Mayfield Residential Care Ltd

Mayfield Residential Home

Inspection report

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Date of inspection visit:
07 December 2016

Date of publication:
14 February 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an unannounced inspection of the service on 7 December 2016. Mayfield Residential Home provides accommodation for up to 29 people who require nursing or personal care. Some of the people living at the home were living with dementia. On the day of our inspection 24 people were using the service.

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

People told us they felt safe living at the home. Staff understood how to identify and report allegations of abuse; however these were not always reported to the CQC. The assessment of the risks to people's safety was carried out. However, the environment in which people lived was not always safe, with storage cupboards containing potentially harmful cleaning products left unlocked and equipment such as wheelchairs and walking aids stored in communal areas. Accidents and incidents were investigated. People told us there were enough staff to support them at night, but raised concerns in relation to staffing numbers during the day. We saw staff did not always respond quickly enough when call bells were pressed. Our observations showed there were enough staff to support people on the day of the inspection. People's medicines were stored in locked cabinets and cupboards, although on one occasion the room in which they were stored was unlocked. People's medicine records were not always appropriately completed.

Attempts had been made to ensure the principles of the Mental Capacity Act (2005), including Deprivation of Liberty Safeguards, had been followed when decisions were made about people's care. However, the documentation used to carry out the assessments did not always follow these principles.

People were supported by staff who had completed an induction and training programme, however agency staff did not always receive a formal induction. Some staff required refresher training in some areas and this was being addressed. Staff received regular supervision of their work. People spoke positively about the food provided at the home. People's day to day health needs were met. The environment in which people lived did not offer sufficient support for people living with dementia.

There were some positive interactions between people and staff, but people were not always treated with respect and dignity by staff. People were involved with decisions about their care and support needs. People were encouraged to lead independent lives. Information for people on how to access independent advice about decisions they made was available. People's records were not always stored securely. People's friends and relatives could visit the home when they wanted to.

People and relatives felt the activities provided at the home required improving, with some people receiving little stimulation throughout the day. Only three out of seven days had a member of staff allocated to supporting people with their activities and hobbies and interests. People's care records contained care

plans to support staff with providing responsive care. People felt able to make a complaint and were confident it would be dealt with appropriately.

Auditing processes were in place, but these were not always effective and had not identified many of the areas highlighted in this report. The registered manager was not fully aware of their responsibilities to inform the CQC of incidents that could affect people's lives. People, relatives and staff spoke highly of the registered manager. People were encouraged to become involved with the development of the service and were given the opportunity to give their opinions during 'resident meetings' and via regular reviews with the registered manager. Staff were not always held accountable for their actions. Staff were aware of the provider's whistleblowing policy and understood how to report any concerns.

We identified one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see the action we have told the provider to take at the back of this 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 consistently safe.

The assessment of the risks to people's safety was carried out. However the environment in which people lived was not always safe.

People told us there were enough staff to support them at night, but raised concerns in relation to staffing numbers during the day. Staff did not always respond quickly enough when call bells were pressed. Our observations showed there were enough staff to support people on the day of the inspection.

People's medicines were stored in locked cabinets and cupboards, although on one occasion the room in which they were stored was unlocked. People's medicine records were not always appropriately completed.

People felt safe living at the home. Staff understood how to identify and report allegations of abuse; however these were not always reported to the CQC.

Accidents and incidents were investigated.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The principles of the Mental Capacity Act (2005) had not always been appropriately applied when decisions were made about people's care.

People were supported by staff who had completed an induction and training programme, however agency staff did not always received a formal induction. Some staff required refresher training in some areas.

The environment in which people lived did not always offer sufficient support for people living with dementia.

Staff received regular supervision of their work.

People spoke positively about the food provided at the home.

People's day to day health needs were met.

Is the service caring?

Requires Improvement

The service was not consistently caring.

There were some positive interactions between people and staff, but people were not always treated with respect and dignity by staff.

People's records were not always stored securely.

People were involved with decisions about their care and support needs.

People were encouraged to lead independent lives. Information for people on how to access independent advice about decisions they made was available.

