Flightcare Limited

Broadway Residential

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 12 and 13 April 2017 and was unannounced.

Broadway Residential is a residential care home situated in the middle of a housing estate in a suburb of Liverpool, providing support for up to 17 people. It is an old school building converted into a residential care home. During the inspection, there were 15 people living in the home.

A registered manager was 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. Feedback regarding the management of the service was positive.

We found that consent was not always sought in line with the principles of the Mental Capacity Act 2005 (MCA). The registered manager was aware this process required improvement and had developed new tools for staff to use. We viewed a completed assessment using the new tool and saw that it followed the principles of the MCA. We made a recommendation regarding this process.

Care plans were not in place for all identified needs and risk assessments had not all been updated to accurately reflect current risk to people.

Systems were in place to assess and monitor the quality and safety of the service and it was evident that actions were taken to address identified issues, however these systems did not identify the concerns highlighted during the inspection.

All of the people we spoke with told us they felt safe living in Broadway Residential and their relatives agreed that they were safe. Staff had completed risk assessments to assess and monitor people's health and safety. We found that appropriate support was being provided to people to manage identified risk.

Staff we spoke with were knowledgeable regarding safeguarding procedures and how to raise any concerns they had.

We found that medicines were managed safely within the home. A policy was in place to guide staff and staff had received training and had their competency assessed.

We looked at how the home was staffed and found that there was sufficient staff on duty to meet people's needs in a timely way. We looked at how staff were recruited within the home and found that safe recruitment practices were followed.

Arrangements were in place for checking the environment to ensure it was safe. External contracts were maintained and regular internal checks were also completed to help ensure the building and equipment remained safe. The home was clean and well maintained.

The registered manager had a clear understanding of their responsibility in relation to Deprivation of Liberty Safeguards and appropriate applications had been made.

Staff were supported in their role through regular training, supervision and an annual appraisal and staff told us they felt well supported. A comprehensive induction was in place; however this had not yet been fully completed by new staff.

People told us they enjoyed the food and that there was plenty to eat and drink. The chef and staff were aware of people's dietary needs and preferences to ensure people's nutritional needs were met.

People told us that staff were kind and caring and treated them with respect. We observed people's dignity and privacy being respected by staff in a number of ways, such as staff knocking on people's door before entering their rooms.

People we spoke with told us that they had choice regarding how they spent their day and care plans we viewed showed that choice and independence were promoted within the home. We observed independence being encouraged during the inspection.

We observed relatives visiting throughout both days of the inspection. The registered manager told us there were no restrictions in visiting, encouraging relationships to be maintained. For people who had no family or friends to represent them, contact details for a local advocacy service were available for people to access.

Care plans in place were detailed and reflected people's preferences. Not all people we spoke with could recall being involved in the development or review of their plans of care, however they contained information about what was important to the individual and it was clear that care had been discussed with people.

Feedback regarding activities was positive. People told us they enjoyed the activities available.

Systems were in place to gather feedback from people that were relevant to the service. People had access to a complaints procedure and this was displayed within the home. We found that complaints were investigated and managed appropriately and in line with the provider's policy.

Staff were aware of the home's whistle blowing policy and told us they would not hesitate to raise any issue they had.

There were policies and procedures in place to guide staff in their roles and staff we spoke with were aware of these policies and their responsibilities within them.

The registered manager had notified the Care Quality Commission (CQC) of most events and incidents that had occurred in the home in accordance with our statutory notifications.

Ratings from the last inspection were on display within the home as required.

You can see the action we told the provider to take at the end of the full version 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 always safe.

Risk assessments were not all up to date and plans of care were not evident for all identified health needs.

Staff were knowledgeable regarding safeguarding procedures and how to raise any concerns they had.

People told us they felt safe living in Broadway Residential.

Medicines were managed safely within the home. A policy was in place to guide staff and staff had received training and had their competency assessed.

Staff were recruited following safe recruitment practices. There were sufficient staff on duty to meet people's needs in a timely way.

The home was clean and well maintained.

Is the service effective?

Requires Improvement

The service was not always effective.

Consent was not always sought in line with the principles of the Mental Capacity Act 2005.

Appropriate applications had been made to lawfully deprive people of their liberty.

Staff were supported in their role through regular training, supervision and an annual appraisal and staff told us they felt well supported.

