Island Care Limited

Cherry Blossom Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on June 2017 and was unannounced. The home provides accommodation for up to 35 older people with personal care needs, including people living with a cognitive impairment. There were 34 people living at the home when we visited. All areas of the home were accessible via a lift and there were lounges/dining rooms on both floors of the home. There was accessible outdoor space from the ground floor. All bedrooms were for used for single occupancy and some had en-suite facilities.

There was a registered manager at the home. 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 and relatives were able to complain or raise issues on a formal and informal basis with the registered manager and were confident these would be resolved. However, the provider did not have a duty of candour policy in place to help ensure staff acted in an open way when people came to harm. Visitors were welcomed and there were good working relationships with external professionals.

There were systems in place to monitor the quality of the care provided and the safety of the environment. However, these were not always robust. For example, appropriate checks of lifting equipment had not been completed and medicine audits had not highlighted gaps in the Medicines Administration Record (MAR) chart or mitigated the risk of prescribed creams being used beyond their safe to use by date.

The risks relating to people's health and welfare were assessed and these were recorded along with actions identified to reduce those risks. Risk assessments and care plans were personalised and provided sufficient information to allow staff to protect people whilst promoting their independence and choice.

Staff sought verbal consent from people before providing care. However, not all people's ability to make decisions had been assessed in line with legislation designed to protect people's rights.

People and their families told us they felt the home was safe. Most of the staff and the registered manager had received safeguarding training and all staff were able to demonstrate an understanding of the provider's safeguarding policy and explain the action they would take if they identified any concerns.

There were safe recruiting practices in place which ensured that all appropriate checks had been completed before staff started working at the home. Staff were well supported in their roles. However, not all staff had received appropriate or up to date training as required.

There were mixed views about the staffing levels in the home but people and their families felt that care needs were met. People had access to health professionals and other specialists if they needed them.

People were supported to have enough to eat and drink. People were given a choice about what they would like to eat and where food and fluid intake was reduced this was closely monitored and responded to appropriately. However, mealtimes were a rushed experience and a choice of drinks was not always provided.

Staff developed caring and positive relationships with people and were sensitive to their individual choices. They treated people with dignity and respect. People were encouraged to maintain relationships that were important to them.

There was an opportunity for people and their families to become involved in developing the service; they were encouraged to provide feedback on the service both informally and formally.

People and their families told us they felt the home was well-led and were positive about the provider who understood the responsibilities of their role. Staff were aware of the provider's vision and values, how they related to their work and spoke positively about the culture and management of the home.

We identified one breach of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have taken 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

The service was not always safe.

Lifting equipment had not been tested appropriately to ensure it was safe to use. However, other environmental and individual risks to people were managed effectively.

Medicines were not always managed safely.

We received mixed views from people, their families and staff about the staffing levels in the home but people's essential care needs were met.

People and their families felt the home was safe and staff were aware of their responsibilities to safeguard people.

There were safe recruiting practices in place which ensured that all appropriate checks had been completed.

Is the service effective?

Requires Improvement

The service was not always effective.

Managers did not always follow the Mental Capacity Act 2005 (MCA) when planning people's care. However, staff sought verbal consent from people before providing care.

Not all staff had received mandatory training or had updated their training in accordance with the providers training policy, although staff did receive a period of induction and regular supervision.

People were supported to have enough to eat and drink. However, mealtimes were a rushed experience and choice of drinks was not provided.

People had access to health professionals and other specialists if they needed them.

Is the service caring?

Good

The service was caring.

People were treated with dignity and respect. Staff interacted with people in a kind and positive way.

Staff understood the importance of respecting people's choices and their privacy. Choices were offered in line with people's care plans and preferred communication style.

People were encouraged to maintain friendships and important relationships.

Is the service responsive?

Good

The service was responsive.

Staff were responsive to people's needs and understood what was important to them.

Care plans were personalised and focused on individual needs and preferences.

Care and support was planned proactively and in partnership with the people, their families and healthcare professionals where appropriate.

The registered manager sought feedback from people using the service and had a process in place to deal with any complaints or concerns.

