Mrs T Schneider

Pinehurst Rest Home

Inspection report

Zig-Zag Road
Mickleham
Dorking
Surrey
RH5 6BY

Tel: 01306889942
Website: www.pinehurstcarehome.com

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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 was an unannounced inspection that took place on 15 December 2015.

Pinehurst Rest Home is a residential care home for up to 19 older people, with a range of support needs including personal care and for some of who live with dementia. On the day of our inspection there were 16 people living at the home.

The provider was also the designated manager. The provider was responsible for the day to day management of the home. They are also have oversight of the management of the regulated activities and the main contact for the service with CQC. Providers have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Staff recruitment processes were not always robust. The provider had not always obtained references and Disclosure and Barring Service (DBS) checks before employees started work.

People were not always safe from harm as risk assessments for people were not always in place and some risk assessments had not been reviewed regularly. This included the use of bed rails for people.

People's medicines were not always managed safely. For people that were prescribed PRN medication (this is medicine that can be taken as required, such as pain relief medicine) there were no guidelines in place to tell staff when and how to administer. However, people's medicines were stored safely.

Mental capacity assessments had been completed, however the form the provider used to evidence the assessment was not robust as it did not follow the Mental Capacity Act Code of Practise guidance.

Staff had knowledge of safeguarding adult's procedures and knew what to do if they suspected any type of abuse. Staff had received training regarding safeguarding and this was confirmed from the training records. People told us they felt safe in the home "Yes it's safe here, I have nothing to feel unsafe about. I have a secure room, there are always people around and the call bell at a touch of a button they will come and help."

There were sufficient staff deployed to meet people's needs. The majority of people we spoke with told us that they thought there was enough staff to deal with their needs. One person told us "There is enough staff, very good. Everything done so well."

People were supported to have enough to eat and drink. The chef and staff had a good knowledge of people's likes and dislikes reading food and drink. Another person said "I am a fussy eater. I tell them if I don't like something. If I don't like the dinner they give me a choice I generally have an omelette."

People were supported to access to healthcare services and maintain good health. There was evidence that

people saw the GP, optician and community nurses. Health professionals told us that the home responded proactively and always contacted them if they were concerned about anyone.

People told us that they were happy living at the home. One person said "The staff treat me very well. They are happy and jolly and I can have a laugh with them. I haven't had to do any washing for five years. My carer will do anything I ask."

People's privacy and dignity were respected. Staff knocked on doors before entering and referred to people by their preferred name. People appeared relaxed and content.

People told us staff always involved them in decisions on what care they were going to have. One person said "The staff always asks what you want to do. If you decide you want to have your dinner in your room that is okay. They always ask what help you want." Staff knew peoples preferences, likes and dislikes well.

Care plans contained peoples personal history's which provided staff with information as to what the person did prior to moving in and an initial assessment. People generally received personalised care and staff were responsive to peoples changing need. It was not always recorded in people's care plans that they were involved in planning or reviewing their care or that there needs had changed.

There was a fixed weekly activity timetable. Relatives said that the activities on offer could be improved. There were regular outings to the local town for shopping and coffee. One person said "We have lots of activities here. A lady comes in and gets me to do exercises. This is good for me mentally and physically. A man comes in and plays the piano. He is very good."

People told us that they knew how to make a complaint and they were confident it would be resolved. One person said "Once I made a complaint about the food. The owner listened to what I was saying and my suggestions for improvement and dealt with it straight away. The provider said "I speak with people and their relatives daily, so people can raise concerns to me and I can deal with them straight away."

Recording keeping was inconsistent. The provider had not always recorded accidents and incidents appropriately, despite some people who had falls. The provider told us "I am aware that the paperwork is lacking and know that it requires improvement, this is something that we will work on." The provider did not keep a record of complaints. There were no systems in place to monitor and improve the quality of care.

Staff did not have regular supervisions and appraisals. We asked the provider for evidence that staff had received this support of these and they were unable to provide us with any information. This was confirmed by staff. As staff supervisions did not occur, there was a risk that people may not be effectively cared for. Staff meetings did not occur on a regular basis.