People were supported by the staff and external health care professionals to maintain their health and wellbeing.

People told us they enjoyed the food and that there was plenty to eat and drink.

Is the service caring?

Good

The service was caring.

People told us that staff were kind and caring and treated them with respect and we observed people's dignity being protected during the inspection.

People had choice regarding how they spent their day and we observed independence being encouraged.

People told us their relatives could visit whenever they wanted to.

People's private information was stored securely to ensure confidentiality.

Is the service responsive?

Good

The service was responsive.

Care plans in place were detailed and reflected people's preferences.

People had been involved in the development of their care plans.

Feedback regarding activities was positive.

Systems were in place to gather feedback from people that were relevant to the service.

Complaints were investigated and managed appropriately.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Systems were in place to assess and monitor the quality and safety of the service but were not always effective.

Feedback regarding the management of the service was positive.

Staff were encouraged to share their views regarding the service.

There were policies and procedures in place to guide staff in their roles and staff we spoke with were aware of these policies and their responsibilities within them.

The registered manager had notified the Care Quality Commission (CQC) of most events and incidents that had occurred in the home in accordance with our statutory notifications.

Ratings from the last inspection were on display within the home as required.

Broadway Residential

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 12 and 13 April 2017 and was unannounced. The inspection team included two adult social care inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed the information we held about the service. This included the statutory notifications sent to us by the provider about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We also contacted the commissioners of the service.

We used all of this information to plan how the inspection should be conducted.

During the inspection we spoke with the registered manager, the chef, the activity coordinator, three members of the care staff and six people living in the home. We also spoke with a visiting health professional, two relatives who visited the home and two relatives who we spoke with on the phone during the inspection.

We looked at the care files of three people receiving support from the service, three staff recruitment files, medicine administration charts and other records relevant to the quality monitoring of the service. We also observed the delivery of care at various points during the inspection.

Requires Improvement

Our findings

Care files we viewed showed staff had completed risk assessments to assess and monitor people's health and safety. We saw risk assessments in areas such as falls, nutrition, mobility, pressure relief and specific assessments for the use of aids, such as wheelchairs and walking frames. Although these assessments were reviewed regularly, they were not always updated when changes occurred. For example, one person's care file reflected that they had a fall, although this had not been included within the falls risk assessment. We found however, that appropriate support was being provided to the person to manage this risk. Another person's file included a risk assessment on how to support the person with specific behaviours and this involved a relative that was no longer involved with the person's care. This meant that staff may not have access to accurate information about how to manage risk.

We viewed care plans in areas such as mobility, personal care, diet and fluids, continence and medicines. Care plans were mostly detailed and specific to the individual. We found however, that care plans were not in place for all identified needs. For example, one person's care file indicated that they had a medical condition that could lead to seizures, but there was no plan in place to guide staff how to support the person and what actions they should take if the person was to have a seizure. We also found that not all people who had diabetes had a care plan in place to inform staff what support they required in relation to their diabetes. The registered manager told us they would review these plans and ensure all relevant care plans are put in place.

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

All of the people we spoke with told us they felt safe living in Broadway Residential. Their comments included, "There is always someone to go to day and night", "The main reason is you are not in any danger whatsoever, and the building is safe" and "Staff are here for the safety of [people who live here]." Relatives we spoke with agreed; one relative told us, "Security measures are very good."

We spoke with staff about adult safeguarding and how they would report any concerns if they had any. Staff we spoke with were able to explain different types of abuse, potential signs of abuse and how they would report any concerns. Staff told us they would inform the registered manager of any concerns immediately. A policy was in place to guide staff on actions to take in the event of any safeguarding concerns and details of the local safeguarding team were also available and on display within the home. This enabled referrals to be made to the relevant organisations. We found that appropriate safeguarding referrals had been made.

We looked at the systems in place for managing medicines in the home. This included the storage and handling of medicines as well as a sample of Medication Administration Records (MARs), stock and other records for people living in the home. A medicine policy was available for staff and included guidance on areas such as actions to take in the event of a medicine error, self-administration, controlled drugs and safe administration of medicines. Nationally recognised best practice medicine management guidance was also available for staff to refer to.

Staff told us and records we viewed confirmed, that staff had completed training in relation to safe medicine administration and had their competency assessed to ensure they were sufficiently skilled to manage medicines safely. MAR charts included information regarding people's allergies and were fully completed without any gaps in the recording.