Is the service well-led?

Requires Improvement

The service was not always well led.

Management oversight of the service was not always robust. The provider did not have a duty of candour policy in place to help ensure staff acted in an open way when people came to harm.

There were systems in place to monitor the quality and safety of the service provided and manage the maintenance of the buildings and equipment.

People and their relatives felt the home was well organised. Staff understood their roles and worked well as a team.

The provider was fully engaged in running the service and their vision and values were clear and understood by staff.

Cherry Blossom Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. The inspection was also in response to concerns we had about the safety and quality of the service.

The inspection was unannounced and was carried out on 25 May 2017 by two inspectors. Before the inspection we reviewed information we held about the home including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with 10 people using the service, five visitors and one health professional. We also spoke with a director of the providers company, the registered manager, the head of care, five care staff, one of the activity coordinators, the cook and the maintenance person. We observed care and support being delivered in the communal areas of the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at care plans and associated records for eight people using the service, staff duty records, three staff recruitment files, records of complaints, accidents and incidents, policies and procedures and quality assurance records.

The home was last inspected in June 2016 when no issues were identified.

Requires Improvement

Is the service safe?

Our findings

People told us and indicated they felt safe. One person said, "Yes, I feel safe". Another person told us, "Staff help me, they look after me". Family members told us they did not have any concerns regarding their relative's safety. One family member said, "I've never seen anything of concern. [My relative] is terribly safe here, for sure."

However, we identified a concern relating to the testing of equipment. The provider did not use an accredited specialist to check the safety of lifting equipment, such as standing hoists and bath hoists, but used a staff member to check them every six months. The staff member had signed the records to show that they had tested each piece of equipment to the specified weight rating. For example, the largest hoist was rated to a maximum of 190 kgs which meant it could safely support a person up to this weight. However, when we spoke with the staff member who had conducted the tests, they told us the hoists had only been tested for their own weight, which was less than half of the maximum weight limit. Therefore the provider could not confirm that lifting equipment was safe to use for all of the people who needed to use it. This put people at risk. We discussed our concerns with a director of the provider's company who made immediate arrangements for the equipment to be tested properly.

The providers and staff actively managed and reduced other environmental risks. For example, staff were aware of the procedures to follow in the event of a fire and regular tests of fire safety systems and equipment were conducted to make sure they were working effectively. Hot water temperatures were checked monthly and were all within recommended limits. All external fire doors were alarmed so staff would be aware if a person left the home without support.

The registered manager had assessed the risks associated with providing care to each individual. Each person's care file contained robust risks assessments which identified the risks along with the actions taken to reduce these risks. Risk assessments in place included; falls, nutrition, pressure area care and moving and handling. Risk assessments were reviewed on a monthly basis or more frequently if required. Staff were able to explain the risks relating to people and the action they would take to help reduce the risks. Where an incident or accident had occurred, there was a clear record, which enabled the registered manager to identify any action necessary to help reduce the risk of further incidents. For example, following an investigation into an incident where a person did not receive appropriate post-operative care, new procedures were introduced, including the completion of body maps for people when they returned from a hospital stay.

The risk of people falling was managed appropriately. The provider maintained a record of all falls in the home which they analysed each month to identify any trends or patterns. Following a series of falls at night, staffing numbers were increased so more staff were available to provide support to people; this had reduced the frequency of falls at night. When people experienced multiple falls, staff took appropriate action to review the person's risk assessment and refer them to their GP or other specialists, such as occupational therapists, for advice. Following two falls, one person was offered and accepted an alternative room that enabled staff to monitor them more closely. For other people, pressure mats were used to alert staff when

they moved to an unsafe position. A family member told us, "[My relative] had a couple of falls, so they got him a bed with bed rails. They were very quick at getting them too." Other risks were also mitigated, for example, one person had declined to have a pureed diet as recommended by health professionals. The registered manager had contacted the health professionals who had recommend this and it was agreed jointly with the person that a soft diet could be given. Robust risk assessments were in place to ensure this person's safety when eating.

