sit down this side of you," and they met their needs in a sensitive and patient manner.

We observed the lunch time meals on the units. People sat at tables set with tablecloths and place mats, however downstairs we observed the tables were not tidied from the breakfast meal. Specialist equipment such as cutlery and plate guards were available to help people. People sat at tables set for three or four and staff were available to provide help and support to people. Some people remained in their bedrooms to eat. Staff were mostly respectful to people and they provided full assistance or prompts to people to encourage them to eat, and they did this in a quiet, gentle way and explained to people what they were getting to eat. For example, staff comments included, "This smells good," "Have you had enough to eat," and, "What can I get you to drink." However, we did observe downstairs that some staff members were not respectful to people and spoke amongst themselves as they helped people. Some staff talked over people as they assisted them and they appeared distracted whilst assisting people. For example, we observed a person who was served their meal on a tray was not assisted to remove the cover protecting their food and it was 10 minutes before a member of staff noticed the person could not access their meal. We discussed this with the registered manager who told us it would be addressed.

Staff we spoke with had a good knowledge of the people they supported. They were able to give us information about people's needs and preferences which showed they knew people well. A one page profile that included information about how the person wanted to be supported, and what made them happy was also available in their bedroom. This was to inform new staff, who didn't know people, how people wanted and needed to be supported. For example, one profile recorded, "I like to sit and read the Bible or a newspaper," and, "I'm happy if I'm able to have a glass of beer in the evening." Staff described how they supported people who did not express their views verbally. They gave examples of asking families for information and showing two items of clothing so people could choose what they would like to wear. This encouraged the person to maintain some involvement and control in their care. Staff also observed facial expressions and looked for signs of discomfort when people were unable to say for example, if they were in pain.

Important information about people's future care was stored prominently within their care records, for instance where people had made advance decisions about their future care. Records looked at, where these were in place, showed the relevant people were involved in these decisions about a person's end of life care choices. The care plan detailed the "do not attempt cardio pulmonary resuscitation" (DNACPR) directive that was in place for the person. This meant up to date healthcare information was available to inform staff of the person's wishes at this important time to ensure their final wishes could be met.

We were told the service used advocates as required but most people had relatives to speak up on their behalf. Advocates can represent the views for people who are not able to express their wishes. We were told two people were supported by Independent Mental Health Care Advocates (IMHCA) because they lacked the mental capacity to make decisions with regard to their well-being. Information was displayed that advertised what advocacy was and how the service could be accessed.

Requires Improvement

Is the service responsive?

Our findings

We considered improvements were required to ensure a range of activities were available for people on both floors of the home to keep them entertained and occupied if they wanted to be involved. People's comments about activities included, "I just sit and wait for my relative to take me out," and, "I wait for my [Name] to visit," "We need a library here," I'd love to go swimming," "I just sit here all day and watch television," "We went to a pantomime at Christmas," "I can come and go as I wish," and, "There isn't much to do here," and, "I spend time in my room listening to music."

An activities organiser was available. A programme of activities was available and these included, bingo, baking, games and puzzles, pamper sessions, cinema, karaoke, card games and one to one shopping. In the morning we saw the activities person went shopping with one person, when baking was advertised. They told us they wouldn't have time for the activity as it was near lunch time. We saw in the afternoon a group baking session took place that a number of people on the ground floor enjoyed. However, during the day we did not see any activities taking place with people on the top floor and people sat on their own for long periods of time as staff were busy. We observed care was task centred and not person centred as staff did not have time to interact with people except when they carried out care. We spoke with the activities person and were shown photographic evidence of entertainment and activities that had taken place between 2005 and 2010. Recordings of activities in people's care records were spasmodic and did not show they took place regularly around the home as advertised. We noted meeting minutes with people showed activities were an item for regular discussion as improvements were required. However, we did not see evidence of action taken. We discussed with the registered manager the comments that had been received and that more people should have the opportunity to be involved in activities.

We recommend the service considers the range of current activity provision to ensure it is extended and reflects peoples' different interests.

Records reflected peoples' care and support needs. Assessments were carried out to identify people's support needs and they included information about their medical conditions, dietary requirements and their daily lives. Care plans were developed from these assessments that outlined how these needs were to be met. Records showed that monthly assessments of peoples' needs took place with evidence of evaluation that reflected any changes that had taken place. Examples included, nutrition, communication, pressure area care, mobility and falls and personal hygiene. Evaluations were more detailed and included information about peoples' progress and well-being. Staff had up to date information and guidance about people's care and support needs which also detailed how their care was to be delivered. For example, one person's nutritional care plan recorded, "[Name follows a diabetic diet, they don't like tea and coffee, staff to monitor [Name] while eating."

