Barker Care Limited

St Teresa's Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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?	Requires Improvement

Summary of findings

Overall summary

St Teresa's Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The home is registered to provide nursing and personal care for up to 70 older people accommodating people across three separate units, each of which have separate adapted facilities. One of the units specialises in providing care to people living with dementia. At the time of the inspection 59 people were living at the service.

The inspection took place on 24 and 25 July 2018. The first day was unannounced.

At the previous inspection on 09 June 2016 we found improvements were required in recording the effectiveness of pain relief, pressure relieving mattresses, people's dietary requirements and pressure ulcer dressing changes. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found some improvements had been made; however shortfalls still remained in relation to food and drink monitoring. This was because fluid intake targets had been calculated incorrectly. Charts we looked at did not show that people had enough to drink. Food monitoring charts did not detail what people had eaten. This meant staff would be unable to assess if people had received a nutritionally balanced diet. Other monitoring charts, such as position change charts had not always been completed in full.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Quality assurance systems did not always identify shortfalls found during this inspection. There were extensive quality assurance systems in place; however, the inaccurate monitoring of people's fluid intake targets had not been identified during audits. Actions arising from audits had not always been completed within specified timeframes. Shortfalls such as recording of complaints and statutory notifications had not been consistently completed.

Staff had been trained to keep people safe. People using the service and their relatives told us they felt safe. Care plans contained risk assessments. When risks were identified the plans provided clear guidance for staff on how to reduce the risk of harm to people.

Incidents and accidents were reported and analysed to identify trends. There was evidence that lessons were learned when incidents happened.

Medicines were managed safely.

Comprehensive pre-assessments had been completed before people moved to the service.

Staff were trained to undertake their roles. Staff had regular supervisions with a supervisor.

People using the service spoke highly of the staff and all were happy with the support they received. We observed positive interactions between staff and people.

Care plans were person centred; however, end of life plans did not always reflect people's choices and preferences.

Air mattress checks were in place and all of the mattresses we looked at were set correctly.

Complaints were logged. However, investigations and outcomes of complaints had not always been documented.

We received mixed feedback from people using the service about the activities available to them and the level of social interaction they received.

All of the staff told us the service was well managed. People using the service and their relatives gave positive feedback about the management team.

Although the majority of statutory notifications had been sent to the commission, one incident in relation to an allegation of verbal abuse had not.

We found one breach of the Regulations in 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?

Good

The service was safe.

People felt the service was safe.

Risk assessments were carried out and care plans guided staff how to keep people safe.

There was enough staff on duty to meet people's needs.

The service followed safe recruitment practises.

Medicines were managed safely.

The service was clean. Staff knew how to prevent the spread of infection.

Is the service effective?

Requires Improvement

The service was not always effective.

Food and fluid monitoring records were not robust.

Staff were trained to carry out their roles.

Staff had regular supervision sessions and annual appraisals.

People had access to ongoing health care.

The service followed the principles of the Mental Capacity Act.

Is the service caring?

Good

The service was caring.

People were supported by staff who were kind and caring.

Staff treated people with dignity and respect.

Staff provided privacy and support when required.

Is the service responsive?

Good

The service was responsive.

Care plans were person centred and individualised.

Staff knew people well and understood their needs.

There was a range of activities available. People and their relatives gave mixed feedback about whether these met their needs.

Investigations and outcomes of complaints had not always been recorded.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Quality assurance systems in place did not always identify shortfalls found during this inspection.

The service sought people's views with feedback cards at the reception however questionnaires had not been sent in the last year.

Most statutory notifications had been sent when required however we found one had not.

People and their families spoke highly of the registered manager.

St Teresa's 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 took place on 24 and 25 July and was unannounced on the first day. On both days the inspection team consisted of two adult social care inspectors and one 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 reviewed other information we held about the service, including previous inspection reports and notifications sent to us by the provider. Notifications are information about specific important events the service is legally required to send to us. We also looked at information in the Provider Information Return (PIR). 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 the inspection we spoke with 11 people, ten visitors, eight members of staff, the chef, the registered manager and the area manager. We also spoke with one health professional during the inspection and received feedback from three others following the inspection. We also spoke with one relative by telephone.