Medicines were only administered by trained staff. Staff administering medicines had received appropriate training and had their competency assessed by the registered manager. Staff were observed administering medicines competently; they explained what the medicines were for, did not hurry people and remained with them to ensure that the medicine had been taken.

There were systems in place to manage medicines and ensure that people were receiving medicines as prescribed. The Medicines Administration Record (MAR) chart provides a record of which medicines are prescribed to a person and when they were given. Staff administering medicines were required to initial the MAR chart to confirm the person had received their medicine. However, on viewing four people's MAR charts, gaps were identified on three of these which meant people may not have received medicines as needed. This was discussed with the registered manager who told us that medicine audits were completed weekly and was due on the day of the inspection. The registered manager agreed to review medicine administration processes.

Prescribed topical creams were kept in people's rooms along with guidance for care staff about which creams had been prescribed and when and where these should be applied. Once opened topical creams must be used within a specified time. The provider's way of monitoring this was to require staff to record the date when each cream was opened. However, the date of opening had not been recorded on some prescribed creams meaning staff would not know when they should be replaced or were no longer safe to use.

Systems were in place to ensure the safe storage of medicines, the ordering of repeat prescriptions and disposal of unwanted medicines. This was supported by an audit system to check the medicine stock in the home and to ensure all medicines were accounted for. However, on checking the stocks for one medicine we found that the number of tablets still available for the person were slightly below the expected number as recorded on the MAR chart. This meant that the person may have had more medicine than recorded on the MAR chart or they may run out of medicine unexpectedly meaning that they would not have access to medicine as needed.

Guidance had been developed to help staff know when to administer 'as required' (PRN) medicines, such as pain relief and medicines to help reduce people's anxiety. Where people were not able to state they were in pain, a pain assessment tool was used. We saw that PRN medicines had been given to people and the reasons why this had been administered had been clearly recorded.

Where people self-administered their own medicines this was managed safety and effectively. For example, people were provided with a locked box to safely store their medications and appropriate risk assessments were in place.

Staff had the knowledge and confidence to identify safeguarding concerns and acted to keep people safe. Staff told us how they would safeguard people and the action they would take if they thought someone was experiencing abuse. One staff member said, "I would report concerns to the manager, I would be confident they would respond". Another staff member said, "I would report my concerns to the deputy care manager

or manager. If I needed to I would go directly to the local safeguarding team or CQC." The registered manager explained the action they would take when a safeguarding concern was raised and records confirmed this action had been taken.

We found there were enough staff to meet people's essential care needs, although we received mixed views from people, their families and staff about the whether there was sufficient staffing levels within the home. One care staff member felt there was not enough staff and told us, "After 11:00, we only have two [staff] upstairs and two down, plus a senior. If we're doing a double and the senior is doing medicines, there's no one to supervise the lounge and respond to [call] bells. Most of the time its rush, rush, rush." Another care staff member said, "There is never enough staff, we have to rush and sometime rush the people, but we do manage to meet their needs". Other care staff members thought there was enough staff. Their comments included, "We have got more staff now and have time to spend with people" and "We have enough staff at the moment". A family member said, "There is not enough of them [staff], I do worry about [name of relative] in case something happens to them and there is no staff around to help". Although another family member told us, "You can ring the bell and they [staff] come quickly." During the inspection we saw that call bells were responded to quickly, staff were available within the communal areas of the home to support people when required and people looked clean and well cared for.

The registered manager told us that they used a dependency tool to support them to determine staffing levels when required. This dependency tool took into account the level of support people using the service required but did not consider the size or layout of the building. The registered manager told us they took account of this by listening to feedback from people and staff, regular walk rounds of the home, observing care and monitoring response times. There was a duty roster system in place, which detailed the planned cover for the home. This provided the opportunity for short term absences to be managed through the use of overtime or cover from staff employed by the provider at another home nearby. The registered manager and head of care were also available to provide extra support when required.

Care staff were also supported by other ancillary staff, such as housekeeping, an activities coordinator, a cook and a maintenance person. This meant they were able to focus on providing care. Staff were deployed according to a pre-arranged format that helped ensure there were staff available on each of the floors at all times.

