Primrose House Care Home Limited

Primrose House Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

This inspection took place on 28 April and 2015 and was unannounced.

During a previous inspection of Primrose House in November 2013 we found that the home not meeting the requirements of the law in relation to management of medicines. We carried out a follow up inspection in March 2014 and found that the service was meeting the regulation and there were no concerns.

Primrose House is a nursing home situated in Harrow and is registered to provide care with nursing to up to 24 older people. At the time of our inspection there were 22 people living at the home, the majority of whom had dementia.

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

Summary of findings

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 who lived at the home told us that they felt safe, and this was confirmed by family members whom we spoke with.

People were protected from the risk of abuse. Staff members had received training in safeguarding, and were able to demonstrate their understanding of what this meant for the people they were supporting. They were also knowledgeable about their role in ensuring that people were safe and that concerns were reported appropriately.

Medicines at the home were well managed. People's medicines were stored, managed and given to them appropriately. Records of medicines were well maintained.

Staff at the home supported people in a caring and respectful way, and responded promptly to meet their needs and requests. There were enough staff members on duty to meet the physical and other needs of people living at the home. People who remained in their rooms for some or part of the day were regularly checked on.

Staff who worked at the home received regular relevant training and were knowledgeable about their roles and responsibilities. Appropriate checks took place as part of the recruitment process to ensure that staff were suitable for the work that they would be undertaking. All staff members received regular supervision form a manager, and those whom we spoke with told us that they felt well supported.

The home was generally meeting the requirements of The Mental Capacity Act 2005 (MCA). Assessments of capacity had been undertaken and applications for Deprivation of Liberty Safeguards (DoLS) had been made to the relevant local authority. The majority of staff had received training undertaken training in MCA and DoLS, and those we spoke with were able to describe their roles and responsibilities in relation to supporting people who lacked capacity to make decisions. However the risk assessments for people regarding use of bedrails did not show that this was the least restrictive option available to meet their needs which is a requirement of the MCA.

People's nutritional needs were well met. Meals were nutritionally balanced and met individual health and cultural requirements as outlined in people's care plans. Alternatives were offered where required, and drinks and snacks were offered to people throughout the day. People's food and liquid intake was recorded and monitored. Health professionals were involved where there were concerns about nutritional needs.

Care plans and risk assessments were person centred and provided guidance for staff, but it was not always easy to access information that was linked within the care documentation. The registered manager was showed us a new, more accessible care planning tool that they would be introducing as care plans were reviewed and updated.

The home provided a range of individual and group activities for people to participate in throughout the week. Staff members engaged people supportively in participation in activities. People's cultural and religious needs were supported by the home and this was confirmed by a family member.

People and their family members that we spoke with knew how to complain. There was a picture-assisted version of the home's complaints procedure, and this was discussed with at the regular monthly service user's meeting.

Care documentation showed that people's health needs were regularly reviewed. The home liaised with health professionals to ensure that people received the support that they needed.

There were systems in place to review and monitor the quality of the service, and we saw that action plans had been put in place and addressed where there were concerns. Policies and procedures were up to date and staff members were required to sign that they had read and understood any new or amended ones.

People who used the service, their relatives and staff members spoke positively about the management of the home.

We found one breach of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. People and their family members told us that they felt that the service was safe and that people's needs were well met.

Staff we spoke with understood the principles of safeguarding, how to recognise the signs of abuse, and what to do if they had any concerns. We saw evidence that safeguarding concerns had been appropriately reported and managed.

Risk assessments were in place and included guidance for staff around how to manage identified risks. These were updated regularly as people's needs changed.

Medicines were well managed and recorded, as were people's finances.

Is the service effective?

Requires improvement

The service was not always effective. Appropriate assessments of capacity had been undertaken under The Mental Capacity Act, and applications for Deprivation of Liberty Safeguards had been made for people assessed as lacking capacity. However, risk assessments for use of bed rails did not demonstrate that this was the least restrictive means of ensuring that people were safe.

Staff members received the training and support they required to carry out their duties effectively.

People who used the service and their family members were involved in decisions about people's care. People were supported to maintain good health and to access health services when they needed them.

People chose their meals and were provided with the support they needed to eat and drink. Nutritional assessments were in place and these included guidance for staff in supporting people around their eating and drinking requirements.

Is the service caring?

Good

The service was caring. People who used the service and their family members told us that they were satisfied with the care provided by staff. We observed that staff members respected people's privacy and dignity.