During the inspection we found breaches 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.

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.

Safe recruitment practice was not always followed.

Risk assessments were not always completed and reviewed regularly.

Medicines were not always managed safely however people's medicines were stored correctly.

Staff had knowledge of safe guarding adult's procedures. There were sufficient staff deployed in the home to meet people's needs.

Is the service effective?

Requires Improvement

The service was not always effective.

Mental capacity assessments had been completed for people who lacked capacity to make decisions. The assessment did not provide the required evidence.

There was a training programme in place which gave care staff the skills to support people. However staff did not receive regular formal supervision.

People were supported to have sufficient food and drink; people had a choice of what they ate and where they could eat.

People had access to health care professionals to maintain their health and wellbeing.

Is the service caring?

Good

The service was caring.

Staff had good relationships with people and their relatives.

Staff were kind and caring and there were positive interactions between staff and people.

Staff and the management knew peoples preferences, likes and dislikes.

People's privacy and dignity was respected.

Is the service responsive?

Good

The service was always responsive.

People told us they were involved in the planning of their care.

People received a personalised service.

There were a range of activities in place which people told us they enjoyed.

People knew how to make a complaint and were confident they would be acted upon.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider did not have robust quality assurance systems in place to improve the quality of care provided.

Views of people and their relatives were not always obtained.

Peoples care plans were not always reviewed and updated regularly

Recording keeping was inconsistent. No record of accidents and incidents. However the provider sent notifications into CQC.

Staff meetings and appraisals did not occur on a regular basis. However staff said they felt supported.

Pinehurst Rest 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.

The inspection took place of 15 December 2015 and was unannounced.

The inspection team consisted of three 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 care service.

Before the inspection we gathered information about the home by contacting the local authority safeguarding team, care management and quality assurance team. In addition, we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

On this occasion we did not ask the provider to complete a Provider Information Return (PIR) as we bought the inspection forward. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During and after the visit, we spoke with seven people, three relatives, the provider, the assistant manager, the head of care and three members of staff. After the inspection we spoke with two health care professionals. We also spent time observing care and support.

We looked at three people's care records, medicine administration records, staff rotas, and three recruitment files for staff, supervision and training records. We looked at mental capacity assessments. We looked at records that related to the management of the service. This included minutes of staff meetings and audits of the service.

We last inspected the service on the 19 June 2013 where no concerns were identified.

Requires Improvement

Is the service safe?

Our findings

People's safety may be at risk because appropriate checks were not always carried out on staff to ensure they were suitable to support the people that lived at the service. The provider had not always checked that staff were of good character, including carrying out Disclosure and Barring Service (DBS) checks. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. The home had employed one staff member who worked in domestics who did not have a current DBS check in place. This meant that the person may be unsuitable to work at the home. The provider told us that "The member of staff is under continual supervision, until the DBS has come back." However throughout the inspection we observed this person spending time alone talking with people in communal areas. We requested that the provider completed a risk assessment to ensure that the staff member was not working at any time alone to reduce the potential risks of abuse to people. The risk assessment was completed that assured us that the staff member would be under continual supervision until the correct paperwork was in place.

The provider had not always ensured that the staff references had been obtained. Some staff files did not have any references. This meant that the provider could not always ensure that staff that have been recruited were of good character. References also ensure that staff had given the correct employment history. The provider told us that two people were agency staff; however there were no profiles in place ensuring that the correct checks had been done. Since the inspection, the registered manager provided us with evidence that all care staff have had DBS checks.

Not all staff had the appropriate checks in place to ensure staff were safe to work with people at the home. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risk assessments were not always in place or up to date for people. One person required a moving and handling belt to support them to stand and on occasions required the use of a standing hoist to assist them from sitting to standing. A moving and handling assessment for this person was not in place. A moving and handling assessment would advise staff on how to safely use the equipment to support the person to transfer. We observed staff using the equipment to transfer the person. Staff were not using the equipment safely as they lifted the person using the belt, rather than supported the person to stand with the belt. This placed the person and the staff at risk of injury.