The provider had a safe and effective recruitment process in place to help ensure that staff they recruited were suitable to work with the people they supported. All of the appropriate checks, such as references and Disclosure and Barring Service (DBS) checks were completed for all of the staff. A DBS check will identify if prospective staff had a criminal record or were barred from working with children or vulnerable people.

Requires Improvement

Is the service effective?

Our findings

People and their families told us they felt the service was effective; staff understood people's needs and had the skills to meet them. One person told us, "The staff are very good". A family member said, "They are brilliant with [my relative]. They understand their condition and pick up on any changes." A health professional told us, I have no concerns, the staff do a good job".

People told us that staff asked for their consent before supporting them. However, the registered manager and staff did not always follow the Mental Capacity Act 2005 (MCA) when planning people's care. The 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 decisions made on their behalf must be in their best interests and as least restrictive as possible. In some cases, MCA assessments had been completed and best interest's decisions had been recorded for people. However, for three people, we found this had not been done. Information in their care files indicated they had a cognitive impairment and the registered manager had made the decision for staff to deliver care and support in the best interests of the person. However, the decisions had not been preceded by an MCA assessment of the person's capacity to make these decisions and there was no record to confirm that people close to the person had been consulted. We discussed this with the registered manager, who agreed to review and complete the necessary assessments and consultation for these three people.

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 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. We found the provider was following the necessary requirements. DoLS authorisations were in place for two people and applications had been submitted for other people where needed. A family member told us the registered manager had consulted with them about the DoLS decision before it had been imposed.

Staff had the skills and knowledge to carry out their roles and responsibilities effectively. Family members were confident in the abilities of the staff. A family member said, "They seem well trained." A person told us, "I find the staff are all okay. I think they know what they are doing."

The provider had a training policy in place which highlighted that staff must complete all 'mandatory training' which included, fire awareness, health and safety, manual handling, infection control and safeguarding. The system used to record the training that staff had completed and to identify when training needed to be updated showed that some staff had not received all mandatory training or had not updated their training as required. For example, two staff members who had worked at the home for over one year had not received any safeguarding training, one staff member had not received infection control training since being in post and two staff members health and safety training was out of date. Therefore, the provider was unable to confirm that staff had the necessary knowledge to support people effectively.

All staff had completed moving and handling training and dementia awareness training. They demonstrated how they would apply this training in practice. For example, they explained how they would support a person with a cognitive impairment and how to use moving and handling equipment appropriately. Staff members comments about the training they received included, "The quality of the training is very good", "We get a variety of training; groups, face to face and DVDs" and "The training is very good, it's interesting. We get all the training we need". Staff also said they could ask for additional training if they wished.

Arrangements were in place to ensure all new staff received an effective induction to enable them meet the needs of the people they were supporting. New staff completed shadow shifts and worked alongside experienced staff before being permitted to work unsupervised. The registered manager told us the length of the induction was dependent on the experience of the staff member and would be extended if required. New staff received mandatory training which followed the principles of the Care Certificate. The Care Certificate is a set of standards that health and social care workers adhere to in their daily working life. It aims to ensure workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. All new staff received a probationary appraisal meeting with the registered manager three months after starting work at Cherry Blossom care home to discuss any concerns or issues and additional areas of training that may be required.

Staff received supervisions every two months with the registered manager. Supervision provide an opportunity for management to meet with staff, feedback on their performance, identify any concerns, offer support, assurances and identify learning opportunities to help them develop. All supervision was clearly documented and action taken if needed. The registered manager told us that, when required, the frequency of supervision was increased. Staff who had worked at the home for over a year had also received an annual appraisal. Staff told us that supervisions and appraisals were helpful and spoke positively about the support they received from management on a day to day basis. Staff comments included, "The [registered manager] is approachable and supportive; we can go to her anytime" and "The manager is approachable; you can knock on her door any time and talk about anything that's worrying you."