Not everyone was able to tell us about their experiences so we used the Short Observational Framework for Inspection (SOFI) to help us make our judgements. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed eight people's care plans and four staff files. We also looked at records relating to the management of the service such as incident and accident records, meeting minutes, recruitment and training records, policies, audits and complaints

Good

Is the service safe?

Our findings

People using the service said they felt safe. Comments included, "Yes I feel safe here. The doors are locked and I feel happy here." Another person told us, "It is very good here and I feel safe." Relatives we spoke with confirmed this. Their comments included, "It makes me feel better that I know she is in a good safe place." Another relative said, "Safe? Yes I don't have any qualms about [person's name] safety."

Staff were trained to keep people safe from avoidable harm. They were aware of their responsibilities to report any concerns to the registered manager or outside agencies as appropriate. Staff said they felt confident to raise any concerns to the registered manager or "higher up."

The Met Office had issued a Level 2 Heat-Health action Alert for the area which covered the first day of our inspection. The guidance described high risk groups of people as those aged over 75, female, frail, with severe physical or mental illness and those on multiple medications. Public health recommendations were for people to 'keep out of the sun between 11am and 3pm' and 'if you have to go out in the heat, walk in the shade, apply sunscreen and wear a hat and light scarf.' We were provided with a copy of the provider's Severe Weather policy which included the advice detailed above. However, we observed twenty people sat outside at 14.30 hours. Not all people were sat in the shade. We observed drinks were available, but they were not always within reach of people and nobody had a drink in their hand. Some people had hats on, but not all. We were concerned that the NHS England Heatwave plan was not being followed. We discussed this with the area manager who asked staff to ensure all of the people were in a shaded area and were comfortable.

Care plans contained risk assessments for areas such as mobility, falls, malnutrition and skin integrity. The assessments had all been regularly reviewed. When risks were identified, the plans provided clear guidance for staff on how to reduce the risk of harm to people. For example, when staff needed to use specialist equipment to move people, this was documented, such as hoist and sling details. We observed one person being moved using a standing frame to transfer from a chair to a wheelchair. Staff used the equipment safely and gave reassurance and encouragement to the person throughout the manoeuvre.

When people had been assessed as being at risk of pressure sores, the plans detailed the pressure relieving equipment in use such as air mattresses and pressure cushions. At our previous inspection we found that air mattresses were not always set correctly. At this inspection checking processes were in place. These were effective and all of the air mattresses we looked at were set correctly. Plans also guided staff on the frequency people should have their positions changed. Although position change charts showed that people's positions were changed regularly, staff had not consistently documented which position they had supported people to be in. We discussed this with the registered manager who said they would address this with staff.

One person said, "I like going around the village on my scooter. They did risk assessments first to make sure I would be safe". The registered manager said, "We promote independence. We also focus on risk assessments and how well we manage risks."

There was enough staff on duty to meet people's needs. People told us they thought that there were enough staff on duty all of the time. They said, "They answer my bell pretty quickly. Mostly takes two to three minutes" and "They come when I ring my alarm. There is enough staff here both day and night." Another person told us, "There are enough staff with good continuity of care." One visiting health professional said, "It's very unusual for me not to be able to find a member of staff to speak to." Another health professional told us, "I have always been able to speak to a nurse when I visit."

The service did not use agency staff. There was a dependency tool used to calculate the number of staff required based on people's needs. Staff confirmed there were enough of them on duty. One member of staff said, "If we need extra staff we just ask."

The provider had procedures in place to ensure staff had checks undertaken before commencing their employment. These included inviting them for a formal interview and carrying out pre-employment checks. Within these checks the provider asked for a full employment history, references from previous employers, proof of staff's identity and a satisfactory Disclosure and Barring Service clearance (DBS). The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with vulnerable adults.

Medicines were managed safely. We looked at all of the medicine administration records (MARs) and saw these had all been signed by staff and completed in full. People confirmed they received their medicines on time and when required. One person said, "The nurses sort out the tablets for me. They give them to me and I stick it in my mouth." Another said, "I need painkillers at night and I always get them." There were photographs at the front of MARs which had been dated to indicate they remained a true likeness of people. People's preferences for how they liked to take their medicines had been documented.