Another person had a risk assessment in place due to them living with dementia; however this had not been reviewed since August 2013. This goes against the homes policy on Dementia Care that states "It ensures that the health of all service users who have a diagnosis of dementia is regularly monitored and reviewed."

Risk assessments had not been completed for people who used bed rails on their beds. Guidance from the Medicines and Healthcare Products Regulatory Agency states that people must be risk assessed for those who use bed rails to minimise the risk of entrapment of body parts which can cause injury or even death.

Risks to people had not always been assessed and managed to ensure peoples safety. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's medicines were not always managed safely. One person's medicine administration record (MAR) stated that a prescribed medicine to manage a neurological condition was to be stopped on the day prior to inspection. We asked staff why this was; staff told us that this should not be the case and could not explain why this had been recorded as such. Staff contacted the GP and arranged for an emergency prescription. The person was administered the prescribed medicine later that afternoon. This meant that the person had not received the dose of medicine that morning, which put the person at risk of becoming significantly unwell.

There was a risk that people were not always receiving medicines when they needed it. For people that were prescribed PRN medication (this is medicine that can be taken as required, such as some pain relief medicines) there were no guidelines in place to tell staff when and how to administer.

There were a small number of people prescribed a medicine to treat heart failure. Current guidance from the Royal Pharmaceutical Society states that people should have their pulse taken prior to the medicine been administered. Staff were not aware of this and therefore not completing this task. This left people at risk of not receiving the right treatment to manage their condition.

The register of people using the service who have medicines administered to them was not current. Four people on the register had since left or passed away. We also found that there were boxes of a cold remedy in the medicines cabinet that had no names on. One staff member told us "This is a homely remedy for anyone to use that needs it." Homely remedies are medicines that can be shop bought that treat ailments such as colds and headaches. The homes medication policy which stated that 'Homely remedies for general use are no longer acceptable. These remedies must be specifically prescribed by the GP for individual service users and listed in the care plan. 'It could mean that people may be administered medicine that may have been detrimental to their health.

The provider was not always managing people's medicines safely. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they were always given their medicines on time and if they needed a pain killer they would ask. One person told us "I always get my medicine on time. I suffer with my back and one night I needed some relief from the pain. The staff came straight away and I was given some pain relief medicine which the doctor had prescribed." Another person told us "When I have asked for some pain relief, someone comes and give me tablets straight away. These had been prescribed by the GP."

Medicines and controlled drugs were stored correctly in a separate medicines cabinet were safely and appropriately stored. The homes use a local pharmacy to dispense people's medicines in a monitored dosage system. This enabled staff to safely administer people's medication. All MAR charts for non-controlled drugs were signed for correctly.

The registered manager had ensured that personal emergency evacuation plans (PEEPs) were in place, in case of fire or emergency. This is a plan that should be tailored to people's individual needs and gives detailed information to staff and the Fire and Rescue Service about supporting peoples movements during an evacuation of the home.

The provider ensured that a contingency plan was in place. This detailed how the home will manage to provide care to people if there is a fire or flood etc.

The home had a choking policy in place. However it did not include relevant information from Surrey County Council's choking policy. The policy recommends a number of strategies that providers can use to identify individuals risk of chocking, including providers role in considering reporting choking incidents and concerns to the local safe guarding team. The provider was not aware of Surrey's choking policy. There were two people that were at risk of choking living in the service, referrals to the Speech and Language Therapist (SALT) have been made for both of them.

Care staff managed accidents and incidents safely. Staff knew how to respond to an incident, for example one person had a seizure witnessed by staff and it was necessary for staff to call for paramedics.

