Devonshire House Care Limited

Devonshire House

Inspection report

The Green
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Date of inspection visit:
29 January 2016

Date of publication:
09 March 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection visit took place on the 15 January 2016. This was an unannounced inspection which meant that the staff and provider did not know that we would be visiting.

Devonshire House is situated in the village of West Auckland close to all amenities. It currently provides residential and respite care, nursing care and care for people with dementia and people with physical disabilities. There are 21 single occupancy rooms and 2 double occupancy rooms. Three of the rooms within the home have en-suite facilities. The service is family owned and it has a close knit, family feel to the home.

There is 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. The registered manager had just completed their registration prior to our visit and was a registered nurse and had worked at the home before they applied to be the registered manager.

All people we spoke with told us they felt safe at the service. Staff were aware of procedures to follow if they observed any concerns. We saw safeguarding incidents were very well recorded, investigated and managed by the registered manager.

There were policies and procedures in place in relation to the Mental Capacity Act and Deprivations of Liberty Safeguards (DoLS). The service did not have many people subject to a DoLS safeguard and it had an open door policy. The registered manager agreed that they may need to make further applications subject to a capacity assessment if they needed to secure the front door on a more permanent basis.

We saw that staff were recruited safely and were given appropriate training before they commenced employment. Staff had also received more specific training in managing the needs of older people such as end of life care and dignity. There were sufficient staff on duty to meet the needs of the people and the staff team were supportive of the management and of each other.

Medicines were not stored and administered is a consistently safe manner. There was a risk that people were not receiving their medicines as prescribed due to poor record keeping.

There was a regular programme of staff supervision in place and records of these were detailed and showed the home worked with staff to identify their personal and professional development.

We saw people's care plans had been well assessed. The home had developed care plans to help people be involved in how they wanted their care and support to be delivered. We saw people were being given choices and encouraged to take part in all aspects of day to day life at the home and people were able to

visit local shops and facilities.

Staff had a good awareness of people's dietary needs and staff also knew people's food preferences well. We saw everyone's nutritional needs were monitored and mealtimes were well supported.

We observed that all staff were very caring in their interactions with people at the service. People clearly felt very comfortable with all staff members. There was a warm and caring atmosphere in the service and people were very relaxed. We saw people were treated with dignity and respect. People told us that staff were kind and professional.

We also saw a regular programme of staff meetings where issues where shared and raised. The service had a complaints procedure and staff told us how they could recognise if someone was unhappy and how to report it.

Any accidents and incidents were monitored by the registered manager to ensure any trends were identified. This system helped to ensure that any patterns of accidents and incidents could be identified and action taken to reduce any identified risks.

The service had a comprehensive range of audits in place to check the quality and safety of the service and equipment at Devonshire House. Action plans and lessons learnt were part of their on-going quality review of the service as well as a service improvement plan to improve décor and signage within the service.

The home was very much part of the local community and people were free to come and go as they pleased. Many visitors popped in during the course of our visit and were warmly welcomed.

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.

People told us they felt safe at Devonshire House.

Staff knew procedures to follow to keep people safe and their were policies and information to support them. Staffing levels were good and were built around the needs of the people who used the service.

We saw that medicine records were not always completed fully which meant people were at risk of not receiving safe and effective care and treatment.

Is the service effective?

Good

This service was effective.

People were supported to have their nutritional needs met and mealtimes were well supported. People's healthcare needs were assessed and people had good access to professionals and services designed to help them to maintain a healthy lifestyle.

Staff received regular and worthwhile supervision and training to meet the needs of the service.

The registered manager had an understanding of the Mental Capacity Act 2005 and Deprivations of Liberties (DoLS) and should ensure that if required capacity assessments are required then they are undertaken applications submitted straight away.

Is the service caring?

Good

This service was caring.

It was clear from our observations and from speaking with staff they had a good understanding of people's care and support needs.

Wherever possible, people were involved in making decisions about their care and independence was promoted. We saw people's privacy and dignity was respected by staff.

Is the service responsive?

Good

This service was responsive.

People's care plans were relevant to people's needs and reviewed regularly.

The service provided a choice of activities based on individual need.

There was a complaints procedure available that was well publicised around the service. People and staff stated the registered manager was approachable and would listen and act on any concerns.

Is the service well-led?

Good

This service was well-led.

There were effective systems in place to monitor and improve the quality of the service provided. Accidents and incidents were monitored by the registered manager to ensure any trends were identified and lessons learnt.