Staff members spoke positively about the people whom they supported, and we observed that interactions between staff members and people who used the service were caring and respectful.

People's religious and cultural needs were respected and supported.

Summary of findings

Is the service responsive?

Good

The service was responsive. People and their relatives told that their needs were addressed by staff.

Care plans were up to date and person centred and included guidance for staff to support them in meeting people's needs. The provider was taking action to improve the quality of written care plans to ensure that information was more easily accessible.

People were able to participate in a wide range of individual and group activities.

The home had a complaints procedure that was available in a picture-assisted format. People knew how to make a complaint.

Is the service well-led?

Good

The service was well-led. There were systems in place to monitor the quality of the service and we saw that these were evaluated with improvements made where required.

The registered manager demonstrated leadership and accountability. She was approachable and available to people who used the service, staff members and visitors. A deputy manager had recently been appointed to support the management of the service.

Staff members told us that they felt well supported by their managers. Family members of people who used the service felt that the home was well managed.

The registered manager had a good working relationship with health and social care professionals and organisations. Links with the community were promoted on behalf of people who used the service.

Primrose House Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.'

This inspection was unannounced and took place on 28 April and 1 May 2015. The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection the provider had completed a Provider Information Record (PIR). This is a form that asks the provider for key information about the service, what the service does well, and what improvements they plan to make. We also reviewed our records about the service, including previous inspection reports, statutory notifications and enquiries. We spoke with representatives from a local authority that places people at the service and reviewed a copy of their recent quality assurance audit of the home.

During our visit we spoke with seven people who lived at Primrose House Nursing Home, three of their relatives, and a friend of a person who used the service. We also spoke with the registered manager, the provider, two nurses, three care staff, a cook, an activities co-ordinator and a manager from another home owned by the provider who was undertaking a quality assurance audit at the home. We spent time observing care and support being delivered in the main communal areas, including interactions between care staff and people who used the service. We looked at records, which included six people's care records, four staff recruitment records, policies and procedures, medicines records, and records relating to the management of the service.

Good

Is the service safe?

Our findings

People told us that they felt safe. One person said, "I feel very safe here and very well looked after. It's much safer for me here than outside." A family member told us, "they are very safe here and there is always enough staff."

Risk assessments for people who used the service were personalised and had been completed for a selection of areas including people's behaviour, medicines, falls, pressure ulcers, infection control and moving and handling. We saw that these were up to date and had been reviewed on a regular basis. Risk management plans were generally detailed and included guidance for staff around how they should manage identified risks. Behavioural risk assessments included guidance for staff around providing positive approaches to supporting people. This showed us that suitable arrangements were in place to protect people from risk.

There was an up to date policy on safeguarding that included contact details for the local authority. Staff members that we spoke with demonstrated that they understood the principles of safeguarding, and were able to describe different types of abuse and provide examples of indicators that abuse might be taking place. They referred to the home's safeguarding policy and procedures and their responsibilities in immediately reporting and recording any concerns. We saw evidence that training in safeguarding had been received by all staff members. Staff members that we spoke with understood the process of 'whistleblowing' if they had any concern about poor practice that could not be dealt with through the usual reporting procedures. The records maintained by the home showed that recent safeguarding concerns had been appropriately managed.

Medicines were stored, managed and recorded appropriately, and administered to people safely. An up to date medicines policy which included procedures for the safe handling of medicines was available to staff. Nurses administered medicines. We observed a nurse administering medicines. She waited for each person to swallow their medicines, and asked people if they required some pain relieving medicine, and administered them when a person required them. Appropriate checks were carried out of medicines, including when they were received from the pharmacist. Checks of controlled medicines were carried out during every shift by nursing staff. Nursing staff had received training in medicines administration. Appropriate records and guidance were in place for a person who needed to take their medicine covertly. These showed that a GP, a pharmacist, staff and the person's next of kin had been involved in the best interest decision made in relation to this. Another person received the blood tests they were required to undertake when having a particular medicine. The registered manager told us she observed nursing staff administering medicines to monitor their practice.

The home manages small amounts of cash for people. Most people's relatives managed their money and provided the home with cash to pay for hairdressing, chiropody and other items. Records of financial transactions were recorded including cash income and expenditure. Receipts of expenditure were available. The registered manager carried out regular checks of the management of people's monies. We were satisfied that the arrangements in place to support people with their monies reduced the risk of any financial abuse.