Medicines were stored safely in a locked clinic room and the temperature of the room and medicine fridge were monitored and recorded daily and were within safe ranges. If medicines are not stored at the correct temperature it may affect how they work. We looked to see how controlled medicines were managed. Controlled drugs are prescription medicines that have controls in place under the Misuse of Drugs Act and associated legislation. We found that they were stored appropriately and regular checks were made to help ensure the stock balance remained accurate.

We saw that PRN (as required) protocols were in place for some medicines to help ensure people received their medicines when they needed them. PRN medications are those which are only administered when needed for example for pain relief. We found however, that one person was prescribed a medicine to support them when they became agitated, but there was no guidance as to when to administer this. The MAR chart clearly reflected when it was administered and the reverse of the chart was used by staff to explain why it was administered. It was evident that staff understood when to provide the medicine and on the second day of the inspection, a PRN protocol had been implemented. People we spoke with told us they got their medicines when they needed them.

We looked at how the home was staffed. On the first day of inspection there were three carers, the registered manager, a chef, activity coordinator and domestic on duty to support 15 people living in the home. People living in the home and their relatives all told us that there were enough staff on duty to meet their needs. One person told us, "There are plenty of staff on site." Our observations during the inspection showed that staff were visible, responded quickly when people requested support and offered assistance in a relaxed and unrushed manner. Staff rota's we observed showed that these staffing levels were consistently maintained. We found that there was sufficient staff to meet people's needs in a timely way.

We looked at how staff were recruited within the home. We looked at three staff personnel files and evidence of application forms, appropriate references and Disclosure and Barring Service (DBS) checks were in place. DBS checks consist of a check on people's criminal record and an additional check to see if they have been placed on a list for people who are barred from working with vulnerable adults. This assists employers to make safer decisions about the recruitment of staff. All but one file contained photographic identification of staff members. We discussed this with the registered manager, who told us the person did not have any formal photographic identification such as a passport, so have provided additional forms of identification. We found that safe recruitment practices were followed.

We looked at accident and incident reporting within the home and found that they were reported and recorded appropriately. The registered manager maintained a monthly log of all accidents and incidents within the home and reviewed them each month to look for any potential themes or trends. We saw that relevant actions were taken following accidents, such as referrals to other health professionals and to the

local safeguarding team when necessary.

Arrangements were in place for checking the environment to ensure it was safe. External contracts were in place for areas such as gas, electric, fire safety, legionella and lifting equipment. We viewed the certificates for these checks and found they were in date. Regular internal checks were also completed, such as fire alarm checks, water temperatures, automatic closure devices, call bells, window restrictors and profiling beds. A fire risk assessment of the building was in place and people who lived at the home had a PEEP (personal emergency evacuation plan) to ensure their safe evacuation in the event of a fire.

The home appeared to be clean and well maintained. We asked people what they thought about the cleanliness of the home and responses were all positive. One person told us, "Yes, they clean my room every day." A recent infection control audit had been completed and the home scored 76.5%. The registered manager told us they were working on an action plan to improve this score and we saw that some of the actions had already been completed, such as bins purchased for bedrooms, dispensers in place for gloves, infection control training completed and the dining room had been painted. Bathrooms we viewed contained liquid soap and paper towels in line with infection control guidance and we saw staff wearing personal protective equipment appropriately. For instance, staff wore aprons when serving meals.
□

Requires Improvement

Our findings

We looked to see if the service was working within the legal framework of the 2005 Mental Capacity Act (MCA). 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 make 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).

The registered manager told us that nine DoLS applications had been made and that these were being processed by the Local Authority and no authorisations were in place as yet. The registered manager maintained a log of all applications made, with space to record the dates authorised and when they would require a review. When the registered manager had made an urgent application there was a detailed care plan explaining the reason for the application and how this would impact on the person. The registered manager had a clear understanding of their responsibility in relation to DoLS and effective systems were in place.

Staff told us they asked people for their consent before providing care to people and records showed that when able, people signed to give their consent to the plan of care in place for them. When people were unable to provide consent, mental capacity assessments were completed. We found however, that they were not always completed in line with the principles of the MCA. For example, one person's care file included a capacity assessment that was not decision specific. It included information on what the person could make decisions about, such as meals and choice of clothes and the assessment was not dated. A best interest document was in place, however there was no indication that relevant people had been involved in the decision making and no evidence as to who completed the record. The care file also contained a record of consent to the care plan in place, signed by the person themselves.