Staff and people said they could raise any issues with the registered manager and registered providers.

People's views were sought regarding the running of the service and changes were made and fed-back to everyone receiving the service.

Devonshire House

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 29 January 2016 and was unannounced.

The membership of the inspection team included one adult social care inspector, a specialist advisor who was a registered nurse 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 for older people.

We reviewed all of the information we held about the service including statutory notifications we had received from the service. Notifications are changes, events or incidents that the provider is legally obliged to send us. We received no negative feedback from commissioners.

At our visit to the service we focussed on spending time with people who lived at the service, speaking with staff, and observing how people were supported. We undertook an in-depth review of care plans for four people to check their care records matched with what staff told us about their care and support needs. We reviewed the medicines records of five people.

We spoke with two visiting healthcare professionals during the course of our visit. They were positive in their comments of the staff and care at the home.

During our inspection we spent time with ten people who lived at the service, four visiting relatives, seven care staff, the registered manager and the deputy manager. We observed support in communal areas. We also looked at records that related to how the service was managed, looked at staff records and looked around all areas of the home including people's bedrooms with their permission.

Requires Improvement

Is the service safe?

Our findings

People we spoke with had an understanding of staying safe. We asked people if they felt safe at the service and everyone we spoke with confirmed they felt safe and happy. One person told us; "I am very happy here, the staff are nice and very helpful". We spoke with relatives who told us; "My father has improved considerably since he came here. I am so happy with his care and yes he is very safe here". Another relative said; "You could not get a better place than this. The care is excellent and I do not know where they find such nice staff, it gives you faith in young people".

Staff we spoke with told us they had received training in respect of abuse and safeguarding. They were all able to describe the different types of abuse and the actions they would take if they became aware of any incidents. One staff member told us; "There is nothing to worry about as you can whistleblow confidentially if you wish". Training records showed staff had received safeguarding training which was regularly updated. We saw that safeguarding information was displayed around the service with contact information and staff we spoke with knew the name and details of the local authority safeguarding service. This showed us staff had received appropriate safeguarding training, understood the procedures to follow and had confidence to keep people safe. We saw records that demonstrated the service notified the appropriate authorities of any safeguarding concerns. The service had a safeguarding event earlier in 2015 and the registered manager told us; "We had lots of paperwork that was out of date so we have put a lot of work in on it. (The local authority) safeguarding team were great, they helped us with ideas for the format of new care plans". The registered manager was not in charge at the time of the safeguarding event, but it showed the service worked and listened to the safeguarding authority.

The training information we looked at showed staff had completed training which enabled them to work in safe ways. Staff we spoke with confirmed they knew the procedures to follow in the event of an emergency. One staff member told us; "We all know the fire alarm procedures well."

There were effective recruitment and selection processes in place. We saw that checks to ensure people were safe to work with vulnerable adults called a Disclosure and Barring Check were carried out for any new employees and also on a three yearly basis for established staff members. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also to prevent unsuitable people from working with children and vulnerable adults. We looked at two staff records relating to the recruitment and interview process. We saw references had been sought and identity checked using documents including passports, driving licenses and birth certificates. We saw the registered provider had robust arrangements for assessing staff suitability; including checking their knowledge of the health and support needs of the people who used this type of service. For example an interview question asked candidates; "A resident who is diabetic asks for a slice of cake, what would you do?" The records were well organised. This showed the service had robust recruitment processes in place.

On the day of our inspection there was the registered manager, deputy manager who was the nurse in

charge, an activity co-ordinator, a nurse, one housekeeper, the chef and four care staff on duty for 24 people. We looked at the staff rota for the current week and it confirmed that there was a minimum of one nurse and four care staff on duty during the day and at night-time.

Both people and staff told us they felt there were enough staff, we observed that there was always a staff member in the main communal lounge and staff often sat with people chatting. We saw that staffing levels met the needs of the people who used the service.