People's friends and relatives could visit them when they wanted to.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People and relatives felt the activities provided at the home required improving, with some people receiving little stimulation throughout the day.

There were limited assigned staffing hours focusing on supporting people with activities.

People's care records contained care plans to support staff with providing responsive care.

People felt able to make a complaint and were confident it would be dealt with appropriately

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Auditing processes were in place, but these were not effective and had not identified many of the areas highlighted in this report.

The registered manager was not fully aware of their responsibilities to inform the CQC of incidents that could affect people's lives.

People, relatives and staff spoke highly of the registered manager and people were encouraged to become involved with development of the service.

Staff were aware of the provider's whistleblowing policy and understood how to report any concerns.

Mayfield Residential 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 7 December 2016 and was unannounced.

The inspection team consisted of one inspector and an Expert-by-Experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a 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. Before our inspection, we reviewed the PIR and other information we held about the home, which included notifications they had sent us. A notification is information about important events which the provider is required to send us by law. We also contacted local authority commissioners of adult social care services and Healthwatch and asked them for their views of the service provided.

We spoke with seven people who used the service, six relatives or visitors, four members of the care staff, the activities coordinator, the senior supervising care worker, a senior care worker and the registered manager.

We looked at all or parts of the care records and other relevant records of eight people who used the service, as well as a range of records relating to the running of the service.

Requires Improvement

Is the service safe?

Our findings

People told us staff did not always respond quickly enough when they pressed their call bells for attention. One person said, "I suppose it's anywhere between one and 15 minutes to respond. Lunchtime is the busiest time and means a wait." Another person said, "I sometimes have to wait, it can be ten to 15 minutes if they're [staff] busy." A third person said, "It can be five to 10 minutes wait, they tell me they'll be back when they can." A relative said, "They'll come and tell [my family member] if they're busy and cancel the bell and come back."

We spoke with a representative of the provider about the comments relating to a 15 minute delay on responding to call bells. They told us they had spoken with their staff and none could recall a delay of this length having taken place. However, the representative assured us that all staff have been reminded of the need to respond to calls bells in as timely a manner as possible.

We noted there were times throughout the day when staff were particularly busy and calls bells were ringing for up to five minutes at a time before staff responded. We also found not all staff responded quickly to call bells when they were pressed. For example, one member of staff was writing notes in a person's care plan. The call bell had been ringing for at least five minutes whilst we were in the room. We checked the monitor to see which room the call related to. The staff member saw us do this and asked us which room it was; when we told them, they then said they would go and see the person. The lack of urgency from the staff member meant the person waited longer than was needed. However, we did also note that when the emergency call bell was pressed all staff responded immediately. The registered manager told us the current call bell system did not permit them to monitor call bells response times, but they would discuss this with the staff.

We received mixed feedback when we asked people and relatives if there were enough staff to support them during the day. One person said, "I see them [staff] being busy but they're good and give me regular help." Another person said, "They seem to manage ok as they are." However, a third person said, "There's not enough on, things are irregular. Our meals can be half an hour late arriving." A relative said, "Sometimes it feels like there's not enough on." Another relative said, "They seem to have the minimum on."

However, people and relatives felt there were sufficient staff available at night. One person said, "I hear them peep in [to the person's bedroom] but they don't disturb me." Another person said, "They turn me regularly at night." A relative said, "[My family member] gets regular checks through the night." The staff we spoke with did not raise any concerns about the number of staff available, day or night, to support people.

Although a formal assessment of people's level of dependency was not carried out, the registered manager told us that as the people living at the home had been there for long periods of time, they were able to identify if more staff were needed to support them at certain times of the day. Our observations concluded that, on the whole, there were enough staff available to support people safely on the day of the inspection.

We checked the staff rota and found the numbers of staff matched the number of staff that were working

during the inspection. Safe recruitment procedures were in place. Checks on staff suitability to carry out their role before they commenced work were carried out. This included checks to establish whether a potential member of staff had a criminal record, whether they had sufficient references and proof of identity. This reduced the risk of people receiving care and support from unsuitable staff.

We found from people's care records that where risks associated to people's needs had been identified, appropriate action had been taken to reduce and manage these risks. Staff were able to give examples of how they supported people safely. We observed staff move people safely throughout the day when using a hoist.