Some people had been prescribed additional medicines on a PRN (as required) basis. In these instances there were PRN protocols in place. These were personalised and detailed when and why people might require them. Protocols for pain relief informed staff how to recognise signs of pain in people who were unable to verbally express it. The effectiveness of administered pain relief was monitored. Some people had been prescribed medicines for when they were agitated. The protocols in place for these people included the steps staff should take before resorting to the use of medicines.

Medicines were stored safely. The temperature of the medicines storage areas was monitored. Although temperatures had exceeded the recommended 25 degrees Celsius on a number of occasions, the provider had sought advice from the pharmacist on whether this was safe. Controlled medicines were stored safely. Regular stock checks were carried out.

Topical medicine administration charts had been filled in by staff. This showed that people had creams and lotions applied as prescribed.

Incidents and accidents were reported and analysed to identify trends. There was evidence that lessons were learned when incidents happened. For example, we saw that incidents were discussed during staff meetings, and refresher training was arranged if required. The registered manager said, "Any problems, we take it as a learning. We will have group discussions, such as what can we learn from this?". However, although one incident of alleged abuse had been reported and investigated appropriately, the registered manager had not notified us about it which they have a legal requirement to do. The registered manager addressed this during the inspection.

The premises were well maintained and safe. Safety reviews and regular servicing of utilities such as

electrical checks, regular fire alarm testing and drills were carried out.

The environment was clean throughout and free of odour. Staff had access to personal protective equipment such as gloves and aprons. When assisting people with meals we saw that staff also wore aprons. One visitor said, "It is spotless here."

Requires Improvement

Is the service effective?

Our findings

At our last inspection we found people's records were not always accurate and up to date. This related to inconsistent records of wound care, effectiveness of pain relief not being monitored, people not receiving modified diets as required and incorrectly set air mattresses. At this inspection we found sufficient improvements had been made to wound care records and that the effectiveness of pain relief was being documented. Air mattresses were set correctly and there was a monitoring process in place. We did not see consistent evidence that people received food and fluids in line with care plan guidance.

People's nutritional needs were assessed. People's weights were monitored. When people lost weight, advice was sought in a timely manner. One health professional told us, "Referrals are made in a timely manner and are appropriate. In my recent experience I have felt staff understand the recommendations made and adhere to them." There were good systems in place for staff to be aware of special diets, including those to prevent choking. When people required textured diets, this information was displayed in people's bedrooms and staff knew which people were at risk. The chef showed us how the kitchen staff were kept aware and informed about risk and specialist diets.

However, in one person's plan the guidance for staff was "risk of aspiration and choking if left alone with food. Normal fluids – no straws, no spouts." We saw the person was left alone in their bedroom when eating their lunch. We also saw on their table a bottle of supplement drink with a straw in it and a beaker of juice with a spout and a straw. We discussed this with the registered manager who said the person preferred to use a straw and had the mental capacity to make this decision. This had not been documented and the care plan had not been amended to reflect this.

Some people were having their food and/or fluid intake monitored. Although food charts had been filled in by staff, they did not record all information relating to the persons care. For example, one record confirmed, 'Main meal, all'. Another record confirmed, 'SW x 2. All.' Records did not confirm the details of the quantities eaten and this meant it was difficult for staff to assess whether people were receiving adequate nutrition to meet their needs. We discussed this with the registered manager during the inspection and they said they would address this with staff.

People's fluid monitoring charts were not always accurate and up to date. Although the provider's guidance defined how staff should calculate daily fluid targets for people, the charts we looked at had incorrect targets and some of these were considerably below what the actual target should have been. For example, one person's target was documented as 800 millilitres. The actual target, based on their recorded weight, should have been 2055 millilitres. We discussed this with the registered manager and area manager during the first day of the inspection. On the second day of the inspection this issue had not been rectified because we looked at a further five charts and all had incorrect daily targets recorded. One person's target was written as 800 millilitres when the actual target should have been 1866 millilitres. Staff had completed the charts each day, but there was nothing to indicate that staff had noted the error. Additionally, the recorded fluid intake for this person was recorded as 310 millilitres on one day, although there was nothing written to show that staff had escalated this to a senior member of staff. Another person with an incorrect target had a

recorded intake on one day of 450 millilitres. No action had been taken when the person's fluid intake was below their daily (incorrect) intake target. We found only one record that confirmed staff had documented when one person had not drunk much. This meant during the period of hot weather prior and during the inspection people could be at risk of not having their hydration needs met due to inaccurate and incomplete records.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although people were happy with the food we found improvements could be made to people's dining experience. For example, people were asked the previous day to choose what they would like to eat for the next day. There were menus on dining tables which detailed the meal options for the week; however these were in small print which meant some people might find them difficult to read. There were no pictorial menus available for people however a member of staff confirmed they were due to be introduced.