At the time of our arrival the deputy manager, who was a nurse, was administering medicines. Medicines were given from the container they were supplied in and we saw the nurse explain to people what medicine they were taking and why. The nurse gave people the support and time they needed when taking their medicines. People were offered a drink of water and the nurse checked that all medicines were taken. The Medicines Administration Records (MAR) showed that staff recorded when people received their medicines and entries had been initialled by staff to show that they had been administered. However, we noted that there were a number of prior entries had not been initialled by staff, therefore we were unsure as to whether the medicines had been administered. We saw for one person they had been prescribed a food supplement (as noted on the food supplement bottle), however the information had not been transcribed onto the MAR chart, and the food supplement had been administered as noted on the food/fluid chart rather than a Medicine Administration Record (MAR). We saw some MAR sheets with hand written instructions which had not been signed by two members of staff. This meant there was the risk of error, in that people may not receive the correct medicines. The registered manager and deputy manager agreed that the medicines records required improvement and it was an area they also had concerns about. They agreed to action improvements straight away.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Safe Care and Treatment.

Fridge temperatures were monitored and recorded together with room temperature. We noted that in the main minimum, maximum and current temperatures relating to refrigeration had been recorded daily and were between 2 and 8 degrees centigrade; However we saw some gaps on 14.01.2016 and 22.01.201616 and the registered manager reassured us that this would be addressed immediately. There was a monthly count of controlled drugs signed for by nursing staff. Medicines were stored safely and securely.

We did not see written guidance kept with the MAR charts, for the use of "when required" (PRN) medicines, and when and how these medicines should be administered to people who needed them, such as for pain relief. The registered manager told us that they were currently developing PRN medicines care plans and these would be implemented as soon as possible. We did not see evidence of topical medicines application records to show the topical preparations people were prescribed, including the instructions for use and the associated body maps and the expiry date information. The registered manager told us that they were currently developing Topical MAR charts and would implement them as soon as possible.

We discussed the ordering, receipt and storage of medicines with the deputy manager who was responsible for administering medicines on the day of our visit and for general ordering and medicines management. Medicines were securely stored in a locked treatment room and only the nurse on duty held the keys for the treatment room. Medicines were transported to people in a locked trolley when they were needed. They explained how the system of receiving medicines into the home worked and how a record was kept to ensure there was a clear audit trail of any medicines that were awaiting delivery from either the GP or the pharmacy, so stock could be maintained.

The service was clean and homely. The service would benefit from decoration improvements and we saw that this was part of the service's development plan.

There were effective systems in place for continually monitoring the safety of the premises. These included recorded checks in relation to the fire alarm system, hot water system and appliances. We saw recorded checks on safety equipment, such as fire extinguishers and the fire alarm and equipment in relation to moving and handling. These checks were regular and up-to-date. The deputy manager also explained the process for reporting any faults to him which would then be assessed and addressed accordingly.

Risk assessments were also held in relation to the environment and these were reviewed on a regular basis by the registered manager. The four care plans we looked at incorporated a series of risk assessments. They included areas such as the risks around moving and handling, skin integrity, falls, and a nutritional screening tool. We saw that people or their families agreed to the care plans and risk assessments that were in place and this was recorded. The risk assessments and care plans we looked at had been reviewed and updated regularly. We saw one person was in the home on a short term placement until alternative accommodation could be arranged. We staff quickly intervene to verbally prompt the person to maintain their safety. Staff we spoke with knew about the risks involved with this person and we saw these were recorded clearly in the person's file.

Any accidents and incidents were monitored by the registered manager to ensure any trends were identified. This system helped to ensure that any patterns of accidents and incidents could be identified and action taken to reduce any identified risks. We saw there were clear actions for example, for one person who had been identified from the analysis of falls, we saw they had a sensor mat placed at their bedside and they had been referred to the specialist falls team. This showed the service worked to keep people safe.

Good

Is the service effective?

Our findings

We asked a visiting healthcare professional whether they felt staff were trained to understand people's needs. They told us; "Yes they recognise when people are well and not well, they can recognise if people are more sleepy, not eating and drinking and do something about it".

All staff had an annual appraisal in place. Staff told us they received supervision every month and records we viewed confirmed this had occurred. We saw that the discussion included workload, support and professional development. There was a planner in place, which showed for the next twelve months all the dates when staff were booked in to have supervision sessions or their appraisal, as well as when staff meetings were scheduled to take place.

The staff came across as happy, well-motivated, and interacted well with people and visitors. They were able to tell us about peoples' needs. It was interesting to note that there was a college student who was on placement in the home and staff were constantly saying to the student; "We will show you how to do it (the task) and how to write it up". We saw an example of this when one person only ate half their meal stating they were full. The student was told this needed recording and she would be shown what to do. We spoke with the student who told us; "It's been great here, everyone has been really helpful and kind to me."

