Five Stacks Residential Home Limited

Five Stacks Residential Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Five Stacks Residential Care Centre is a residential care service that provides accommodation and personal care for up to 30 adults including those living with dementia. The service includes a self-contained wing specifically for up to 7 people with learning disabilities. There were 27 people in the service when we inspected on 4 May 2017. This was an unannounced inspection.

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.

Systems in place to reduce people being at risk of potential abuse were not robust. We were not assured that all incidents which could constitute abuse had been appropriately referred to the relevant safeguarding authority.
The inappropriate management of people's medicines placed them at risk of harm. People were not protected from the risks associated with moving and handling, pressure care or catheter care. The provider had failed to take the necessary actions to ensure that the risks to the health and safety of service users were assessed, mitigated and reviewed appropriately.

Despite our concerns, people presented as relaxed and at ease in their surroundings and with the staff. People told us they felt safe and there were enough staff to meet their needs. Concerns and complaints had been investigated, responded to, and appropriate action taken.

Care plans did not always accurately reflect people's current care and support needs. Records were disorganised and it was not clear what was current information and what should be archived. However, care plans were written in a person centred manner and gave details about what was important to people, their likes and dislikes. People told us that they received personalised care which was responsive to their needs.

Staff were encouraged by the management team to spend time socialising with people throughout the day and engaging in activities with them. We discussed with the management team how people would benefit from a more structured approach to activities to ensure resources available to them were put to good use.

The management team and staff understood their responsibility to comply with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff sought people's consent before providing support or care and acted in accordance with their wishes. However we were concerned that people were not always supported to have maximum choice and control of their lives and staff did not always support people in the least restrictive way possible.

Staff were compassionate, attentive and caring in their interactions with people. They understood people's preferred routines, likes and dislikes and what mattered to them. They were trained and received regular

supervision, however there were some areas such as moving and handling and challenging behaviours where additional training was needed.

People's nutritional needs were assessed and met. People were offered meals that were suitable for their individual dietary needs. People were supported to see, when needed, health and social care professionals to make sure they received appropriate care and treatment. The service proactively engaged with these professionals and acted on their recommendations and guidance in people's best interests.

The provider had quality assurance systems in place but these systems had failed to identify shortfalls and areas where improvements were needed. Quality assurance systems needed to be more robust to ensure all potential shortfalls were identified and responded to appropriately to ensure the delivery of safe, effective and responsive care and to drive continuous improvement.

During this inspection we identified a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The Commission is considering its enforcement powers.

The management team were open and transparent throughout the inspection, seeking feedback to improve the service provided. Following our inspection the manager and providers put together a robust action plan to address all of the concerns raised and immediately started work on making the required improvements.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Systems in place to reduce people being at risk of potential abuse were not robust.

The inappropriate management of people's medicines placed them at risk of harm.

Not all risks to the health and safety of service users had been assessed, mitigated and reviewed appropriately.

There were enough staff to meet people's needs.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff were trained and received regular supervision however there were some areas where additional training was needed.

Staff understood the importance of gaining people's consent. However we were concerned that people were not always supported to have maximum choice and control of their lives.

People had access to appropriate services which ensured they received on-going healthcare support.

Is the service caring?

Good

The service was caring.

Staff were compassionate, attentive and caring in their interactions with people.

Staff understood people's preferred routines, likes and dislikes and what mattered to them.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans did not always accurately reflect people's current care and support needs.

Despite the shortfalls within people's records, people told us that they received personalised care which was responsive to their needs.

Although people engaged in activities, a more structured approach would enhance their experience.

Concerns and complaints had been investigated, responded to, and appropriate action taken.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Quality assurance systems had failed to identify shortfalls and areas where improvements were needed.

The management team were open and transparent throughout the inspection, seeking feedback to improve the service provided.

Five Stacks Residential Care Centre

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 unannounced inspection took place on 4 May 2017 and was carried out by an inspector, a specialist advisor who had knowledge and experience in nursing care, 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.

Before the inspection the provider completed a Provider Information Return [PIR]. This is a form which asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed information we had received about the service such as notifications. This is information about important events which the provider is required to send us by law. We also looked at information sent to us from other stakeholders, for example the local authority and members of the public.

We spoke with seven people who used the service and six relatives. We also received feedback from a health care professional who visits the service. We used the Short Observational Framework for Inspections (SOFI). This is a specific way of observing care to help us understand the experiences of people. We also observed the care and support provided to people and the interaction between staff and people throughout our inspection.