People told us "Yes it's safe here; I have nothing to feel unsafe about. I have a secure room, there are always people around and the call bell at a touch of a button they will come and help." Another person told us "I feel safe; I have the sides of the bed up to stop me from falling out. Staff are perfectly alright I cannot reach the buzzer but my door is always open so I shout if I need someone. They always respond very quickly. "Another person said "Yes. Safe as houses. They gave me a zimmer frame which I use when I walk. This has given me confidence and support when I am moving about." Another person told us "Staff treat you courteously I have never witnessed any impatience with anyone. Sometimes it is too safe. I have always liked walking on my own and yesterday they had to find someone to walk with me."

Staff had knowledge of safeguarding adult's procedures and knew what to do if they suspected any type of abuse. Staff had received training regarding safeguarding and this was confirmed from the training records. One staff member told us "Look after, respect people, don't neglect, highest standards, no shouting, or rushing people, not giving people time, ensuring people's belongings safe." Another staff member told us "Safe guarding is about being mindful of any kind of abuse, potential for example sexual, physical, and financial. Report to manager straight away. I have never been in a position to use the whistleblowing policy, but I know where it is if I need it."

There was a safeguarding adult's policy in place. However the policy was not up to date with current legislation. Staff told us that they knew who to contact if they had a safe guarding concern. There was safe guarding information and the contact details of the local safe guarding team and CQC details were on display in the communal areas of the home.

There were sufficient staff working to meet the people's needs. The provider told us there should be four care staff working in the morning with the provider, head of care and the deputy manager and in the afternoon three care staff. On the morning of the inspection we observed three care staff on shift, the cook and a house keeper. The provider had arranged extra cover as one staff member had called in sick.

The majority of people we spoke with told us that they thought there was enough staff to deal with their needs. One person who preferred to stay in their room told us "Enough staff here. I just press the buzzer and somebody always comes." Another person said "There is enough staff, very good. Everything done so well." However, another person told us "There seemed to be some difficulty this morning, didn't appear to be enough staff everyone rushing about, but okay now." And someone else told us "Yes there is enough staff particularly during the day. Personally I think the night staff have a lot to do and could do with some help."

Requires Improvement

Is the service effective?

Our findings

People's human rights could be affected because the requirements of the Mental Capacity Act 2005 (MCA) were not always followed. 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 made on their behalf must be in their best interests and as least restrictive as possible.

People's next of kin were often asked to consent to the care on the persons behalf. This meant that decisions made on the person's behalf may not have always been made in the person's best interest. Next of kin does not give people the legal right to make choices about people's care. For example, one person who had capacity to make a decision regarding if they wanted bed rails to be used on their bed. However, the consent form was signed by a relative, with no evidence of discussion with the person had been involved in the decision.

The provider had mental capacity assessments in place and were used when people did not have capacity to make decisions regarding their care and support. However the recording tool was not robust as it did not follow the Mental Capacity Act Code of Practise guidance. The form did not include evidence of how the assessor arrived and the decision that a person lacked capacity and did not evidence how the person was supported to make a decision.

Staff had some knowledge of the Mental Capacity Act; however they were not always sure how someone could be deprived of their liberty. For example, staff said that people should always be escorted when outside. Staff knew about consent, we heard staff ask people to consent prior to them receiving care. Staff explained to people what they would be doing to support them, such as "would you like me to help you put your cardigan on."

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).The provider told us that there was no one in the home that was subject to DoLS and there were no applications. The front door was locked and the key was not kept in the door. The provider advised us that this was due to security reasons. There was a side door that was unlocked and people were free to come and go as they chose and to move around the house freely.

Staff did not have regular supervisions and appraisals. Staff told us they had regular informal chats with the manager and provider and that they felt supported by the manager. The provider and manager confirmed that staff were not having supervision. We asked the provider for evidence of staff one to ones and appraisals. No evidence of one to ones could be provided. The homes supervision policy states that formal supervision should occur three monthly and would be a mixture of observing duties and dialogue. As staff supervisions did not occur, there was a risk that people may not be effectively cared for as staff were not given the regular opportunity to have their skills and knowledge evaluated, develop skills through the

exchange of information or review and discuss individual people's welfare issues.