People were not always protected from the risks associated with the environment in which they lived. We noted a storage cupboard, used to store cleaning products was not locked when it was not in use. The laundry door was also wedged open, and although at times a member of staff was present, this was not always the case. These areas contained products that could cause people harm if accessed. We also saw a number of walking aids and wheelchairs were stored in communal areas which made it difficult for people to move freely around the home. For example, we saw a person trying to walk through the dining area, but they struggled due to the limited space available for them.

Regular reviews of accidents and incidents that occurred at the home were carried out. Where trends or themes had been identified, preventative measures were put in place to reduce the risk of reoccurrence.

People had individualised personal emergency evacuation plans in place that enabled staff to ensure, in an emergency, they were able to evacuate people in a safe and timely manner. A business continuity plan, which outlined how people would be protected in an emergency, was also in place and available to staff. Records showed regular servicing of the lift and other equipment such as hoists, walking aids, gas installations and fire safety and prevention equipment were carried out to ensure they were safe to use.

People told us they felt safe living at the home. One person said, "I feel very safe and I like it here, such lovely people." Another person said, "I feel safe, the staff give us reassurance." A relative said, "[My family member] is ever so safe. It just feels right." Another relative said, "I've got peace of mind that [my family member] is ok here."

Staff demonstrated a good awareness of how to protect people from avoidable risk. They knew the different categories of potential abuse and what their responsibilities were if they had concerns about a person's safety. One staff member told us, "I wouldn't hesitate to let the authorities know about poor practice." Another staff member said, "I'd report abuse to the manager, then go to the CQC if I had to."

The registered manager was aware of their responsibilities to report allegations of abuse to the local authority safeguarding team, however, we did note that the CQC were not always notified. This meant we were not always aware of incidents that had occurred at the home. We discussed this with the registered manager and they told us they would amend their systems to ensure the CQC was notified where appropriate.

People told us they were happy with the way their medicines were managed at the home. One person said, "They [staff] always wait with me [to take the medicine]." Another person said, "They often leave my tablets with me and trust me to take them and do my eye drops too. It can vary depending who brings them in though. A relative said, "I've had no concerns with them [staff] doing [my family member's] medications."

We observed a senior member of staff administering medicines. They did this competently and safely

following good practice guidance. The senior member of staff stayed with the person to ensure they had taken their medicine safely. Where pain relief was prescribed to be taken as required, the senior member of staff was seen to ask people if they required this.

We also noted, people's medicine administration records (MAR) were not always accurately recorded. We saw gaps in four of the six of the records that we looked at. We could not determine whether the person had not received their medicines, or, if it was because the member of staff had failed to record they had administered it. We raised this with a senior member of staff, who then started to complete records retrospectively. This retrospective recording could give a false impression of what actually occurred for the person.

People's medicines were stored within locked cabinets and cupboards in a locked room. However, we did note on one occasion the door to the room where the medicines was stored was unlocked, which could increase the risk of people accessing medicines that could cause them harm. Checks of the temperature the room and fridges where people's medicines were regularly completed. These checks are important to ensure the effectiveness of people's medicines is not compromised due to too high or low temperatures. We checked the temperatures during the inspection and found them to be within the recommended safe limit.

Records showed that staff who administered medicines had received the appropriate training. The registered manager told us staff competency was regularly assessed to ensure medicines were administered safely and in line with current best practice guidelines.

Requires Improvement

Is the service effective?

Our findings

People told us staff asked their permission before providing them with care and support. One person said, "They come in all bright and breezy and tell me what's happening before we do anything." Another person said, "They usually ask me first before helping." A third person said, "They always ask me and I feel respected."

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. We checked whether the service was working within the principles of the MCA.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We looked at the documentation for three people and found staff adhered to the terms of the DoLS.

The staff we spoke with had a basic understanding of the MCA and DoLS and how these were used in their role. Where people were unable to make decisions about their care and support needs, attempts had been made to carry out formal mental capacity assessments. However, the records that we viewed did not always follow the correct process as determined in the MCA 2005. Where decisions had been made for people, we saw some examples of best interest documentation having been completed. However these lacked detail and were not always completed for each specific decision.