We spoke with the registered manager and a director representing the provider. We also spoke with eight other members of staff.

To help us assess how people's care and support needs were being met we reviewed ten people's care records and other information, for example their risk assessments and medicines records.

We looked at four staff personnel files and records relating to the management of the service. This included recruitment, training, and systems for assessing and monitoring the quality of the service.

Inadequate

Is the service safe?

Our findings

Systems in place to reduce people being at risk of potential abuse were not robust. Staff had received up to date safeguarding training and knew how to recognise and report any concerns. A member of staff told us, "I'd go straight to the manager or owner. Personally I'd phone up CQC for advice. I think we've got the details on the wall." However, we were not assured that all incidents which could constitute abuse had been appropriately referred to the relevant safeguarding authority. Incidents where a person had hit out at other people living in the service had not been reported, neither had two other incidents involving another person which could have indicated potential abuse. Providers should ensure that all allegations or evidence of abuse are reported to the appropriate safeguarding authority so that these can be investigated and appropriate action taken to keep people safe.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The inappropriate management of people's medicines placed them at risk of harm.

There was a lack of guidance relating to medicines administered covertly. There was no evidence in people's care records to support which medicines had been agreed to be given covertly and how these were to be administered accurately. Advice had not been sought from a pharmacist which meant that there was a potential risk people may not receive their medicines as they had been prescribed in a way which would not compromise their safety or effectiveness.

At one point during the day we observed that the medicines trolley was left unattended, in an area of the service frequently used by people, with one section unlocked. We were able to access the medicines stored in that section. The controlled drugs register containing confidential information had been left on the trolley. Despite there being a designated space to store the trolley in the treatment room, this area was cluttered. The trolley was not put away after each medicines round and remained in the dining room the whole day. The unsecure storage of medicines put people at risk.

The procedures for the management of controlled drugs were not robust. There were entries in the controlled drug register where staff had not completed all details required such as dose and time of administration. Corrections made in the register were unclear which meant we could not be certain how two tablets had been accounted for. A member of staff told us, "We check them each time we give them." However, there was no overall audit of the controlled drugs held in the service which meant that discrepancies or errors had been missed.

There was poor practice in the way that medicines patches were being disposed of. A member of staff told us that they placed these in the general waste. Medicines patches can still contain some of the medicine after removal from the skin and should be disposed of appropriately in line with guidance from the supplying pharmacy. Medicines that were applied as patches were not being recorded appropriately. The site of administration was not being recorded in order to ensure rotation of the patches occurred as

recommended by the manufacturer. For one person it was unclear from the MAR chart whether one or two patches should be applied. This put the person at risk of receiving more medicine than had been prescribed.

Where people were prescribed topical medicines there was no guidance to advise staff as to where to apply these and no documentation to demonstrate that this had been done. We could therefore not be assured that people were receiving this type of medicine as prescribed. We noted that barrier creams were not always named and did not have date of opening written on them. A member of staff told us, "I think we use them until they are empty." There was no monitoring to ensure that topical medicines were disposed of in line with the manufacturer's guidance. One person had a barrier cream in their en-suite bathroom with an expiry date of September 2014. This meant that people were at risk of harm due to medicines becoming contaminated or ineffective.

Care records did not give guidance to staff regarding the support people needed with their catheter care. The manager told us that care staff were aware how frequently the bags should be emptied or changed but this was not evidenced in the care records. Without sufficient guidance and accurate monitoring, people's catheter bags may not be emptied regularly putting them at risk of discomfort or infection.

Information in care records with regard to people's moving and handling support needs was inconsistent and did not include all of the information staff required in order to move people safely. A moving and handling assessment for one person did not provide information regarding the type of hoist needed, size of hoist sling or how this should be used. Another person's care records stated in parts that they could, 'walk short distances.' Other parts of the care records stated staff should use a standing hoist and other documentation said the person now needed the assistance of two carers with a hoist. The manager told us that they were confident that staff knew people well and were aware of their moving and handling needs. However, insufficient or conflicting information in the care records meant staff may not be fully aware of people's current needs putting them at risk of harm.