People were provided with enough to eat and drink, however mealtimes in both the dining areas was a rushed experience and did not provide people with a calm and relaxed atmosphere to eat their meals or promote social interactions. For example, people were not given the opportunity to sit, relax and interact before or following their meal. We saw that people arrived at the dinner table when their meal arrived and were returned to the lounge as soon as the meal was finished. Additionally one staff member said, "There's always a rushed atmosphere at lunch". During lunchtime, on the ground floor the television was on very loudly in the background. Meals were placed in front of people with little or no explanation about what was provided. Staff did not check with people if they were happy with the choice they had made earlier in the day or offer condiments until part way through their meals. However, a staff member did offer to cut up someone's food for them and another person was provided with gentle encouragement to eat. The mealtime experience was discussed with both the registered manager and a director of the providers company who agreed to review the arrangements at mealtime.

People told us they enjoyed their meals. People's comments included, "The food is good and there's a good choice. You can have something different if you want", "I've got no complaints about the food" and "There's always a choice [of meals] and we're well fed." A family member told us, "The food is amazing. There's a choice of two or three things at lunch. [My relative] always wants a jam sandwich as well as something else and they always do them one." However, People were not always provided with a choice about what they would like to drink throughout the day. For example, during the morning all people sat in the ground floor communal area were given a cup of blackcurrant squash which had been pre poured in the kitchen and at lunchtime in the upper dining room a staff member poured out orange juice for everyone without asking if

they wanted it or offering any alternatives. This was discussed with both the registered manager and a director of the providers company, who told us that people should be offered choices in what they wanted to drink. They confirmed that this will be discussed with staff.

Staff who prepared people's food were aware of their likes and dislikes, allergies and preferences. The menu for the week was published on a noticeboard in the dining area and people were approached in the morning to make food choices for the day. People were told what food was on offer and were given time to make informed choices in a relaxed and unhurried way. Where people declined the choice of main meals, alternatives were offered. One person requested a sandwich and the staff member said, "That's on brown bread isn't it". The person appeared pleased this was remembered by the staff member. Meals were appropriately spaced and flexible to meet people's needs. One person was given their meal early as they had an appointment to attend.

People had nutrition care plans in place, which included information about people's food and drinks preferences, allergies, levels of support needed and special dietary requirements. One person's care plan highlighted that they required a pureed diet and required a cup with a straw due to risk of choking. It also stated, 'Carer must remain with me until I have finished [eating]'. When people's food and fluid intake was reduced or poor this was closely monitored by the care staff supported by the use of individual food and fluid intake charts and where issues and concerns were highlighted appropriate action was taken. Action included requesting guidance from health professionals and making changes to the menu.

People were supported to maintain good health and had access to appropriate healthcare services. Their records showed they had regular appointments with or contact had been made with GPs, nurses, mental health specialists and other health and social care professionals as appropriate. Input from healthcare professionals was fully recorded within peoples care files. In one person's care record it highlighted that a GP had been called to review a person's medicines due to regular refusal. Another care record showed that Speech and Language therapists had been contacted when a person declined their recommended pureed diet.

Some adjustments had been made to the environment to consider the needs of people living with dementia. For example, there were some direction signs to help people find the lounge, bathrooms and toilets and some people's doors had notices or pictures of interest to them, together with their preferred name, to help them easily identify their rooms. Most floor coverings had been replaced with vinyl to make cleaning easier and more effective.

Good

Is the service caring?

Our findings

Staff developed caring and positive relationships with people. One person said, "It's very good here. They treat you like you were in your own home." Another person pointed out two staff members and told us, "Those two are brilliant to me". Family members also told us that the staff were kind and caring. Their comments included, "They do an awfully good job", "All the staff are very kind and very supportive to families too" and "I'm really happy [my loved one] is here". A health professional told us, "The staff are very caring, I have never heard any unkindness and they [staff] always have a smile on their face".