We viewed the staff training records and saw the majority of staff were up to date with their training. We looked at the training records of all staff members which showed in the last 12 months they had received training in infection, fire, safeguarding, dementia, nutrition and hydration, Deprivation of Liberty Safeguards and the Mental Capacity Act 2005 amongst others. We saw that the service had implemented the new Care Certificate induction workbook for any new staff and the service had utilised other aspects of the Care Certificate induction to give established staff refreshers in training such as health and Safety. We saw that nursing staff had also accessed specialist training in the last year in relation to catheter care. The registered manager had previously worked in a hospice and they had undertaken training with all staff in end of life care and they informed us they had registered the service to undertake the GOLD framework. The GOLD framework provides standards in palliative care and ensured training for all staff. Staff were also undertaking a programme of 'Focus on Undernutrition' which people told us they were about to be trained in the next few weeks.

Staff told us they met together on a regular basis. We saw minutes from staff meetings in 2015, which showed that items such as day to day running of the home, training, and any health and safety issues were discussed.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

At the time of the inspection two people at the service were subject to a DoLS. A deprivation of liberty occurs when a person is under continuous supervision and control and is not free to leave, and the person lacks capacity to consent to these arrangements. We were told by the registered manager that the service did not have a locked door arrangement and people were free to leave. They told us the authorisations had been sought for the two people who may leave the home but they had not attempted to do so. We saw that peoples consent was sought in relation to their care plans, photographs and also in maintaining confidentiality. The service had sought advocacy support for two people in relation to their deprivation of liberty. The registered manager told us that they would seek a capacity assessment from the GP or social worker if they had any concern that people may be at risk of being deprived of their liberty and they showed us how they had done this for one person in relation to their finances and that had been subject to a Court of Protection order.

Plenty of drinks were available during the day, twice during the morning and afternoon as well as meal times. Staff also offered to make people extra drinks if they wished. Everyone said the food was very good with choice given. There was a menu on display in the dining room but the cook also asked people during the morning what they would like to eat and at lunchtime one person changed their mind and an alternative was arranged. Lunch was fish & chips with peas, or jacket potato. Desert was rice pudding, yoghurt or fruit and later on at tea -time people had bacon sandwiches and cakes. The meal was nicely presented and was hot with reasonable portions. People were asked if they wanted extra. The tables were nicely set with napkins and condiments and there were three staff assisting people with lunch. We observed that staff let people be as independent as possible with eating and used plate guides and gently encouragement.

We saw from care plans that there were systems to ensure people were identified as being at risk of poor nutrition and were supported to maintain their nutritional needs. People were routinely assessed using the Malnutrition Universal Screening Tool (MUST). MUST is a five-step screening tool to identify if adults were malnourished or at risk of malnutrition. We saw an example nutrition care plan for a person which stated "[Person] only likes tea if they have a piece of cake, likes a jug of juice in their room, instead of hot drinks person will have glass of milk, likes poached egg, battered fish, all kinds of meat dinners, dislikes parsnips, roast potatoes, brussel sprouts and ice cream". Where people were identified as being at risk of poor nutrition staff completed daily 'food and fluid balance' charts. The food charts used to record the amount of food a person was taking each day, accurately documented the amount of food a person consumed, for example portion sizes. In addition, we actively saw care staff discussing and completing fluid and food charts on an on-going basis. This meant that people's nutritional needs were monitored.

The registered manager told us that healthcare specialists visited and supported people who used the service regularly. They said; "We have links with three local GP practices and we have really good relationships with them." Care plans reflected the advice and guidance provided by external health and social care professionals. One person received a visit from an advanced nurse practitioner on the day of the inspection which we were told was part of an on-going treatment and care plan. This demonstrated that staff worked with various healthcare and social care agencies and sought professional advice, to ensure that the individual needs of the people were being met, to maintain their health and wellbeing.

Good

Is the service caring?

Our findings

We asked a visiting healthcare professional what the staff were like and whether there were enough staff. They replied; "Yes it's always been really lovely, they know the residents really well, it's very homely and friendly, lots of staff around in resident areas and they socialise with residents, residents always seem happy".

Both people and visitors were very complimentary about staff. One person said; "I am very happy with my care, staff are really good", while another person told us; "I have been in the home quite a while now and the staff are always pleasant and helpful".

One visitor stated "The staff here provide excellent care, I am so happy with everything they do". Another visitor stated "This place is really a one off. Staff are so helpful and kind, they know the care needs and will sit and talk. My husband gets as many baths as he wants and is always very presentable. I do not know where they find such nice young people. It is very reassuring".