People were seen to have the use of pressure relieving cushions and mattresses where appropriate. However, risks associated with the use of pressure relieving equipment had not always been fully assessed. There was no information in people's care plans of the type of equipment being used or the setting they should be used at. Pressure relieving mattresses should be set according to people's individual weight to ensure the mattress provides the correct therapeutic support. The charts used to record repositioning did not show how frequently repositioning was required. Without clear guidance staff could not be sure they were providing support in line with the recommendations from the community nursing team, placing people at increased risk of acquiring a pressure ulcer.

Bedrail assessments were included in people's care records to establish whether they were appropriate and safe to use. However, these assessments had failed to identify that gaps in the bedrails which had not been fully covered meant there was a risk of entrapment to limbs. We discussed this with the manager who took immediate action to replace rails and bumpers to reduce the risk of harm.

Risks to people injuring themselves or others were not always appropriately managed. There was a lack of assessment relating to environmental risk. This meant the management team were unable to demonstrate how appropriate and specific control measures were being implemented to protect people from the risk of harm. We identified a number of areas of potential risk, including pictures with glass frames which could be easily removed, potential trip hazards, a staircase with a low banister and an ineffective automatic door closer. Care records for one person stated that they were, 'easily agitated and can try to pick things up which are too heavy and dangerous. i.e. 60 inch TV in lounge.' However assessments did not show that the risks to this person and others had been considered and appropriate control measures put in place to reduce the

risk of harm.

We were concerned that bedroom en-suites did not have disposable hand towels easily available for use. There were no wall dispensers holding hand towels. The registered manager told us that paper hand towels were usually kept in a basket in each area but there was no evidence of these being in place when we checked. Although fabric towels were available these are not suitable for use by staff due to the risk of cross infection.

All of the above constitutes a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed all of the above with the registered manager and provider. Following our inspection they put together a robust action plan to address all of the concerns raised and immediately started work on making the required improvements.

Despite our concerns, people presented as relaxed and at ease in their surroundings and with the staff. People told us they felt safe. One person said, "It's nice and safe here." A relative commented, "It's so nice to know she's safe and sound here."

People told us they felt there were sufficient numbers of staff to care for and support people according to their needs. One person told us, "There are always plenty [of staff] around." A member of staff said, "We normally have one person on doubles, another on singles. You just work as a team. It's always been ok. When we have learning disability people here we always have extra." The family of a person receiving support in the self-contained wing of the home told us, "It's one to one all of the time. They've got two to one for an hour where they can take [person] out." The registered manager told us that wherever possible they tried to use their own staff. They explained, "We rarely use agency. I prefer to cover the shift myself because they don't know my residents."

Our observations told us that there were enough staff to cover the areas of the service being used. However, we had concerns that one area remained locked the majority of the time, restricting people's movement within the service. Additional staff would be needed to ensure safe and responsive care should this area be freely available throughout the day.

Recruitment records showed that checks were made on new staff before they were allowed to work in the service. These checks included if prospective staff members were of good character and suitable to work with the people who used the service.

Equipment, including electrical items, had been serviced and regularly checked so they were fit for purpose and safe to use. Regular fire safety checks were undertaken to reduce the risks to people if there was a fire and there was guidance in the service to tell people, visitors and staff how they should evacuate the building if this was necessary.

Requires Improvement

Is the service effective?

Our findings

We observed that staff sought people's consent before providing support or care and acted in accordance with their wishes. For example, we observed a member of staff asking a person whether they would like assistance to move into the dining area for lunch. We heard another member of staff ask a person, "Where would you like to sit?"

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 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. 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. Records showed that applications had been made under DoLS to the relevant supervisory body, where people living in the service did not have capacity to make their own decisions. Mental capacity assessments had been undertaken in relation to DoLS to establish whether people were able to make their own decision about whether they could leave the service unaccompanied.

The part of the service designated for use by people with a learning disability receiving support on a respite basis was locked throughout the day. Other people's bedrooms were also in this area and we saw that these appeared to be unused during the day. The manager told us, "They can go to their bedroom if they wish but they wouldn't have any quality of life over there." We were concerned that people had not been fully supported to make this decision for themselves. We asked a member of staff how they supported people who wanted to stay in their bedrooms in this area if they were unwell. They told us, "I've never known that to happen." Another member of staff said, [Person] will always ask if [they] can go up to [their] room about 4pm. We say no, go after tea." They added, "I think it's part of [person's] dementia and at certain times of the day [person] says when can I go over there." The member of staff went on to say, "[Another person] will say, I want to go to bed. You take [person] over there and [they'll] buzz." We observed a person asking if they could go to their bedroom and heard that this was discouraged.