People did not always have clear communication from staff regarding their dining experience. For example, on two occasions we observed staff place meals in front of people without saying anything or confirming what the person had chosen the day before. One person had their meal put in front of them and the member of staff said nothing but proceeded to cut the food up into small pieces for them without asking or explaining what they were doing. The person was left unsupported for five minutes. In those five minutes they didn't eat any of their meal. One member of staff assisted with one spoonful but then left again. It took another five minutes for the person to be assisted with their meal from a different member of staff. This member of staff provided a positive experience for the person by talking and encouraging them to eat. We did observe other positive examples of staff communicating well with people and explaining what the meal was and asking if they were enjoying it.

People and relatives felt happy with the meals. They said, "The food is excellent. They bring it to my room." Another person said, "The food is good more often than not. If I want anything kept in the fridge they will do that for me. The choices suit me." One relative said, "The food is excellent here. [Person's name] is eating well and putting weight back on." Another said, "He eats well. They [staff] have assured me he will be weighed once a week to monitor his weight."

People had access to ongoing health care. A GP visited weekly and during the inspection we observed staff gaining advice from a GP about one person's changing pain relief needs. The registered manager said, "We work very closely with the GP's. It's like we're partners in care." Records showed that people were reviewed by the mental health team, the speech and language therapist, palliative care nurse and the diabetes nurse. One relative told us, "The GP comes every week and [person's name] gets asked if she wants to see them. Her eyes are tested here too."

The environment was light, bright and airy. Communal spaces were all well maintained, spacious and uncluttered. There were plenty of different small areas to sit in and a varied choice of comfortable seating. Communal spaces and corridors were well lit and pleasantly decorated to give an air of calm and comfort. Handrails were painted white and on Gainsborough unit the wall colour varied in different sections to give a contrast to aid orientation and navigation for those living with dementia. Good clear dementia friendly signage was used throughout and this was displayed at eye level.

Staff were knowledgeable about the principles of the Mental Capacity Act. Some people using the service had the capacity to make their own decisions and staff supported them with this. Other people lacked the capacity to make some decisions about their care and support needs. Mental capacity assessments had

been carried out and there was documentation in place to show how best interest decisions had been reached.

We observed staff asking people to agree and consent before care and assistance was provided. They used phrases such as "Would you like me to…?", "Is it alright if……?" and "Where would you like to sit?". Staff took time to explain to people what they were going to do, why they were doing it and what the outcome was likely to be. For example, when one person was feeling unwell a nurse asked them, "Are you comfortable. This [top] may be a bit uncomfortable – a bit tight. Are you too hot in that top? Shall I change it for something cooler?". When the person agreed, the nurse went to help them change into a cooler top.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager maintained a log of DoLS applications and authorisation and had notified us of all approved applications.

People were supported by staff who were competent and were trained to carry out their roles. Staff spoke positively about the training they had received; in particular training that was specific to people's needs, such as stress management and wellbeing. Nurses confirmed they had access to training in order to meet their professional registration requirements. People using the service and their visitors confirmed they believed staff were sufficiently skilled.

There was an induction programme in place for new staff to complete. One new member of staff said, "The induction was good and helped me when I first started."

Staff told us they had regular supervision sessions and records we saw confirmed this. The records showed that topics discussed during supervisions were used for training. These included infection control and safeguarding.

Good

Is the service caring?

Our findings

People using the service spoke highly of the staff. Comments included, "They are caring and kind. They will come in and have a chat. There is usually someone walking around to talk to. They're a nice bunch". Another person said, "They are kind and caring." One person said, "I can't fault it in any way; they [the staff] have been marvellous."

Visitors and relatives to the service also spoke highly of the staff. Comments included, "As long as Mum is happy, I'm happy. We can rest knowing she is well looked after" and "The care has been exceptional. Staff are so friendly and can't do enough for you. The staff really know us well. [Relative's name] is clean and well cared for." One visitor told us, "I think they are wonderful. They treat people with great sensitivity. I am very happy with the care."