There was a training programme which included all essential training for staff. Training included fire safety, moving and handling and dementia awareness. There was an annual competency check to prior to staff administering people's medicines. The provider had management oversight of all staff training, which meant that training was monitored and reviewed when necessary.
Care staff had the knowledge and skills to support people safely and effectively. One person told us "I have seen people being very well looked after. When the new staff member started they were shown what they needed to do and how to do it. They are very good." Another person told us "Most of the staff have been here a long time and are very knowledgeable. They know how to look after people."

Staff told us the training they received enabled them to understand people, for example dementia training had helped them provide appropriate care for people with early stages of dementia or short term memory loss. Staff displayed a good working knowledge of dementia and when people became anxious or upset support was provided appropriately. There had not been many recent newly employed staff as staff turnover was very low. Any new staff that had been employed had a period of induction and were supported throughout this time by management and other care staff. New staff would shadow existing staff to familiarise themselves with the home and to meet people.

People were supported to have sufficient food and drink. One person said "I have always had wine with my lunch and supper every day and this has not been an issue here. They encourage you to do what you have done previously." Another person said" I am a fussy eater. I tell them if I don't like something. If I don't like the dinner they give me a choice I generally have an omelette." Another said "I don't eat a lot of vegetables but there is always a lot fruit so I get my vitamins." Another said "I am waited on by the staff very well here."

We observed a lunch time. People were offered a choice of sitting in the lounge, going into the dining room for lunch or having lunch in their rooms. The day's menu was displayed on the two tables in the lounge along; the menu was difficult to read as it was typed in a small size font. Staff told people what the choices were.

We saw that those on pureed diets were given their food all mixed together in a dessert bowl which did not look appetising. The chef told us that they used to display each food stuff separately but that care staff had told him they mixed the food together.

There was water in the rooms which people told us was replaced daily and people could help themselves. In the morning and afternoon hot and cold drinks were offered with biscuits.

One person required support to eat their meal; the staff member did this with patience, respect and maintained the person's dignity throughout. People had a choice of what to drink during the meal and of pudding. Staff and the cook had a list of people's likes and dislikes for meals and preferences for drinks recorded in the kitchen. People's weights were monitored regularly and followed up with the GP if people were gaining or losing weight.

People were supported to have access to healthcare services and maintain good health. Referrals had been made to other health professionals when required. This included GPs, community nurses, tissue viability nurses and opticians. One person told us "I have had my flu jab recently and the chiropodist comes every six weeks to do my feet and the physiotherapist comes every four weeks. I like to go to Specsavers in Dorking for my eye tests. They come here as well, it is entirely up to you if you see them here or go to their shop."

We spoke to health professionals who visited the home regularly. They gave very positive feedback about the manager, staff and overall feeling of the home. Telling us that the home responded proactively and always contacted them if they were at all concerned about anyone. One visiting health care professional told us "There are low admission rates (to hospital) from this home, which correlates to people receiving good care."

Good

Is the service caring?

Our findings

People told us that they were happy living at the home. One person said "The staff treat me very well. They are happy and jolly and I can have a laugh with them. I haven't had to do any washing for 5 years. My carer will do anything I ask." Another told us "Staff seem very kind and helpful". Staff interacted with people in a kind and caring way. One person told us "Staff are very caring, very much so. I had to give up my home and I chose to come here. I couldn't be any happier than I am here. One night I was in agony with my back my carer stayed all night to keep an eye on me."

Staff had developed positive and caring relationships with people. One health professional told us "I found also that they were kind and respectful to the residents at every intervention. " One relative told us "Staff treat my relative well, I have no reasons to doubt the quality of care provided to my relative. Staff have been here for many years, so we get consistency that is what drew us here." Another relative told us "Staff are very welcoming." Another relative told us "I come daily to see my relative and I often sit and have lunch with her. Staff always ask how I am."

Staff spoke with people and their relatives with respect and kindness. The provider and manager spoke with people and their relatives in a very warm manner and knew people and their relatives well. The provider told us "We provide excellent care. Different to the norm, family orientated, like one big family, very open". We heard a staff member ask a relative "Have you had your coffee yet? Shall I get it for you?"