We discussed our concerns with the management team who told us that people would be at risk of isolation if they were to stay in their bedrooms. It was also thought that people would not be safe as they may go into this area without the knowledge of staff and be at risk of harm. However there were no mental capacity assessments or best interest decision documents in relation to this.

There was no mental capacity assessment in relation to the administration of medicines for one person who

received their medicines covertly. If people are to be administered medicines without their knowledge there should be clear documentation to show that this decision has been made in their best interest in consultation with relevant healthcare professionals. This demonstrated that the service was not following the principles of the mental capacity act in relation to the administration of medicines.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had received training in areas such as dementia, safeguarding, diabetes, end of life care, and medicines. However, there were some areas where the training provided did not adequately equip staff to meet people's needs safely and effectively. A member of staff told us, "All my training is up to date. [registered manager] lets us know." They went on to say, "It's e-learning now. I don't think any is face to face. Moving and handling is all on e-learning as well." Another staff member confirmed, "Moving and handling is online. Next year we are doing face to face." We were concerned that staff had not recently taken part in practical moving and handling training to ensure they knew how to use the equipment provided and were up to date with current best practice. Insufficient training together with a lack of detail in people's moving and handling assessments put people at risk.

The service supported some people with learning disabilities, many of whom had complex support needs and could become unsettled or distressed at times. Some people living in the service with dementia had times when they showed verbal or physical aggression towards other people and staff. Staff had received some training relating to learning disabilities and administering specific medicines. A member of staff told us, "When [person] first came I had [specific medicine] training." However, staff would benefit from additional training to assist them to support people during times when they became emotional or distressed. This would help staff to have a greater understanding of strategies they could use to ensure people and others in the service received effective care.

We discussed our concerns with the management team. They informed us in the week following our inspection that a member of staff who was qualified to deliver moving and handling training would be assisting staff with further training. Challenging behaviour training had also been booked for all staff.

Staff told us that they felt supported in their role and had regular one to one supervision where they could talk through any issues, seek advice and receive feedback about their work practice. Staff felt that they were able to go to the registered manager at any time with any concerns that they wished to discuss. One member of staff commented. "I know I can go to [registered manager] with any concerns." Supervisions included observations of care being provided to people and also prompted staff to think through how they would respond in certain situations. For example, what they would do if they noticed a mark, scratch or bruise on a person. This demonstrated that there was a proactive support system in place for staff that developed their knowledge and skilled and motivated them to provide a quality service.

People's nutritional needs were assessed and they were provided with enough to eat and drink and supported to maintain a balanced diet. Where issues had been identified, such as weight loss, guidance and support had been sought from health professionals and their advice was acted upon where possible. A person told us, "I had bananas in my porridge. Quite a healthy breakfast." They added, "Our diet is not spelt out for us. We do get quite a variety."

People were complimentary about the food. One person said, "The food is lovely." Another person told us, "I had a nice lunch. Sausages. I don't normally like sausages, but these were really nice." A third person told us how they were able to request food they particularly liked, "We get lambs liver. I stipulate that. I'd like lambs

liver please. To give them their due they bring it along. We observed that people had the choice of when they would like to eat. One person had decided they would like to get up later than usual that morning and had asked staff for a bacon and sausage sandwich which was provided for them.

Although choices were available some people felt that they were not always aware what they were. At observed that at lunch time the majority of people had the same meal. One person told us, "The dinners are OK here, but I never hear what's on, but it's normally OK. I don't think they do alternatives, but I'm alright with what they give me." We spoke with one person for whom verbal communication was difficult. A member of staff came to show them photo cards of choices for lunch to help them communicate what they would like. We asked the person whether they usually chose their meals this way and their facial expressions told us that this didn't happen on a regular basis.

People had access to health care services and received ongoing health care support where required. We saw records of visits to health care professionals in people's files. A relative told us, "When [person] wasn't well they monitored [person] and called the ambulance. They called us at 5.30 in the morning. They'll call if there is any problem." This showed that staff were aware of people's routine health needs and involved health and social care agencies when additional support was required to help people stay well.

Good

Is the service caring?

Our findings

The atmosphere within the service was relaxed and welcoming. A person told us, "I'm happy. They look after me." A relative commented, "It's fabulous. Absolutely fabulous. We were full of trepidation [prior to person moving in]. This is paradise." A relative of one person who stayed at the service on a respite basis said, "[Person] loves coming here."