People were cared for with dignity and respect. Staff were heard speaking to people in a kind and caring way, with interactions between people and staff positive and friendly. Staff knelt down to people's eye level to communicate with them. We heard good-natured, friendly conversations between people and staff, showing they knew people well. Staff were attentive to people and checked whether they required any support and were happy. For example, one person complained about a draught from the open windows. The staff member closed one window, checked if that was enough, then closed a further two windows until the person was happy. The staff member also checked that the other people in the lounge were happy with these windows being closed. During a person being transferred using a stand aid, staff worked well together, offered reassurance and explained what was happening throughout.

With the exception of offering a choice of drinks, staff understood the importance of respecting people's choice. Staff were heard offering people choices around what they wished to eat, where people wanted to spend their time and if they wished to participate in activities. Choices were offered in line with people's care plans and preferred communication style. A staff member said, "When people are confused and can't decide what to wear, I open the wardrobe and ask what colour they would like to wear. Then I get two clothes of that colour and show them to the person to help them decide." Throughout people's care files there were comments about providing choices to people in relation to their care. Comments in care files included, 'Preferred time to go to bed: on request', Preferred time to get up in the morning: when awake', 'I am able to tell staff when I would like to go to bed' and 'I am able to choose what I want to wear'. All viewed care files also included information about people's preference for a male or female staff member for personal care. People and staff confirmed that people received the gender preferred to support with personal care. Within people's daily records we saw that where care and support was declined this was respected.

People's privacy was respected when they were supported with personal care. We observed that personal care was provided in a discreet and private way. Staff knocked on people's doors and waited for a response before entering. Staff were able to describe the practical steps they took to preserve people's dignity and privacy when providing personal care. One staff member said, "We close doors and cover people with towels." A family member told us, "They [staff] always close the door and ask me to leave when they're doing personal care." Another family member said, "They always ask if they can come in [to my relative's room]." Comments in care plans included: '[When delivering personal care] avoid leaving [the person] completely uncovered. To provide dignity and privacy place a towel over her lap when dressing upper body'. Confidential care records were kept securely and only accessed by staff authorised to view them.

People were encouraged to be as independent as possible. A person told us, "I get the help I need". Comments in care plans highlighted to staff what people could do for themselves and when support may be needed. For example one care plan stated, 'I can wash my face, hands and upper body with lots of guiding and prompting'. A person's daily care record stated, '[Person] washed themselves and declined support with personal care from staff'.

People were supported to maintain friendships and important relationships; their care records included details of their circle of support. This identifies people who are important to the person. All of the families we spoke with confirmed that the registered manager and staff supported their relatives to maintain their relationships. A person told us, "The family can visit whenever they want" and this was echoed by visitors at the home. A family member said, "I am always welcomed when I visit".

People's bedrooms were individualised, reflected people's interests and preferences and were personalised with photographs, pictures and other possessions of the person's choosing. One person had been supported to bring their birds with them when they moved into the home. These personal touches helped people feel valued and helped them settle into the home.

Good

Is the service responsive?

Our findings

People and their families told us they felt the staff were responsive to their needs. A person told us, "There's always someone to help me." Another person said. "I get the help I need when I need it". A family member said, "I am confident that [my loved one] gets the care they need". A second family member told us, "The staff will always phone a doctor if needed, I have peace of mind". A visiting healthcare professional told us, "I am contacted appropriately when needed" and added, "I am confident they [staff] will follow any advice I give"

Staff were responsive to people's communication styles and gave people information and choices in a way they could understand. Staff spoke clearly to people and repeated messages as necessary to help them understand what was being said. Staff were patient when speaking with people and understood and respected that some people needed more time to respond. People's care plans contained clear and comprehensive information on how to best communicate with the people they cared for. For example, one person's care plan stated, 'I have difficulty with communication. Carers are to give me time as I can say a few words or my facial expressions can inform staff how I feel; I will smile at staff if I understand'.

People's care plans provided information to enable staff to give appropriate care in a consistent way. They were individualised and detailed people's preferences, likes and dislikes and how they wished to be cared for. Care plans also included specific individual information to ensure medical needs were responded to in a timely way. For example, one care plan stated, '[Person] requires assistance from one [staff member] with personal care, however person can become agitated and when this happens two [staff members] will be required'. Behaviour charts were in place to monitor situations where people put themselves or others at risk; these allowed staff to pick up on potential triggers and preventative measures to be put in place. Another care plan described how a person's mobility had deteriorated resulting in them no longer being able to use their walking frame and informed staff of the best way to support this person to mobilise.