Staffing rotas showed that there were always two care workers and a nurse on duty at night, and three care workers and a nurse during the day. In addition the home had an activity co-ordinator, cook and domestic workers. The provider showed us a dependency needs analysis that was used to identify the numbers of staff members required to support the people who used the service. We saw that this had been recently reviewed. The staff members that we spoke with told us that they considered that there were enough staff members of shift at any time to meet people's needs.

We saw staff that staff members respond promptly to ensure that people were provided with the assistance they needed. There were enough staff to support people to take part in activities and to be accompanied by staff when needing support to take walks within the home. The registered manager told us that the staffing levels were based upon the dependency needs of people and were flexible. For example, extra staff were put on duty when people needed to be accompanied by staff to appointments including hospital appointments. She told us there was an extra staff member on duty during lunch time to help provide the support people needed with their meals. During our inspection we saw that there were enough staff members on shift to meet the needs of people using the service.

Good

Is the service safe?

We saw staff using equipment to assist people with transferring from their wheelchair to an armchair. Staff explained to people what they were going to do and used the hoists in a safe and unrushed way, and ensured people were comfortable, including putting a blanket on their knees, before leaving them in their armchair. This demonstrated that people with mobility needs were appropriately and safely supported.

The four staff records we looked at showed that appropriate recruitment and selection processes had been carried out to ensure that staff were suitable for their role in supporting people who used the service. These included checks of references relating to previous employment and of criminal records. We saw a monitoring template that showed that the registration of nurses who worked at the home was up to date.

Staff were seen wearing disposable aprons and gloves when supporting people with their care. The registered manager told us the domestic 'deep cleans' one room each day. Alcoholic hand rub was located in several areas of the home to minimise the risk of spread of infection. Guidance for good hand washing was displayed in bathrooms. Soap and paper towels were accessible in bathrooms. One person at the home was being barrier nursed and we saw that clear guidance for staff entering their room was placed outside their door, along with supplies of appropriate personal protective equipment. Staff members that we spoke with were aware of the importance of ensuring that they took action to prevent the risk and spread of infection within the home.

Checks of equipment were carried out. We saw that a service check of a specialist (Parker) bath had recently been carried out. Moving and handling equipment, such as hoists and the home's lift were inspected and serviced regularly in accordance with the Lifting Operations and Lifting Equipment Regulations (LOLER) 1998. One hoist that we saw had failed its recent LOLER inspection, and had been repaired, but was out of use awaiting a further inspection. The provider told us that staff members were aware of this, but that they would place a sign to this effect on the hoist to ensure that it was not used in error.

Temperatures of fridges and freezers, hot food, and the storage of medicines were monitored closely. A food hygiene safety check had been recently (January 2015) carried out by the food standards agency who had rated the service as very good. Fire action guidance was displayed and fire equipment had recently been serviced. Fire drills were carried out monthly and included night staff, and emergency evacuation procedures were in place for individuals. Accident and incident records were well maintained and showed that appropriate actions to address concerns had been put in place. The provider maintained an out of hours emergency contact service and staff we spoke with were aware of this. The home's records demonstrated that actions had been undertaken to reduce health and safety risks to people.

Requires improvement

Is the service effective?

Our findings

People that we spoke with were positive about the support that they received from staff members. A family member told us that the staff at the home, "all seem to be well trained. A friend of a person who used the service told us, "there always seems to be enough staff. It helps that there are trained nurses."

The care records showed that assessments relating to people's capacity to make decisions had been undertaken and that these followed the code of practice associated with The Mental Capacity Act 2005 (MCA). Care plans provided information for staff about how they should support people to make decisions. We saw copies of applications to the relevant local authority team in relation to Deprivation of Liberty Safeguard (DoLS) regarding restrictions in place for people who were under continuous supervision and unable to leave the home unaccompanied due to risk associated with lack of capacity to make decisions. An application for an Independent Mental Capacity Advocate had been made for a new resident in advance of a DoLS application being made.

The staff members that we spoke with demonstrated that they were aware of the requirements of the MCA and understood their roles and responsibilities in relation to this. One staff member told us that, "I have to try all ways of communicating with them to make sure they understand. If I am worried about someone losing capacity I will discuss this with the manager or the nurse on duty" Training records for the home showed that a number of staff had received training in MCA and DoLS. The registered manager told us that there were plans to ensure that all staff received this training, and we saw from the home's training programme that arrangements had been made for this.