We discussed this with the registered manager who told us they had already identified the need to improve records in relation to consent and had developed new documentation to support staff with this. The new documentation had recently been put in place and completed for one person. We viewed these records and saw that the mental capacity assessment was decision specific, followed the principles of the MCA and identified that the person lacked capacity to consent to their care. A best interest document was also in place which stated that the family and social worker had been involved in making decisions in the person's

best interest, however it did not advise who the family or social worker were that had been consulted.

We recommend that the service reviews its policies and updates them accordingly to ensure consent is sought in line with the principles of the Mental Capacity Act 2005.

We looked at staff personnel files to establish how staff were inducted into their job role. We found that staff completed an environmental induction, all mandatory training, as well as a more thorough induction that included the principles of the Care Certificate. The Care Certificate is an identified set of standards that care workers have to achieve and be assessed as competent by a senior member of staff. Records showed that most staff had completed the induction; however one staff member had not fully completed the induction despite being in post for over six months. The registered manager told us the provider's trainer supported staff through this induction, but had not been available to complete inductions as they had been focusing on other training requirements within the company.

Staff we spoke with told us they felt they had received a sufficient induction and felt well supported through supervision and that they could raise any concerns they had with the registered manager at any time. Records showed that staff received supervision every few months and an annual appraisal. Training records showed that staff had completed training in areas such as dementia, safeguarding, fire safety, infection control, equality and diversity, health and safety, moving and handling and MCA and DoLS. All staff we spoke with told us they felt adequately trained to meet people's needs and that they could request additional training if they felt it would benefit them in their role.

People living in Broadway Residential were supported by the staff and external health care professionals to maintain their health and wellbeing. The care files we looked at showed people received advice, care and treatment from relevant health and social care professionals, such as the GP, neurologist, dentist, optician and district nurses. People we spoke with told us they could see a doctor whenever they needed to and that staff would arrange this for them. Relatives agreed that people received appropriate treatment when they needed it. One relative told us, "There has been a marked improvement in [family member's] health since [family member] has been here."

When asked about the food people told us they enjoyed it and that there was plenty to eat and drink. Cooked breakfasts were available to people if they wanted one and we observed people being offered drinks and biscuits throughout the day. We joined people for lunch and found that there was a choice of meal available and a dessert. The chef helped to serve meals and offered people a second helping. One relative told us, "The food is fantastic with lovely puddings."

We spoke with the chef who told us they had a four week rota with a choice of meals, but there were always alternatives available. The chef was aware of people's dietary needs and preferences and these were recorded in the kitchen. This meant that all staff who prepared food had access to this information. Care plans were in place for people who had any specific dietary requirements, such as a person who had diabetes.

We observed the environment of the home and found that the registered manager had taken some steps to assist people living with dementia to maintain their safety and assist with orientation. For instance, the corridors were wide and bright and bedroom doors were coloured and contained pictures that were relevant to the individual. For example, one door contained a picture of a boxing ring and the registered manager told us the person used to be a boxer and enjoyed talking about these days. There were tactile objects displayed along the corridor walls with the aim or providing a topic of conversation and stimulation for people and toilet seats were red which may help people living with dementia to identify the toilet. An

orientation board was also on display in the lounge, informing people of the day and date.

Good

Our findings

People living in Broadway Residential told us that staff were kind and caring and treated them with respect. Feedback from people regarding staff was very positive. Comments included, "It's nice, I like it, staff look after us really well", "They are kind and they listen to me" and "Any problems you can go to [staff] and they'll sort it out." Relatives we spoke with agreed and told us, "[Relative] is always looked after, we are totally satisfied with the care", "The staff are very attentive and can't do enough" and "We wouldn't want [relative] anywhere else, we love it here." Another relative told us that their family member did not like to socialise when they first moved into the home but due to the kind attitude of the staff, their relative now sits in the lounge and joins in with activities. In a recent survey completed within the home, relatives had described staff as, "Very friendly" and "Exceptional."