People told us staff always involved them in decisions on what care they were going to have. One person told us "The other day I didn't feel well, just very grotty and stayed in bed. My carer came in every so often and checked on me. They offered to get me some medicine. I told them I didn't want any fuss." Another person said "The staff always asks what you want to do. If you decide you want to have your dinner in your room that is okay. They always ask what help you want."

Staff knew peoples preferences, likes and dislikes well. A keyworker system was operated which enabled staff to build up relationships with people and their relatives. There was an obvious affection between staff and people living at the home and people responded to staff in a positive way. People were encouraged to spend time how and where they chose. People were actively encouraged to make choices in their daily lives.

People appeared relaxed and content. The overall atmosphere was relaxed and homely. Staff popped into people's rooms regularly to ensure they had everything they needed and chatted to people sat in communal areas. Staff stopped and chatted to people when they passed in the corridors or walked past people's rooms.

People's privacy and dignity were respected. Staff knocked on doors before entering and referred to people by their preferred name. When staff saw that people had someone in the room the staff would apologise for the intrusion and offer to come back later when they were gone. One person told us "The staff always respects our privacy They always knock before they enter." Another said "Staff are very respectful. Everyone knocks before they come in."

Good

Is the service responsive?

Our findings

There was a fixed weekly activity weekly which included one activity per day, activities ranged from music, quizzes and poetry. There were regular outings to the local town for shopping and coffee, one person said "Three of us go into Dorking quite often to look around the shops or have lunch." Another person said "We have lots of activities here. A lady comes in and gets me to do exercises. This is good for me mentally and physically. A man comes in and plays the piano. He is very good." We saw the manager play scrabble with two people; they said that this occurred regularly. In the afternoon we observed a number of people attending a poetry reading session in the lounge.

There were a few activities available for people who spend a lot of time in their rooms or in bed. One staff member told us "X does not like to come out of their room. I spent time with them and got to know them. I found out that X used to enjoy flower arranging. The manager brought in fresh flowers into the home and X now regularly makes small flower arrangements for people. However, relatives said that the activities on offer could be improved they told us that there were few external activities on offer. There are very few external activities in place." One relative told us "For people who spend a lot of time in bed there could be more activities offered on a more regular basis."

Peoples care plans contained relevant information. An initial assessment of people's needs had been completed by the home prior to people moving in. This identified what care and support people need. Care plans identified people's likes, dislikes and preferences for food and hobbies. The plans also contained a personal history, which gave staff a picture of what people have achieved in their life, who they are and where people have come from.

On the whole people received personalised care. People told us they had choice about that they wanted to do; one person said "I like to read and do my crossword so I like to laze in my bed before I get up for lunch. I am not rushed by staff to get up."

People told us that staff were responsive to their needs and cared for them as they wanted. One person told us "I have a care plan and I just let the staff know what I want to do and if there is anything I need help with." Another person said "I was asked if I liked to wash myself or if I would like help. I told them I like to shower every day and that is not a problem. Staff are pretty good here." Another person told us "When I want a wash I use the buzzer to call the staff and they help me have a wash."

One relative told us that the home had been responsive to their relatives changing care needs. The person had recently been hospitalised, the change in their health meant that they required staff to use moving and handling equipment to help them stand. The provider bought the equipment in to the home and trained staff on how to use it with the person. This enabled the person to return back to the home, rather than the home saying they could not meet that person's needs.

People told us that they knew how to make a complaint and they were confident it would be resolved. One person said "Once I made a complaint about the food. The owner listened to what I was saying and my

suggestions for improvement and dealt with it straight away. I suggested healthier pudding options". Another person told us "I had an issue with a member of staff and spoke to the owner. My complaint was dealt with straight away." There was a copy of the complaints policy in a communal area.

Requires Improvement

Is the service well-led?