People stated quite openly that staff were respectful and looked after their dignity. We observed staff explaining to people what they wanted to do e.g. use a hoist, and asking permission to do so. Staff were knocking on doors before entering rooms and responding quickly to call bells.

Visitors told us they could visit at any time and were always made welcome. We saw visitors were made very welcome in the home with staff asking how they were, updating them on care issues and asking if they wanted a cup of tea.

There was a calm, positive atmosphere throughout our visit and we saw that people's requests for assistance were answered promptly. Throughout the visit, the interactions we observed between staff and people who used the service were friendly, respectful, supportive and encouraging. Our observation during the inspection was that staff were respectful when talking with people calling them by their preferred names.

We observed that people were asked what they wanted to do and staff listened. When staff carried out tasks for people they bent down as they talked to them, so they were at eye level. They explained what they were doing as they assisted people and they met their needs in a sensitive and patient manner.

Staff were patient, kind and polite with people who used the service and their relatives. Staff clearly demonstrated that they knew people well, their life histories and their likes and dislikes and were able to describe people's care preferences and routines. When we asked about a specific person's care needs staff were able to tell us what they required and also about their family. Overall, people looked clean, comfortable and well cared for, with evidence that personal care had been attended to and individual needs respected.

The registered manager was a registered nurse who had worked previously in palliative care environments.

The registered manager told us they were developing end of life care plans for people; which meant that healthcare information would be available to inform staff of the person's wishes at this important time, to ensure that their final wishes could be met.

Good

Is the service responsive?

Our findings

The service was responsive. We saw that care records were regularly reviewed and evaluated with, where they were able, the person who used the service. Everyone told us had been involved, with their family, in setting up their care plan. Visitors stated they were kept fully up to date on care issues and the care plan reviewed as necessary. One visitor told me "I have never been refused anything. I raise something and it is talked through and sorted". Another visitor said "I talked to staff about what my father's care needs were and they have done everything asked".

We saw pre-admission assessments were carried out and people's needs were assessed before they moved into the home. Following an initial assessment, care plans were developed detailing the care needs and support that each individual required.

Examination of four care plans showed they were person-centred. Person centred planning provides a way of helping a person plan all aspects of their life and support, focusing on what's important to the person. The care plans covered a full range of skills and needs and we saw that new plans had been drafted where people's needs had changed. The registered manager explained that new plans were in the process of being drafted for every person at the service and was almost complete. Each person's care file contained a daily routine care plan which detailed how the person like to get up, what they responded well to, what they did not respond well to, their morning routine, breakfast (time, where, how served), how they liked to spend the morning/afternoon/evening and their bed time routine. The meant that care staff were aware of the person's daily routine and thus provided meaningful support and enjoyment to them. An example for a person was 'X [person] does not respond well to a lot of noise, or X [person] likes to brush their own hair.' Each person's care file contained a social profile (My Life Story), where the information had been collected with the person and their family and gave details about the person's preferences, interests, people who were significant to them, spirituality and previous lifestyle.

Risk assessments were in place where required. For example, where people were at risk of falls, and these were reviewed and updated regularly. Standard supporting tools such as the Waterlow Pressure Ulcer Risk Assessment and Malnutrition Universal Screening Tool (MUST) were routinely used in the completion of individual risk assessments. Assessments had been carried out which showed people were at risk of developing pressure ulcers; we found people's care plans were up-to-date to inform staff about people's care and support needs. We noted that moving and turning charts and body maps were in use to monitor people's care in this area. An example care plan we found for a person stated 'Change position every two hours, encourage diet and fluids, observe skin daily, report and record any changes, discolouration, breaks or excoriation to skin'. We also saw that preventative pressure relieving measures were in place. This meant that people's care records did contain a detailed care plan to instruct staff what action they should take to maintain skin integrity and showed that people were receiving appropriate care, treatment and specialist support when needed. Staff also told us they encouraged a continence programme ensuring everyone was offered the opportunity to go to the toilet discreetly every two hours and whenever they requested. Staff showed us daily notes were kept for each person, they were concise and information was recorded regarding basic care, hygiene, continence, mobility, nutrition, activities and interests. These records showed

that people's needs, daily care, treatment and professional interventions were communicated when staff changed duty, at the beginning and end of each shift.