Bedrails were used for a number of people who used the service and we risk assessments were in place in relation to this. However, neither the risk assessments nor other information in people's care files demonstrated that use of bedrails was the least restrictive option in order to reduce risk which is a requirement of The Mental Capacity Act. For example, there was no evidence that the use of a lower bed setting and a soft 'crash mat' next to the bed had been explored as a less restrictive alternative to a bed rail.

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

We discussed our concerns about this with the registered manager who told us that use of bedrails would be re-assessed for each person to ensure that this was the least restrictive option.

People were asked for their consent with regards to photos, room sharing, care planning and risk assessment and having a lockable space for personal items, and this was recorded in their care plan. Where people were unable to record consent, the home asked family members or other representatives to support any such decisions, and this was recorded.

Staff members told us that when they started work they had received an induction, and had completed training that was relevant to the care and support that they were providing to people who used the service. They were able to describe the training that they had received and provide details of what this had included. A nurse told us that she had received training on nutrition during the morning of the day that we inspected, and said, "it was really helpful to me in updating my skills and knowledge, especially around malnutrition."

Training records for staff members showed that all staff members had received induction training that met the national minimum standards for staff working in social care services produced by Skills For Care. The registered manager described how the induction training programme for new staff members was linked to the new Care Certificate for staff in social care services. We saw evidence that core training was refreshed on an annual basis as part of an on-going training programme. The training programme included additional training sessions, for example, record keeping, dementia awareness, challenging behaviour and basic life support. Nurses at the service had also received training in end of life care. We saw recorded evidence that knowledge checks took place subsequent to training sessions to check that staff members had understood how to apply the skills and information that had been provided to them. The registered manager told us that they undertook practical skills checks on site, for example of moving and handling, hand washing and use of personal protective equipment. Training on moving and handling of people had been recently updated for all staff members. This showed that staff had been provided with the skills and knowledge they required to support people effectively.

Requires improvement

Is the service effective?

Staff members that we spoke with told us that they received the support that they needed to undertake their duties effectively. One staff member said, "I feel well supported," and a nurse told us, "I always know that I can ask and get an answer for any problem immediately." The records that we viewed showed that staff supervision had taken place on a regular basis. We also saw evidence that staff meetings took place on a monthly basis and that these were well attended. The minutes of recent staff meetings showed that there was a focus on the care needs of people who used the service, and of how this care was delivered and recorded.

People's health care needs were met and monitored. Records showed that people regularly received health checks. They had access to a range of health professionals including; GPs, dieticians, opticians, chiropodists, psychiatrists, and dentists. They also attended hospital appointments.

The home's physical environment was suitable for the needs of the people who lived there. People told us they were happy with their bedrooms and the layout of the home. The garden was accessible for wheelchair users and there was seating for people that was protected from the rain by a gazebo. A person using the service told us the lounge had recently been painted and decorated with pictures and posters of old advertisements. The date and time was displayed in the lounge area which supported people's orientation. The provider told us about changes to the premises that had recently taken place. This included improvements to the garden, enlargement of the kitchen and lounge, changing a shared room to a single room, improved flooring in the lounge, and an extra bathroom facility close to the lounge. The provider told us they planned to provide grab rails for a new toilet facility. We saw that other bathroom facilities had these mobility aids.

People's individual dietary and nutritional needs were met. The day's menu was displayed in picture and written format. The food provided catered for, for example, kosher, halal, and vegetarian diets, diabetic diets, and soft or pureed foods for people who had difficulties with chewing or swallowing. People told us they enjoyed the meals. Fresh fruit and other food items were available for snacks. People were offered hot and cold drinks throughout the day. Prescribed nutritional supplements were available to people with poor appetites. People's nutritional needs were assessed and monitored, and guidance for staff members on supporting people with dietary needs and poor appetites were contained within care plans. The care records showed that people's daily food and fluid intake was recorded and monitored, and any concerns were raised and passed on appropriately. Where there were concerns about weight loss or poor food or fluid intake we saw that relevant professionals, such as a GP or dietician were consulted and guidance developed for staff.

Good

Is the service caring?

Our findings

People spoke of being satisfied with the service. Comments from people included; “It’s fine here, they look after me,” and, “I have no worries.” A family member told us that, “the staff are very kind and patient.” A person’s care plan records included a comment from their relative who said, ‘I am very happy with the care. Thank you.’