We discussed this with the registered manager and asked them to review their processes for assessing people's capacity to ensure the documentation used, adhered with the principle of the MCA 2005. They agreed to do so.

We saw examples of do not to attempt resuscitation orders (DNACPR) in place. The registered manager raised concerns with us that appropriate process for completing these assessments had not always been followed by the GP or other external healthcare professional who completed the forms. Upon review, we found a number of these assessments had not been correctly completed. We recommended the registered manager review each document, and where errors were identified, these were discussed with the relevant person who completed them. DNAR forms that have not been correctly completed could result in people's wishes in an emergency not being met.

Parts of the home were not suitable for people living with dementia. There was limited directional signage around the home to help people to orientate themselves. Attempts had been made to provide people with reminiscent memorabilia relevant to their past. A '1950's lounge' was provided. However, this area was cluttered and limited in space. Parts of the main lounge area on the ground floor were heavily cluttered with equipment, ornaments and boxes, with the layout of the tables and chairs making it difficult for people to

walk freely or when using a walking aid. A review of the living space to ensure it was more suitable for people living with dementia was needed.

People told us they were happy with the way staff supported them and they felt the staff were well trained. One person said, "They seem very capable." Another person said, "They've evidently had training done." A relative said, "They act as well trained." Another relative said, "I've no concerns at all with the place. The staff are lovely."

We viewed the provider's training matrix, used to record when staff had completed their training and also to identify when training needed to be renewed. These included moving and handling, fire and food safety. Records showed that most of the training was up to date, but further refresher training was needed for staff in some areas. The registered manager told us they were aware of the gaps in the training and plans were in place to address this.

Staff told us they felt well trained and were supported by the registered manager to carry out their role effectively. One member of staff told us they received regular training, supervision of their role and an annual appraisal. Records showed an effective supervision and appraisal process was in place. One staff member said, "I feel well trained yes, I've done moving and handling, continence care; when it needs refreshing they [the registered manager] let me know."

We noted agency staff were used at the home from time to time. The registered manager told us wherever possible, the same staff were used to ensure consistency of care for people. However, there was no formal agency induction in place for new staff. The registered manager told us they would provide a formal agency induction process to ensure that all agency staff received consistent information when they arrived at the home.

Staff had a good understanding of how to support people who may present behaviours that challenge. They could explain how they supported people and how they ensured the person involved and others were safe. We saw examples of staff doing so throughout the inspection.

The majority of people spoke positively about the food choices provided for them. One person said, "It's very good. It's always cooked well but you can tell them if you want something else. We get sandwiches and cake for tea." Another person said, "It's very good. We get a good choice and I could ask for anything different." However one person said, "A lot of the meals I don't really like and the options aren't well cooked."

A relative told us they were pleased with the support their relative received with their food, as there was a risk to their health as a result of them living with diabetes. They also said, "They're [staff] careful with [my family member's] food and as a result they don't need a daily blood test now." Staff we spoke with showed a good understanding of people's nutritional needs and preferences and people's dietary requirements both through personal choice and as a result of their health.

We found care records showed people's dietary and nutritional needs had been assessed and planned for. This included consideration of people's cultural or religious needs in association with their diet. Where needed, people were weighed regularly if they had been assessed as being at risk of malnutrition. Referrals to external healthcare professionals such as their GP or dietician were made when expert advice was needed to support people.

We observed lunch being served. People generally received their meals in a timely manner. Where people required assistance with eating their meal, staff supported them appropriately. People received meals that

were personalised to their preference and people appeared to enjoy their meals. We did note that a menu was not available in the dining room. We saw people received regular drinks during their meals and also throughout the inspection. People and relatives confirmed drinks were always regularly offered.

People told us, and records viewed confirmed, they had access to external health care professionals when they needed it and they felt their day to day health needs were being met. One person said, "I've had the optician in and the chiropodist comes regularly. The hairdresser does me each week and I do my own nails still." Another person said, "They're very good at getting the doctor out if needs be." A relative said, "They were quick at picking up [my family member's] chest infection and getting an ambulance. [My family member] has the district nurse in regularly to check their ankle and dress it if needs be."