We saw people being supported by the staff as described in their care plans to maximise their independence. Records of daily care confirmed people had received care in a personalised way in accordance with their care plans, individual needs and wishes. Information provided in daily records was detailed and informative which provided staff with clear and up to date information about people's needs and emotional wellbeing throughout the day. Staff were able to describe the care provided to individual people and were aware of what was important to the person in the way they were cared for.

Staff were kept up to date about people's needs through handover meetings which were held at the start of every shift and from information recorded in people's daily records. During handover meetings staff were made aware of any relevant information about risks, concerns and changes to the needs of the people they were supporting. These meetings also provided staff with the opportunity to share ideas and knowledge of how best to provide support to individual people. People's daily records of care were up to date and showed care was being provided in accordance with people's needs.

Care and support was planned proactively and in partnership with the people, their families and healthcare

professionals where appropriate. The registered manager or member of the management team completed assessments of the people before they moved to the home to ensure their needs could be appropriately met. All care plans had been reviewed monthly or more frequently if people's needs changed, by the person's key worker and the registered manager. Care plans reflected people had been involved in planning their care and family members told us they had been involved in supporting their loved one with the planning of their care. One member of staff told us they would, "sit with people and update care plans jointly with them". A family member said, "They [staff] will always discuss any changes with me". Another family member told us, "They talk to me about [my love one's] care." Each person's care file contained a family involvement form which showed that families had been notified of any changes in their loved one's health or needs.

A limited range of activities was offered to people which included; arts and crafts, bingo, colouring, floor games, and puzzles. These were advertised on the home's notice board and run by two activities staff members. One person told us, "There's enough happening, we have board games; I enjoy those; and we have a telly."

However, staff were unable to demonstrate that people had been involved in designing the activity programme or that the activities had been tailored to meet people's individual interests. Staff told us they felt that there was enough for people to do, but that most people had little interest in the activities and would decline to join in. When we viewed the records of activities, we saw they were not well attended. Some people told us they particularly enjoyed musical entertainment and we saw external entertainers visited once a week; but in between these times, no provision was made to support people's interests in music. Music was not being played in communal areas or in people's rooms and staff did not organise any music-based entertainment themselves.

We discussed activity provision with a director of the provider's company. They told us the activity staff members were new to post and had plans to enhance the level and range of activities in the near future.

The registered manager sought feedback from people's families on an informal basis when they met with them at the home and during telephone contact. People and their families felt able to approach the registered manager at any time. Their comments included, "Any little thing, I only have to go to the manager" and "The registered manager will listen and act straight away if I am concerned about anything".

The provider sought feedback from people and their families, where appropriate, through residents meetings held approximately every three months and the use of survey questionnaires. These showed most people and their relatives were satisfied with the overall quality of service provided. Comments from people were used to improve the service. For example, some people had commented that meals were not always hot and this had been addressed with kitchen staff. Other people had fed back that the laundry was not operated effectively and we saw the arrangements had been reviewed; these had resulted in more positive comments about the laundry at the most recent survey.

People and relatives told us the provider and the manager were, "very approachable" to discuss any concerns. They knew how to complain and there was a suitable complaints procedure in place. This was advertised on the home's notice board. A family member told us they had no complaints, but if they did, they would talk to the registered manager.

Requires Improvement

Is the service well-led?

Our findings

People and their families told us they felt the service was well-led. Family members and staff also said they would recommend the home to their families and friends. One family member said, "We always see the boss [when we visit]. She mucks in with them [care staff]; she's good, really she is." A second family member told us, "It seems well organised". Staff also felt that the home was well run and were confident in the management team. Staff members' comments included, "The manager is good, everything seems well run", "The manager is approachable; you can knock on her door any time and talk about anything that's worrying you" and "Everything runs well and morale is good."