Our findings

Record keeping was inconsistent. Incidents and accidents had not always been recorded appropriately. Since January 2015, two incidents had been recorded in the homes accident book. From reviewing care notes and notifications received from the provider, we noted there were a number of incidents that occurred where people required hospital treatment. Incidents were recorded in people's care plans and not recorded as an incident. The provider told us that "Information is recorded on handover sheets and in individual care notes." Recording certain events as incidents means that the manager can identify possible trends, learn from events and appropriately manage high risk situations.

The provider did not keep a record of complaints, although people told us that the provider responded to complaints. Recording complaints would ensure that the manager can identify trends, learn from events and feedback to the complainant. Other care records, for example care plans were not always updated and reviewed regularly. This meant that staff may not always have the information available to them as to how to support people safely and effectively. The provider told us "I am aware that the paperwork is lacking and know that it requires improvement, this is something that we will work on."

There were no routine systems in place to obtain feedback from people, staff, relatives and visiting professionals. Residents and or relatives meetings did not occur; which was a missed opportunity to obtain people's views. The provider had customer feedback forms; however they were not completed on a regular basis. This meant that the opportunity to continually evaluate feedback from people to identify trends and improve the service was missed.

There were systems in place to audit the quality of care provided. The service's quality assurance policy stated that the provider plan will be put into place to audit key areas that included 'service user care' and 'quality improvement.' However, the provider told us that this was not happening. We asked to see documentation for any quality assurance audits, we were not provided with any. Therefore the provider was unable to monitor, evaluate and improve the quality of care that was provided.

Staff meetings did not occur on a regular basis. Having regular staff meetings would enable staff and the provider to work together to improve the quality of care. Staff did not receive annual appraisals. Appraisals would enable staff and management to review performance and discuss areas of staff development to improve quality of care and to value staff.

Care staff had not always recorded in people's care plans how people were involved in planning or reviewing their care. We saw that some relatives had been involved in people's care plans, but it was not evident if the person had agreed to this. We found that when some people's needs had changed it had not always been recorded in their care plan. For example, a person's weight had dramatically dropped in a short period of time, the head of care was aware and had contacted the GP, however the care plan had not been amended to reflect the change in need. Care plans need to be reviewed regularly to ensure that staff can respond to people's changing needs and provide safe and effective support.

The provider did not have effective and robust procedures in place that enabled the provider to assess, monitor and improve the quality of care is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider carried out health and safety audits on a monthly basis. This means that the home was monitored to ensure that people lived in a safe environment that promoted their wellbeing.

The home had a family orientated culture and it was clear that the provider and manager were passionate about providing good quality care. Staff said that they feel supported and valued by the manager and the provider. One staff member said "The manager is very friendly and very involved with staff and with people we care for." Another said "If anything is needed for the home, the manager will get it straight away." Staff said that the vision of the home was to keep people safe and to provide good quality care "as if they were your own family."

People told us that they felt that the home was well managed. One person said "I think the home is well led, everything runs so nicely. The manager is nice and friendly always stops and chats. Only got to ask for something's and its there." Another said "It is well led. Staff are all very caring; They make a fuss of you. Everyone is very kind."

Family members had written in with gratitude thanks and appreciation of the caring staff and management. The provider said "I speak with people and their relatives daily, so people can raise concerns to me and I can deal with them straight away."

People told us that there was very little that could be done to improve the home. One person told us "I feel really content here, I feel secure and I am well looked after". Another said "My cousin looked around for a home for me. I certainly think he made the right choice for me I don't think there is anything they could do better." One person told us "If the chair in the lounge could be rearranged rather than sitting around the wall, we could then talk to each other easier."

The provider had ensured that appropriate and timely notifications had been submitted to CQC when required and that all care records were kept securely in the home.

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 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 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people had not always been assessed and managed to ensure peoples safety. The provider was not always managing people's medicines safely

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective and robust procedures in place that enabled the provider to assess, monitor and improve the quality of care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Not all staff had the appropriate checks in place to ensure staff were safe to work with people at the home.