The quality of the care records used to monitor people's day to day health needs was variable, with records not always accurately completed. For example, we asked to see the daily records for one person. The staff member brought them to us; noticed parts had not been completed and then commenced completing them retrospectively in front of us. Failure to complete records at the time care or support was offered, or, a short period of time afterwards, increases the risk of inaccurate recordings of what had occurred for each person.

Requires Improvement

Is the service caring?

Our findings

People and relatives, on the whole, spoke positively about the staff and felt they were caring and treated them or their family member with kindness. One person said, "It varies a lot with personalities but they're genuinely helpful." Another person said, "Some are kind, some not so but I've not been bullied." A third person said, "Some are more smiley than others." A relative said, "The staff are so good here – I get a welcome and a smile. They're jolly good with [my family member] and so caring." Another relative said, "They're all very friendly and welcoming." A third relative said, "They're friendly and chatty with [my family member] and us."

We observed some positive staff interactions with people. We saw a member of staff notice that a person appeared to be cold. They offered them a blanket and the person's demeanour visibly improved. We saw another member of staff encouraging and praising a person when supporting them with their meal. They said, 'One more mouthful, angel? Well done! You've done very well. Thank you very much. Shall we have pudding now?'

However, we also saw some poor interactions. We observed two members of staff assisting a person with moving safely from their wheelchair to a chair in the ground floor lounge. Whilst the person was moved safely, staff did not engage with the person in a meaningful way, other than to remind the person to keep their arms in whilst moving. The staff were laughing and joking about an unrelated matter whilst the person was being hoisted. This was disrespectful and compromised the person's dignity.

We also observed two members of staff discuss a person's condition, in front of others. They then proceeded to discuss their views of the person's relatives, and the way they cared for the person when they were out of the home with them. This did not respect the privacy of the resident involved and the family.

We observed other poor examples. We noted the sun was shining brightly into the main living room area on the ground floor. The sun was shining on the face of one particular person. Staff failed to notice this for a period of 30 minutes, with many staff walking in and out of the room. Eventually, when we returned to the room, we saw staff member was in the process of closing the curtains for this person. This showed a lack of awareness of the things that could affect people who were unable to speak up for themselves.

Finally, we observed a member of staff give a person their eye drops and also applied cream to their knees whilst they were sat at the dinner table with other people. Whilst the person did not complain about this, this approach showed a lack of consideration for this person's dignity.

We noted people's care records and other records relating to the support staff provided them were not always kept securely. We noted daily monitoring charts, used to record when a person had a drink, eaten a meal, been to the toilet, or been repositioned; were stored in areas that could easily be accessed by others. We also saw people's care records on the first floor were stored in an unlocked drawer, which again could be accessed by others. This could place people's right to privacy and their dignity at risk.

People told us staff respected their right to privacy and ensured their dignity was maintained when they entered their bedroom. One person said, "They always knock and come in and always do what they should for privacy." Another person said, "They knock, even if my door's wide open." A third person said, "They knock and peep in even when my door's open. They'll close my curtains for me." We observed staff carrying out this approach throughout the inspection.

People told us staff involved them with day to day decisions about their care and support needs. One person said, "The girls help me choose my clothes. If there's a film on TV, I might stay up late. You're your own boss." Another person said, "I decide on everything, I do it all." A third person said, "They ask me if I'm ready for bed so I can decide. I get to choose my meals and drinks too." We observed staff giving people choices throughout the inspection.

We asked people whether they were involved with planning their longer term care needs. The people we spoke with felt generally informed on the care planning process and told us they attended review meeting to discuss any changes. One person said, "[My relative] does the office side of things." Another person said, "My family come in and come to meetings." Another person said, "We're due for a discussion, they involve me and the family. I feel in touch then." A relative said, "I've been to review meetings and they've shown me [my family member's] care plan." Another relative said, "We get a three monthly review and I'm kept well updated."

Information was available for people about how they could access and receive support from an independent advocate to make major decisions where needed. Advocates support and represent people who do not have family or friends to advocate for them at times when important decisions are being made about their health or social care. Information was also available for people if they wished to gain information about specific health needs such as dementia.