People and their families were positive and complimentary about the care they received. A person said, "The staff are so nice and friendly." A relative commented, "I'm so pleased that [person] is here. They look after [person] so well, and they couldn't do more for [them]. They are lovely [staff]. They treat us all like we're part of a large family, I'm always welcomed and often have my dinner here. Christmas was lovely. A great family Christmas." A healthcare professional gave us feedback about the service and told us, "I don't have any concerns regarding the care they've provided for [people] in last five years of working in this area."

Staff demonstrated a knowledge and understanding of people's preferred routines, likes and dislikes and what mattered to them. One person's relative talked to us about their daily routine. They said, "It's up to [person]. They've got the music on because [person] likes that." Staff knew how to respond to Staff had built a rapport with people and this was demonstrated in the warmth they displayed when engaging with them.

People were encouraged by staff to make decisions about their care and support. A person told us, "The [staff] are all very good here and they do everything and anything for you. I decide when I get up and I have breakfast in my room full English if I want it." A member of staff told us, "We ask [people] where they want to be. Ask if they are happy with activity. Give them lots of encouragement and support." People told us how their independence was promoted. One person said, "I can get around ok though. I get the bus into town whenever I want. I can come and go, no problems." This demonstrated that staff were guided by the wishes of the people they were supporting and encouraged people to have independence and control.

People and their families had been involved in discussing their care and support needs. A relative told us, "We had to write everything out. What [person] likes, what [person] eats. They've read all through it. They've got a folder and write down every day what [person] has done." Another relative said, "[Registered manager] has been through the folder with me."

Staff respected people's privacy and dignity. For example we observed the caring manner in which the staff supported people whilst using the hoist. One staff member offered reassurance to a person as they were being lifted and explained what was happening, "Just relax, you're nice and safe. You're just going up slowly. Just putting the wheelchair behind you. Lowering you into the chair now. Whenever the hoist was used we observed that staff used privacy screen to protect people's dignity.

Despite the shortfalls we found at the service, the provider demonstrated caring values. Following our inspection they used our feedback constructively and immediately started to make improvements to demonstrate how they would ensure people would be provided with safe, effective and responsive care which was in line with these values.

Requires Improvement

Is the service responsive?

Our findings

Care plans did not always accurately reflect people's current care and support needs. For example, we found inconsistent details about people's moving and handling needs and it was unclear from some records how they were being monitored to ensure that they were current and effective. Food, fluid, bowel and urine charts were often not dated and did not indicate that they were being monitored to ensure appropriate action was taken if needed. Care records and repositioning charts for people at risk of developing a pressure ulcer did not indicate how often they should be assisted to move. Without clear guidance staff could not be sure they were providing support in line with the recommendations from the community nursing team placing people at increased risk of acquiring a pressure ulcer.

Records were disorganised and it was not clear what was current information and what should be archived. Without up to date information about people's care needs staff could not be certain that they were supporting people appropriately and that all their health care needs were being met. We found an important notice about the use of oxygen for one person mixed with daily care notes. The notice was intended to be visible to staff so that they were aware what precautions they needed to take when assisting with oxygen to ensure the person and others were kept safe.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans were however written in a person centred manner and gave details about what was important to people, their likes and dislikes. The care records of a person who received respite support at the service gave detailed information about their family and home life, what they enjoyed and details about their preferred daily routine. This person could become emotional and distressed at times and the care plan gave guidance to staff about what upset them and how to recognise this. This enabled staff to be aware of potential triggers and strategies they could use to prevent the person becoming upset.

We were shown details of a new initiative where staff had been asked to complete a form entitled. 'Share to ensure excellent care.' This gave staff the opportunity to share their knowledge and understanding about people's care needs to further enhance the service provided. Staff had begun completing these documents and the information provided was to be used to update care records and share best practice.

People told us that they received personalised care which was responsive to their needs and that their views were listened to and acted on. One person said, "They are very kind. They go out of their way to make things happen for you. They are very, very good." They added, "If I feel that I would like to have a nice close shave, they'd do that for me." The person's relative said to them, "When you came back from hospital they looked after you well didn't they?" Another relative told us how staff had recognised that a person needed to go into hospital and had also made sure that they were looked after too. They said, "They keep in touch with me about anything, and when [person] had to go into hospital they arranged a taxi for me to go straightaway with [person]."