Despite what we saw during the lunchtime experience, the majority of staff interacted with people in a friendly, caring and compassionate manner. Staff used first names and treated everyone with respect. All staff we spoke with knew people well and were able to tell us a lot of background information about them. They were able to tell us their likes and dislikes especially regarding food and drink and dietary requirements. One health professional said, "All of the staff are very friendly. I'm always surprised by how well they know people."

We observed that staff made eye to eye contact with people, listened, offered choices, used appropriate body language and did not rush people in any way. For example, one member of staff knelt down next to one person and asked them, "Are you alright? How can I help you?"

Relatives told us that staff kept them well informed. One visitor said, "Communication is good. They keep me very well informed. If [person's name] isn't well they let me know." Another said, "They have advised me on several matters such as the type of clothing he needs to make his care easier."

Staff treated people with dignity. We observed that staff knocked on bedrooms doors before entering people's rooms and all personal care was provided in privacy. One relative said, "Staff are really well trained especially regarding privacy and dignity. They always ask permission and tell [person's name] what they are doing."

Many compliments had been received and these were on display in the reception area. These supported the comments families had told us that they felt staff supported them as well as their relatives. For example, "Thank you so much for the care you showed, not only to [Name], but to us as well. We know she was well looked after by you all". Another comment said, "Just like to say thank you for all the care you've given [person's name] over the past few weeks. Your kindness made it easier for us all to bear". Another comment included, "We would like to thank you all sincerely not only for the care and attention you provided for our mother but also for the help and support and advice you provided to us. You gave us all friendship, care and respect."

Good

Is the service responsive?

Our findings

People's needs had been fully assessed prior to moving to the service. These formed the basis of people's care plans. Care plans contained 'pen portraits' which provided staff with information about people's lives before moving to the service. These also documented people's choices and preferences about how they wanted to be cared for.

Care plans were detailed and personalised. They included details such as when people liked to get up and go to bed, the clothes they liked to wear and whether they had routines they liked to adhere to. For example, in one person's plan it had been documented they liked to wear perfume and enjoyed having their nails done.

Plans in relation to people's health needs were detailed. At our previous inspection we found that wound care plans were hard to follow. At this inspection we saw improvements had been made and in one person's plan the progress of a wound up to when it healed was clear to see. Another person was diabetic. The plan guided staff on what the person's usual blood sugar levels were and the signs and symptoms of hypo or hyperglycaemia and the actions to be taken.

People's care plans had important information relating to their individual behavioural needs. For example, one person's care plan confirmed behaviours they might display. Records showed input from the GP and other health care professionals. Staff recorded details of any incidents and what actions were taken. This had enabled staff to analyse any triggers and identify the best ways to support the person. The care plan for this person guided staff to, "Assess mood, give [them] time, talk about favourite topics and involve [them] in the activity if [they] agree." When we discussed this person with members of staff they demonstrated a good understanding of their needs. A visiting health professional said, "The staff are very good at getting to know people and learning about their past lives. This really helps when we're learning about people's behaviours."

People using the service and their relatives said they were aware of their care plans and had been involved in reviews. One person said, "I am involved in my care plan and get ready access to other health professionals if I need them." One relative said, "I am fully involved with [name] care plan. We also have annual reviews."

Although there were advanced and end of life plans in place, these were not consistently person centred. Staff explained that having these conversations with people could be difficult; however when people chose not to discuss their end of life wishes this had not always been documented. For example, one person had moved to the service for end of life care. This was clearly documented in the pre-admission assessment. However there was no end of life plan in place. We discussed this with one of the nurses and a plan was in place on the second day of the inspection. The registered manager said the service had good links with the local hospice. They said, "We involve [name of hospice] quite a lot. We also have an end of life lead nurse."