The staff we spoke with had a good understanding of people's needs and could explain what was important to them. People's care records contained detailed information about their life history and we saw staff use that information to form meaningful relationships with them.

People were encouraged to do things independently of staff, wherever possible. We observed a member of staff escort a person to the dining room from the toilet. The person used a frame and walked very slowly. The staff member was calm, chatted to the person with their hand on the person's shoulder for reassurance, and they removed obstacles from their path. The person responded positively to this.

People told us staff encouraged them to be independent where able. One person said, "I'm a free agent and plan what I do." Another person said, "I spend all my time in my room from choice as I don't relate to those people with dementia. I can walk ok. I go down to the office for my paper each day. I go out with family for Sunday lunch each week."

The registered manager told us that people's relatives and friends were able to visit them without any unnecessary restriction. We observed and spoke with relatives visiting people throughout the inspection. A person living at the home said, "It's free visiting and family can bring the dog in too." A relative said, "There are no restrictions at all on coming." Another relative said, "We're free to come and go."

Requires Improvement

Is the service responsive?

Our findings

People gave mixed feedback when we asked them about the activities provided at the home and whether they were able to do the things that were important to them. One person said, "I like joining in the games and church service. I sowed some seeds in the garden in the spring and we had some good flowers from them." Another person said, "I watch TV, I'm a Strictly fan as I used to dance. They will ask if I want to join in anything. We went to a garden centre the other day, it was lovely." However, one person said, "I watch TV or sit. There's not much on really that I'd join in with." Another person said, "If I get bored, I just go to sleep. Someone does games sometimes." A relative said, "[My family member] won't join in the activities as they don't like all the noise. This means they don't get the quality time then." Another relative said, "I've not seen [my family member] join in anything yet, they just sit and watch."

We were told by the registered manager that an activities coordinator worked two days a week, with a further day covered by a member of staff. We were concerned that this left four days a week without any member staff assigned to support people with their activities. The registered manager assured us that staff engaged with people on the other days, but agreed that extra hours to support people with their hobbies and interests would be beneficial.

We viewed people's activity record logs, used to record what activities people had been involved with. Some of these records had been completed in detail and reflected regular involvement in activities; however, other people's records showed gaps, some for many days, with nothing recorded. We therefore could not be assured that people were actively engaged in group activities, or, whether they had been supported to follow their own interests. The registered manager assured us that this did not mean that people were not included with activities, but acknowledged more needed to be done to show what people had chosen to do each day.

We observed the activities coordinator carry out a number of activities throughout the day. In the morning we saw the activity co-ordinator spending occasions talking with people in the lounge and putting a music CD on. They were also preparing residents' homemade Christmas wreaths to go on display. In the afternoon, they asked some people if they would like to have a game of dominoes. The activities coordinator then sat for an hour with three people and assisted a person living with dementia with an activity. People responded positively to her, and there was a happy, jovial atmosphere during the activities. A relative said," [The activities coordinator] does things with them and includes [my family member], like ball games." Another relative said, "The activities lady, does well with them she has done 1-to-1 with [my family member] on occasions."

However, some people told us they felt staff did not spend enough quality time with them. One person said, "They're friendly but busy, so they don't sit with us." Another person said, "They haven't got time for us." A relative said, "They [staff] keep a check on [my family member] but [my family member] does spend a lot of time alone." A relative said, "They'll sit and do [my family member's] nails sometimes but that's about all." We noted five people who throughout the day sat in the downstairs lounge with little meaningful interaction, entertainment or stimulation from staff. We also noted limited engagement with people in the

lounge upstairs. Whilst the staff were pleasant and had the odd quick conversation with people, they were clearly busy and focused on their day to day jobs.

People had a pre-assessment of their needs completed before they moved to the service. This information was used to determine whether people's needs could be met at the home. When it had been agreed, detailed care planning documentation was developed to enable staff to support people safely. The care records for each person were regularly reviewed to ensure they met people's needs.

Each person care records contained details of people's preferences, likes and dislikes and routines. The registered manager told us this information was used to support staff in providing a personalised and responsive service.