Staff interacted with people in a respectful manner. We heard them ask people how they were, and saw that they would stop and chat to people about their interests. People were supported to maintain the relationships that they wanted to have with friends, family and others important to them. Records showed the registered manager had regular contact via email with the relative of a person about a person’s progress. We heard staff speaking with visitors in a friendly manner. They provided family members with an update about their relative’s condition. One family member told us that her relative liked to joke with the carers, “there is generally a light hearted atmosphere. It’s nice to visit because everyone is happy.”

We saw that where people required personal support, this was provided in a timely and dignified manner. Some people chose to spend time in their rooms, or were required to stay in bed due to health conditions. We saw that staff members checked on their welfare regularly and asked them about any needs or wishes in relation to care and support.

Staff members spoke positively about the people whom they supported. A nurse told us, “when I come on shift I go and talk to people in their rooms. The little conversations are important and mean a lot.” A care worker said, “the people that I work with have such interesting stories. Sometimes they get upset or angry, but I understand why that is.”

Family members that we spoke expressed satisfaction with the information and contact that they received from the home. A family member told us that, ”they will call us if there is anything we need to know. They have arranged specialists for us too.”

People told us their privacy and dignity was respected. We saw staff members knock on bedroom doors and wait for the person to respond before they entered. People’s care plans included information about preferences in relation to communication needs and preferences in relation to delivery of personal care. Care documentation also included assessment and guidance about promoting people’s independence.

Care plans included information about people’s health, cultural and spiritual needs. A person’s care plan showed the person had been asked if they wanted to attend a place of worship and had said no. Another person had received the support they needed to worship. A family member of one person told us, “they have been very accommodating with (the person’s) special requests. They enable us to do daily prayers and prayer on Fridays.” Care plans showed that people had been asked if they had a preference about the gender of the care staff that assisted them with their personal care needs. This demonstrated that the home respected and supported the individual wishes of people who lived at the home

Care plans recorded some information about peoples’ end of life preferences and needs. Guidance included information about the emotional support and equipment that was required, but there was no information about the person’s wishes, for example, whether they wanted to be admitted to hospital at the end of their life or to remain in the home. We discussed this with the registered manager who told us that this would be included in people’s care plans when they were next reviewed.

The registered manager told us the home received support from the local palliative care team to support a person needing palliative care. Some of the nurses had received training in End of Life Care. The registered manager told us that they would be commissioning palliative care training for nursing staff in the future so that people could be enabled to remain in familiar surroundings where possible as they reached the end of life.

Good

Is the service responsive?

Our findings

One person who used the service told us that the staff, “always come to me when I call for them.” A family member said, “staff make sure that they involve my relative in their care.”

The registered manager told us that, before any new person moved to the home, she and the deputy manager assessed the individual care and support needs of the person to determine if the service was able to meet the person’s needs. They planned to carry out an assessment during the inspection. Care plans showed that a comprehensive assessment of people’s needs had been carried out for each person.

Care plans were up to date and person centred, and contained guidance for staff in relation to meeting people’s identified needs. The care plans were very detailed and it was sometimes difficult to find some of the information linked to needs. For example, a food and fluid intake plan for one person was not held with their nutritional care plan, although it contained information that was relevant to this.

Care plans included guidance to meet people’s particular medical needs, for example, diabetes. However, the guidance contained within one person’s care file did not include details of the action staff should take if a person showed symptoms of high and low blood glucose levels.

We spoke with the registered manager about the care plans and they showed us a new, more streamlined care plan format that they would be introducing as each person’s current plan was reviewed. They told us that this had been designed to ensure that all relevant information and guidance around meeting people’s needs was clear and easily accessible to staff members.

Care plans showed that appropriate action was taken to manage and care for wounds including pressure ulcers. Records and photographs showed that a pressure ulcer that a person had on their admission to the home had improved significantly following care and treatment by the service.

Records showed people’s care plans were reviewed monthly and more frequently if people's needs changed, for example if they lost weight or when their behaviour challenged the service. We saw evidence that placement reviews also took place regularly with the involvement of social care professionals.

People were supported by staff including the activity co-ordinator to take part in activities, including drawing, reading the newspaper, one to one chats, pampering sessions, throwing balloons. We saw an activity programme on the home’s notice board that showed that activities were planned throughout the week. The registered manager told us that a member of the care team was delegated responsibility for ensuring that activities took place at weekends, or when the activity co-ordinator was otherwise absent.