Staff at the service responded to people's changing needs and arranged care in line with their current needs and choices. The service consulted with healthcare professionals about any changes in peoples' needs. For example, the behavioural team were asked for advice with regard to people's distressed behaviour as required. For another person who had difficulty with swallowing a speech and language therapist had

become involved. Staff completed a daily diary for each person and recorded their daily routine and progress in order to monitor their health and well-being. This information was then transferred to people's support plans which were up-dated monthly.

Charts were also completed to record any staff intervention with a person. For example, when staff turned a person in bed, where it was identified a person was at risk of developing pressure areas, when personal hygiene was attended to and other interventions to ensure peoples' daily routines were met. These records were used to make sure staff had information that was accurate so people could be supported in line with their up-to date needs and preferences.

Staff were knowledgeable about the people they supported. They were aware of their preferences and interests, as well as their health and support needs, which enabled them to provide a more personalised service. Care plans were more detailed and provided information and guidance for staff about peoples' care needs and how they liked to be supported. For example, two care plans for personal hygiene detailed, "I like to dress casually in a t-shirt and jogging bottoms," and, "[Name] requires assistance from one member of staff to prompt them." Care plans for other needs were in place. For example, part of a care plan for a bedtime routine recorded, "[Name] normally goes to bed before midnight with a glass of milk and is up early for a cup of coffee."

Meetings were held with people who used the service and their relatives. The registered manager told us meetings were held three monthly and provided feedback from people about the running of the home. Meeting minutes showed that people were asked for ideas about activities and outings and they were kept up to date about the running of the home for example, decorating that was taking place. They were also given information about the recent audit they had completed about the 'quality of life' in the service.

People said they knew how to complain. Peoples' comments included, "I'd speak to the manager if I had any concerns," and, "I've no complaints." The complaints procedure was on display in the entrance to the home. A record of complaints was maintained and we saw a regular audit of complaints was carried out.

Good

Is the service well-led?

Our findings

A registered manager was in post and they had registered with the Care Quality Commission in 2016.

We were told regular analysis of incidents and accidents took place. The registered manager said learning took place from this and when any trends and patterns were identified, action was taken to reduce the likelihood of them recurring. For example, incidents of distressed behaviours were monitored and referrals would be made to the relevant agency as required.

Records showed audits were carried out regularly and updated as required. The registered manager told us a daily audit took place which involved a daily walk around by the manager of the service. It was completed electronically and all responses and outcomes were received directly by head office each day. The responses were escalated electronically and depending upon the category triggered senior management within the organisation to make them aware of any issues that had been identified.

Monthly audits included checks on people's dining experience, staff supervision, medicines management, care documentation, training, kitchen audits, accidents and incidents, clinical governance and nutrition. We were told monthly visits were carried out by a representative from head office who would speak to people and the staff regarding the standards in the home. They also audited and monitored the results of the audits carried out by the manager to ensure they had acted upon the results of their audits. All audits were available electronically and we saw the information was filtered to ensure any identified deficits were actioned. For example, to check meeting minutes were available. Other audits included checking a sample of records, such as care plans, complaints, accidents and incidents, nutrition and hydration, safeguarding and staff files. These audits were carried out to ensure the care and safety of people who used the service and to check appropriate action was taken as required. An annual external audit of finances was also carried out by a representative from head office.

Staff told us and we saw staff meeting minutes to show staff meetings took place regularly and these included nurses meetings and general staff meetings. Staff meetings kept staff updated with any changes in the service and to discuss any issues. Meeting minutes showed areas discussed included, health and safety, staff training, staff performance and safeguarding." Staff said they felt supported and the manager was approachable. Staff members' comments included, "[Name] is really approachable, I can speak to them anytime," and, "The manager is always around."

The registered provider monitored the quality of service provision through information collected from comments, compliments/complaints and survey questionnaires that were available for people who used the service and their visitors to complete. We saw an electronic system that was used in each of the provider's services so an instant response could be collected from people. We saw the monthly visit by the provider's representative audited the responses received including the amount completed each month. The question analysis for the month of April 2016 showed 45 questionnaires had been completed. From the responses received 24.44% said they were extremely likely to recommend the home to other people, 68.89% of respondents said they were likely to recommend the home to other people, and 2.22% were neither likely

nor unlikely to make the recommendation. The questionnaire included many other areas of relevance to people who used the service in order to monitor care provision.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person had not ensured staffing levels were sufficient to provide safe and person centred care to people at all times. 18(1)