The registered manager told us they had responded to people's changing health needs by offering changes to bedrooms where needed. For example, one person's mobility deteriorated and they required more intensive support from staff. They discussed this with the person and their family and it was agreed with them that person would move bedroom. The change in bedrooms enabled staff to support the person more effectively.

People and relatives told us they were satisfied that if they made a complaint that it would be handled appropriately. One person said, "I had a gripe, but that was sorted and that's got better for me." Another person said, "I've never got a bad word to say." A relative said, "We've just raised a few niggly things which have been easily sorted." Another relative said, "I complained recently and it got solved."

People were provided with a complaints policy within their service user guide when they came to the home; however a complaints policy was not easily accessible in communal parts of the home.

We viewed the complaints register and saw the registered manager had ensured that when a complaint had been made this was dealt with quickly and people were responded to in a timely manner, and in line with the provider's complaints policy.

Requires Improvement

Is the service well-led?

Our findings

The registered manager had a series of audits in place which they told us enabled them to ensure that people received a high quality, safe and effective level of care. These audits included regular reviews of people's care records, regular auditing of the processes to provide people with their medicines and reviews of the environment in which people lived.

However, these audits along with other quality assurance processes, had failed to identify many of the issues that we identified during this inspection. The issues such as unlocked storage facilities, poor response times to call bells, lack of reporting of safeguarding incidents to the CQC and the inappropriate storage of people's care records, had not been identified by the registered manager in any of their quality assurance processes. These issues, in addition to the inconsistent approach of staff in ensuring people's records were appropriately completed and up to date, increased the risk of people experiencing avoidable harm.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager acknowledged that more needed to be done to address these issues. They assured us the issues raised during the inspection would be dealt with as a matter of urgency.

People were supported by a registered manager who was committed to their job and regularly worked long hours to support both the staff and the people living at the home. However, it was clear the registered manager required more support to carry out their role effectively. For example, the registered manager was not aware of their all of the responsibilities needed to meet the conditions of their CQC registration. The failure to notify the CQC of notifiable incidents such as allegations of abuse meant the CQC did not hold an accurate account of the incidents that had occurred at the home. We discussed this with the registered manager who told us they would familiarise themselves with the requirements of their registration to ensure all parts of this were met.

Whilst we did not identify any areas of major concern in relation to people's safety at the home, many of the issues identified were as a result of a staffing team not always carrying out their role consistently and effectively. The registered manager told us they were aware that more needed to be done to ensure staff were fully aware of the responsibilities and they, in future, would monitor staff performance more closely.

People told us they felt there was a positive atmosphere at the home. One person said, "It's home from home." Another person said, "It seems a happy place." Staff told us they enjoyed working at the home. One staff member said, "I find the job rewarding." Another staff member said, "I enjoy helping people to help themselves and to be as independent as they can be." Our observations throughout the inspection confirmed what people, relatives and staff had told us. People appeared at ease in each other's company which resulted in a calm atmosphere at the home.

People told us they were able to give their views of ways the home could improve or develop, either via

'resident meetings' or in three month reviews. One person said, "They [staff] often ask us if we're happy or have got any worries." Another person told us they knew of the meetings, but chose not to attend. A relative said, "They've had a few meetings a year. I suppose I've been to four gatherings. I see follow ups done afterwards." Another relative said, "They've not had a meeting for a while, probably as they're poorly attended."

People were supported by a register manager who they felt comfortable raising any concerns with, but was available when they needed them. One person said, "She walks round sometimes. I could talk to her if I had worries." Another person said, "I could talk to any of the staff." A third person said, "The owner is a lovely fella and the manager comes round quite often and is very nice." A relative said, "Mostly they act on what we say or ask." Another relative said, "She listens and is receptive."

Staff told us they would be comfortable raising issues using the processes set out in the whistleblowing policy. They felt that management would take action if any serious concerns were raised with them.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not always ensure that effective quality assurance processes were in place to assess, monitor and improve the quality and safety of the service people received. This increased the risk of people experiencing avoidable harm. People's care records were not always accurately completed and did not always reflect the care provided for each person. Regulation 17 (2) (a) (b) (c)