The registered manager had recently attended a course on ‘well-being through active activities’, and told us there were plans to carry out an individual assessment (Pool Activity Level (PAL)) of the level of people’s ability for activities of daily living and for leisure activity so people could take part in activities specific to their needs. The registered manager told us other activities included accompanying people to the local shops, going to the local garden centre and shopping centre, museum and other outings in a hired bus. Library books were available. One person who used the service was eager to show us the pictures in the book that they were reading. This demonstrated to us that the service was making efforts to ensure that people were enabled to participate in activities that were important to them.

The service had a complaints procedure that was available in an easy read picture-assisted format. The registered manager told us that, even where people could not read the procedure, the format enabled staff members to explain it to them in a way that was more easily understood. We minutes of the monthly residents meeting showed that the complaints procedure was explained to people at each meeting. Family members that we spoke with confirmed that they were aware of the procedure and knew how they should make a complaint if necessary. We looked at the home’s complaints register and saw that complaints had been dealt with appropriately.

Good

Is the service well-led?

Our findings

The registered manager for the home was supported by a deputy manager who had been recently appointed. Both were registered nurses, and the registered manager also had an NVQ at level 5 in management.

We reviewed the policies and procedures.in place at the home. These were up to date and reflected good practice guidance. There was a process in place to ensure that staff members were required to sign when they had read the policies.

The staff members that we spoke with told us that they felt that the manager was supportive and approachable. Family members of people who used the service felt that the home was well managed. One relative told us, "The owner is always trying to improve things for residents and the staff as well." We saw that the manager, deputy manager and provider communicated positively with both people who used the service, their visitors and the members of staff who were on shift.

Staff members had job descriptions which identified their role and who they were responsible to. Clinical supervision was in place for nursing staff and we saw recorded evidence of this.

Staff members spoke positively about the management of the service. A care worker told us, "the manager is really good," and a nurse said, "I feel well supported, and know I can ask for advice at any time of the day or night." Staff members told us that the manager and deputy manager spent time with people who used the service, and would be involved with care where required. We saw evidence of this during our inspection.

There were systems in place to monitor the quality of the service and we saw recorded evidence of these. There was a monthly provider review that was undertaken by a manager from another service owned by the provider. Records of these showed that areas for action were recorded and progress on actions was monitored at the subsequent monthly review. A provider review was taking place during our inspection. The manager who was responsible for these gave an example of an improvement that was made in respect of fire safety. The coloured 'dots' that we were able to clearly see on people's bedroom doors had been put in place following a review in order to identify the level of mobility support individuals might require should there be an emergency evacuation.

Monthly audits were undertaken in respect of dependency needs, accidents and incidents, complaints and medicines. The quality of care plans and care records was audited on a quarterly basis. The records of these contained action plans where required and recorded information about how actions had been addressed. An annual environmental and health and safety review took place on 1 April 2015, and this identified a number of internal and external improvements that were required. We were able to see that some actions had already been taken, for example to the layout of bedrooms, and accessibility of a bathroom. This demonstrated that the provider was proactive in ensuring that the quality of the service was maintained.

Satisfaction surveys took place annually. The most recent survey for people who used the service was provided in a picture-assisted format. Feedback about the care provided at the home was positive, and where a person was unable to understand or complete the survey this was recorded. An annual survey of the views of relatives had taken place in April 2014, and the registered manager told us that another was planned for 2015. Again, satisfaction levels were high. One family member had written, "It would be hard to find something to improve on." We saw that feedback from surveys had been collated and reviewed, and that action plans had been put in place where required.

Minutes of staff team meetings showed that information and concerns arising from quality monitoring activities were regularly discussed. Staff members that we spoke with told us that they valued these meetings. One said, "I have an opportunity to meet with my colleagues and discuss important information." The registered manager told us that urgent information was communicated to staff immediately, and the staff members that we spoke with confirmed that this was the case.

Daily 'handover' meetings took place at the beginning and end of each staff shift. The manager and a nurse told us that these meetings involved a 'round' of the building where issues and concerns were pointed out and discussed, followed by a meeting where information and required actions for the coming shift was passed on and discussed.

Good

Is the service well-led?

Records showed the home worked well with partners such as health and social care professionals to provide people with the service they required. Information regarding appointments, meetings and visits with such professionals was recorded in people's care files.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The provider was not acting in accordance with The Mental Capacity Act 2005 and its associated code of practice. Regulation 11(1)(3)