Staff were encouraged by the management team to spend time socialising with people throughout the day and engaging in activities with them. There was not generally a fixed activity programme but people told us about activities which they had enjoyed. One person told us about their birthday, and other events, "They [staff] threw me a party. We had music and dancing. At Christmas we made a right do of it. At Easter the local vicar came." They also told us how they had enjoyed a recent religious service which had taken place, "A number of members of the church singing. I always ask for Abide With Me." During the day we observed staff chatting to people and engaging in activities such as games with a balloon and encouraging colouring.

There was an area of the service which contained different activities equipment, many of them specifically designed to aid stimulation and/or reminiscence for people living with dementia. There was also a small shop area but this was being used to store wheelchairs. We did not see the activity materials from this area being used. The management team told us that they felt it was important that these resources were available to aid staff in promoting all aspects of people's well-being. However, We felt that opportunities for stimulation and meaningful activities may be being missed and people would benefit from a more structured approach to activities to ensure the available resources were put to good use. This, alongside the spontaneous activity staff engaged in with people would further enhance a holistic approach to people's care and support.

There was a complaints procedure in place which was displayed in the service and explained how people could raise a complaint. A relative said, "There's never a problem, but if we needed to we would see [registered manager], or one of the carers. They're all nice here." Records of any concerns raised showed that they had been investigated and responded to appropriately. These records could be strengthened further with the addition of details about action taken and lessons learnt to drive continuous improvement.

Requires Improvement

Is the service well-led?

Our findings

The provider had quality assurance systems in place but these systems had failed to identify shortfalls and areas where improvements were needed. For example, in relation to medicines, risk management and care planning. This showed that quality assurance systems needed to be more robust to ensure all potential shortfalls were identified and responded to appropriately to ensure the delivery of safe, effective and responsive care and to drive continuous improvement.

We noted that work was needed in the service to ensure that it was a suitable environment to support people living with dementia. For example, there was little in the way of appropriate signage to help people to navigate around the service. However a dementia care audit checklist failed to identify that there were any areas for improvement needed, including with regard to signage. We discussed this with the management team who told us that they had made enquiries some months ago about signage but had not heard back from the supplier. However, this had not been identified as an area for improvement in the most recent dementia care audit in March 2017 and had not been followed up.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager and providers had not fully understood their role and responsibilities in ensuring that the service provided care that met the regulatory standards. They had failed to notify the relevant safeguarding authority about incidents which could constitute as abuse and had also failed to notify us of these significant events. All care providers have a statutory requirement to notify us about certain changes, events and incidents affecting their service or the people who use it. It is an offence not to provide us with this information and the management team should familiarise themselves with the guidance available for registered providers in relation to statutory notifications.

The failure to notify us of these events was a breach of Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents.

The management team were open and transparent throughout the inspection, seeking feedback to improve the service provided. However the above evidence has demonstrated failings which have exposed people to the potential risk of harm. Systems were not sufficiently robust to ensure that the registered provider was operating within expected standards of governance and ensuring effective oversight of the service.

Following our inspection the manager and providers put together a robust action plan to address all of the concerns raised and immediately started work on making the required improvements.

Despite the shortfalls we found, there was an open and supportive culture in the service. Feedback from people and relatives about the staff and management team were positive and complimentary. One person told us, "It's a nice homely home." A relative commented, "It's a lovely home. It's so nice to know that [relative] is being well looked after. They are lovely staff and we've got to know them all really well. We

come every day and spend a few hours with [relative]." A member of staff said, "I certainly wouldn't be working here if it wasn't such a nice place. We have nice residents and a good team of staff"

Staff told us that they felt supported and listened to and that the registered manager and provider were approachable and supported them when they needed it. One member of staff told us, "We have a really nice manager and the owners all pitch in. I feel really well supported. I think it's a nice team, and we meet socially outside. We work well together.' The management team were a visible presence in the home and held in high regard by people living at the service, their relatives and the staff. A relative said, "The proprietors are around. [Registered manager] is good. Very on the ball."

People and their relatives had been asked to complete satisfaction questionnaires and we saw that the feedback received was positive. People had also been consulted and asked their opinion about possible changes within the service so that they had an opportunity to share their views. For example we saw that people had been asked how they felt about the possibility of a cat living in the service and their opinions had been taken into account.