There was a clear policy and procedure in place for recording any complaints, concerns or compliments. The service had a complaints file that showed the exact timescale of complaints, investigations and outcomes and we saw even small concerns raised by people or visitors were recorded and addressed. We saw via the service's quality assurance procedure that the registered manager sought the views of people using the service on a regular basis and this was recorded. This included people who lived at Devonshire House as well as relatives and visitors. The complaints policy also provided information about the external agencies which people could use if they preferred.

There was an activities programme on display and people confirmed they had a choice as to whether or not they got involved. The activities organiser told us people were quite selective about what they took part in, but they were always given a choice. One person told us they spent most of their time doing jigsaws. However other people told us about some of the activities and particularly visiting singers etc. and these sessions seemed to be well liked. There was a reminiscence quiz on the morning of our visit and an exercise session in the afternoon. Care staff also helped with the activities and joined in.

There was a keyworker system at the service which staff told us was good as they did any shopping required for those they were linked with and got more involved with their relatives and care plan.

Good

Is the service well-led?

Our findings

The registered manager and deputy manager told us about their philosophy to maintain a family style home that was person centred and provided a high standard of nursing care. We witnessed a college student being coached and supported by both nursing and care staff throughout the visit. The feedback from this student was excellent, they told us this was a great place to come and learn as everyone helped them. A visiting healthcare professional told us; "The owner has quite a presence and I think they're supportive of staff, when you come in I can hear them with staff and they deal with things when they need them. They always say 'Hi is everything alright'. It's a nice home".

A visiting healthcare professional told us; "X [registered manager] is lovely, really approachable she's very good, good at interacting with families too, manages to get point over, staff are happy with her". People told us the manager was very visible around the home and would sit and talk to people. Staff we spoke with were confident they could report concerns about colleagues as they said the registered manager was very approachable. We saw the manager interacting with staff, people and visitors and enjoying their lunch in the dining room at lunchtime, it was obvious they knew people well and people were very comfortable with them. The registered manager was very open and honest about their areas for improvement, this included items such as the décor, meaningful engagement training, memory boxes and practice such as medicines. They had only been registered with the Care Quality Commission since the previous day but they told us they had gained the manager's post several months prior and had focused on improving care plans. We saw these had now improved. A staff member told us; "The manager had put in hourly checks which are recorded. At the time I wondered why but it's good because there are two people who are nursed in bed and that check means everyone knows they are safe." This showed the management of the home recognised its areas for improvement and took steps to address them.

Most of the staff had worked in the home for quite a long time and said they really enjoyed working for the family run company. A visiting healthcare professional told us; "The best thing about this service is the stable staff, no turnover, good care".

The home carried out a range of audits as part of its quality programme. The registered manager explained how they routinely carried out audits that covered the environment, health and safety, care plans, and medicines as well as how the home was managed. We saw clear action plans had been developed following the audits, which showed how and when the identified areas for improvement would be tackled. This showed the home had a monitored programme of quality assurance in place. We saw policies had been re-written and updated extensively in 2015. The providers also visit the service regularly and carry out a monthly monitoring visit. We saw they got feedback from people and staff as well as checking complaints, safeguarding, the premises and registered manager's audits. Other required paperwork such as notifications the service was legally required to submit to the Care Quality Commission had also been carried out and were securely stored.

We saw the service was working closely with healthcare professionals and the registered manager told us about how the service was involved in the local community. The home had held coffee mornings and charity

bake-offs. The service was also going to be a local community point for a defibrillator that would be sited there and the registered manager told us they were also hosting local community training for people to use this.

Staff told us they had regular meetings and we saw that both nursing and care staff met and issues such as care planning, health and safety and rotas had been discussed. All staff signed to show if they could not attend the meeting then they read the minutes.

Relatives and people who used the service were involved in the review and planning of the service. We saw that regular meetings and surveys were carried out. One relative told us; "This place is a one-off, they are great with everything they do." We saw from the minutes of the previous meeting in September that the home discussed activities, and the new 'Focus on Undernutrition' training with people and relatives. We saw as a result of surveys in 2015 that people were asked about areas such as choice, patience, politeness and actions for improvement. We saw that one relative had proposed a suggestion about name badges and the service explained the reasoning behind its decision for not implementing this suggestion. This showed the service listened and acted on feedback.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not protected from the risk of harm by medicines not being managed in a safe and consistent manner. Records were not completed fully so we could not check if they had been administered as prescribed.