There were two activity co-ordinators in post. One was full time and one part time. There was a range of activities available for people to take part in, such going to coffee mornings at church, music and

movement, bingo and outside entertainers. People we spoke with gave mixed feedback about activities and whether they felt there was enough to occupy them. Some people said they took part in organised group activities and we saw examples of these such as people enjoying a singalong and a quiz. The activities staff said they offered one to one sessions for people who didn't wish to take part or who were unable to because they were in bed. However, although some of these people were happy with the level of interaction, not all were. For example, one person said, "I keep myself amused. I read and I write. I'm not really a 'joiner inner' but I'm always included and they always ask me." Another said, "I will stand back and watch but I'm not an activity sort of person." Other comments included, "It's a long day sometimes. I potter around, I watch TV. Activities? No I haven't seen anything" and "Watching TV is my main hobby. It is not often people come to chat. I've never seen anyone from the activity team." Visitors to the service also gave mixed feedback regarding the amount of stimulation people received. Although some said they believed their relatives had opportunities to take part if they wanted to, others told us they didn't feel this was the case. During the inspection we informed the registered manager of the mixed responses we received.

There was a complaints procedure in place. Complaints were logged and there was a process in place to review the trends and prevent similar occurrences. Eight complaints had been received during 2018. However, the complaints file did not always contain details of investigations or describe how the issues were resolved because there was only evidence of three complaints being closed. For example, we saw one complaint dated 29 March 2018, but there was nothing else documented to show how the complaint had been investigated or resolved. This meant it could be difficult for complaints analysis to be carried out because information was missing. One relative told us they had raised concerns during May 2018 but had not received any confirmation from the registered manager that the issue had been fully investigated and resolved. We discussed this with the registered manager and area manager during the inspection and they provided us with an update and said they would make contact with the complainant to resolve this.

Requires Improvement

Is the service well-led?

Our findings

There were extensive quality assurance processes in place. A range of audits were regularly carried out. These included audits of medicines, care plans, infection control, accidents and falls. Monthly care audits were also undertaken which included an overview of healthcare professional visits, acquired infections and wounds. Shortfalls identified from the audits had an action plan in place. There was also evidence that learning from the audits was shared with staff. For example, refresher training for staff, referrals to other health professionals and review of staffing levels had all been undertaken recently.

However during the inspection we found some improvements were still required to ensure audits identified potential shortfalls in people's care and actions were taken. For example, one person had moved to the service on 9 April for end of life care. A care plan audit on 29 June2018 identified the lack of plans for end of life, pain, breathing and PRN medication. The date for these to be actioned was 16 July 2018, but at the time of the inspection they had not all been put in place.

Additionally, although the care plan audits covered the assessment of people's hydration needs and monitoring, the audits had not identified people's hydration targets had been inaccurately calculated.

Although complaints had been logged, records of how these had been investigated and resolved were not always available. This meant it was difficult to review any trends and there was a lack of assurance that all complaints had been dealt with satisfactorily.

The service sought regular feedback from people using the service. Survey topics included staffing, management, quality of meals, entertainment and the environment. The provider told us they had been reviewing and updating the survey content in order to get more detailed feedback. Because of this, no feedback had been sought during 2017; however feedback cards/surveys were available in the reception area for people to fill in.

There were strong links with the local community. People were able to attend the nearby church, and local coffee mornings. The service held fetes in the grounds which local people were invited to attend and support. Local school children visited during the Christmas period.

Although the registered manager had notified the Care Quality Commission of the majority of significant events which had occurred in line with their legal responsibilities, we had not been informed about one allegation of suspected abuse although this was rectified after the inspection.

People using the service knew who the registered manager was. They said the manager was "visible" and "approachable." Comments included, "It feels like it's well run" and "It is well run generally. I think I'm really lucky to be here." Visitors to the service spoke highly of the registered manager. They told us, "[Registered manager] is lovely, helpful and supportive", "We love [registered manager]. They can put their hand to anything and will do so as they have worked their way up through the ranks" and "This place is led well by [registered manager]. I'm impressed with them; they pop in. They are always there if I need them.

[Administrator] is also very good."

One visiting health professional said, "[Registered manager is very good at what they do. [They] always try to help you and the residents and always look for solutions to support people living here."

Staff also gave positive feedback about the management of the service. For example, one member of staff said, "[Registered manager] listens and I wouldn't hesitate to talk to them. [They're] pretty approachable." Staff also said the morale was "good." Comments included, "It is a nice place. It is like a family. Everybody listens and respects everybody. Views are encouraged and we embrace change" and "Team work is very good. Communication is very good."

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 Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Fluid monitoring charts had targets which were incorrectly calculated. Food monitoring charts did not detail the food eaten or the quantities eaten.