However, we found the provider did not have a duty of candour policy in place to help ensure staff acted in an open way when people came to harm. The registered manager verbally notified family members of the incidents that occurred. However, they did not follow this up with written information, including a written apology, as required by the regulations. We discussed this with the registered manager who said they had not been aware of the need to do this, but would ensure it was done in future. A director of the provider's company told us they would ensure an appropriate policy was developed.

The failure to act in an open and transparent way, by providing information to relevant persons in writing, was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Management oversight of the service was not always robust. The provider had not always followed legislation designed to protect people's rights and not all people's ability to make decisions had been assessed in line with the Mental Capacity Act 2005 (MCA). An accredited specialist had not been used to sufficiently check the safety of lifting equipment and medicine audits had not highlighted or mitigated the risk of prescribed creams being used beyond their safe to use by date. Staff had not all received mandatory training or updates as required as highlighted in the providers training policy. Staff had not all received mandatory training or updates as required as highlighted in the providers training policy.

Other quality assurance system were more effective. These included auditing aspects of the service, such as care planning, the environment, medicines and infection control. Where completed audits noted that changes were needed, specific actions were developed and implemented. For example, the registered manager had identified that staff were not recording the times they provided care to people; they took action and we saw more recent records included the specific times. The infection control audit had identified the need for pedal-operated bins and we saw these had been provided.

A director of the provider's company was actively involved in the running of the service and visited regularly. In addition, they conducted monthly audits of the service where they spoke with people living at the home, visitors, staff and professionals, checked a range of records and completed an inspection of the premises. This had resulted in a number of improvements; for example, new furniture had been ordered and additional training was offered to staff that lacked essential skills.

There was a clear management structure, which consisted of the directors of the provider's company, a registered manager, a head of care, senior care staff and care staff. Staff understood the role each person played within this structure. The management team encouraged staff and people to raise issues of concern with them, which they acted upon. A staff member said, "We all get along and work well together." The registered manager told us, "Staff are on the same page, we have a good team who support each other".

A director of the provider's company told us their vision was to provide a safe environment for people and staff and to deliver 'great care'. They said they aimed to achieve this by having an open relationship with people, families and staff. The registered manager told us they aimed to, "Provide person-centred care to people, give people a happy home life and reassure their loved ones that they were well looked after and safe." Care staff were aware of the provider's vision and values and how they related to their work. A staff member told us, "I want people to feel that this is their home". Another staff member told us, "The owner wants a nice place for people to live, somewhere that is homely." Regular staff meetings provided the opportunity for the registered manager to engage with staff and reinforce the provider's values and vision.

The registered manager and a director of the provider's company were aware of, and kept under review, the day to day culture in the service, including the attitudes and behaviour of the staff. This was done through observations of care provision, working alongside staff, regular staff supervision and during staff meetings. The management team encouraged staff and people to raise issues of concern with them, which they acted upon. Additionally, the registered manager completed regular unannounced spot checks of the service. This was to ensure that they had insight into the quality and effectiveness of the service throughout the day. Observations and feedback from staff showed the home had a positive and open culture. Staff spoke positively about the culture and management of the service. They confirmed they were able to raise issues and make suggestions about the way the service was provided in their one to one sessions or during staff meetings and these were taken seriously and discussed. One staff member told us, "We are listened to and can say what we think would improve the home. For example, we suggested new flooring and it's been changed."

The home had a whistle-blowing policy which provided details of external organisations where staff could raise concerns if they felt unable to raise them internally. Staff were aware of different organisations they could contact to raise concerns. For example, care staff told us they could approach the local authority or the Care Quality Commission if they felt it was necessary.

The provider and the registered manager understood their responsibilities and were aware of the need to notify the Care Quality Commission (CQC) of significant events in line with the requirements of the provider's registration. The rating from the previous inspection report was displayed in the reception area and on the provider's website.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour The provider failed to act in an open and transparent way when people came to harm. People or their families where appropriate were not notified of the incidents that had occurred in writing, including a written apology, as required by the regulations. Regulation 20.