During the inspection we observed interactions between staff and people living in the home and they were warm, familiar and genuine. We observed people's dignity and privacy being respected by staff in a number of ways, such as staff knocking on people's doors before entering their rooms. Personal care activities were carried out in private and people were given plenty of time to eat their meals; they were not rushed. People seemed relaxed and comfortable in the presence of staff and staff addressed residents in a kind manner.

A staff member we spoke with told us that if someone who lived in the home went into hospital, staff would always go and visit them as they are like family. We also saw that presents and cards were purchased for people's birthdays. This shows that the staff had a caring attitude towards the people they supported.

People we spoke with told us that they had choice regarding how they spent their day. One person told us, "I get myself ready in the morning and [staff] come round with the menu" and another person said, "I get up when I want and come down and have a cup of tea before breakfast." Care plans we viewed showed that choice and independence were promoted within the home. For instance, one person's care plan explained how they liked to choose their own clothes and shave themselves, but that they could require prompting from staff to ensure all of their face was shaved. Another person's care plan advised what parts of their personal care they could manage themselves and what support they required from staff. Care files also indicated whether people had a preference regarding the gender of staff that assisted them with their personal care, although those we viewed did not have a preference.

We observed independence being encouraged during the inspection. For example, one person was at risk of spilling their drink, so they were provided with a cup with a lid so that they could continue to manage their own drinks. The service user guide we viewed also advised that people living in the home were supported to

vote should they choose to.

We found that care files containing people's private information were stored securely in order to maintain people's confidentiality.

There was nobody receiving end of life care at the time of the inspection, however one staff member told us they had recently completed training in this area and systems had been implemented within the home to ensure they could meet people's end of life care needs should this be required in the future.

We observed relatives visiting throughout both days of the inspection. The registered manager told us there were no restrictions in visiting, encouraging relationships to be maintained. People we spoke with told us their family members could visit them in private if they wanted to and relatives agreed. One relative told us, "We were told we could visit any time. That is one of the reasons we chose [the home] as they have nothing to hide."

For people who had no family or friends to represent them, contact details for a local advocacy service were available for people to access. The service user guide provided information regarding a variety of organisations that could support people and the registered manager told us they would assist people to access these services if required.

Good

Our findings

Care plans contained information regarding people's preferences in relation to their care and treatment. For example, one person's personal care plan explained in detail their specific requirements in relation to the clothes they wore and another person's plan advised staff that they liked their food to be cut up into small pieces. Preferences were also evident in areas such as activities, people's preferred name, favourite music artists and television shows. The activity coordinator had also developed life history files for each person. They included detailed and personalised information about the person regarding their family, holidays, jobs and pets. They included photographs and it was clear that the person and their family member had been involved in the creation of these files. This meant that staff could provide support to people based on their preferences.

Care files contained a pre admission assessment which helped to ensure that people's needs were known and could be met effectively from the day they moved into the home.

Not all people we spoke with could recall being involved in the development or review of their plans of care, although some of the care plans we viewed contained signed consent from people themselves or their family members. They also contained a section that included what was important to the individual and from the responses read, it was clear that care had been discussed with people. All people we spoke with were happy with the support that they received. One relative told us, "I phone twice a day and feel very involved in [family member's] care" and another relative said, "Everything is spot on and I feel involved."

Relatives we spoke with told us that staff kept them informed of any changes to their family member's health and wellbeing. Staff we spoke with told us they were informed of any changes within the home, including changes in people's care needs through daily verbal handovers, use of a communication book and by viewing people's care files.

We asked people to tell us about the social aspects of the home and feedback was positive. People told us they enjoyed karaoke, picture bingo and memory games. One person told us, "When the weather is good we go outside in the garden; have a sing song or sometimes play games, it's great." We observed activities taking place during the inspection, including making Easter bonnets. We also observed people playing a game of skittles. People were laughing and encouraging each other and they clearly enjoyed the game.

We spoke with the activities coordinator who worked in the home Monday to Friday each week. They told us they based activities on what people liked and were constantly looking for new ideas and suggestions to

ensure people continued to enjoy the activities. They told us there was a local club that some people liked to attend each week and she supported them to access this. A visiting health professional we spoke with told us that there was always an activity taking place when they visited the home.

People had access to call bells in their rooms to enable them to call for staff support when required and people we spoke with knew they could use their call bells and that staff always responded in a timely way. One person told us, "The only time I've used my buzzer is when someone has wandered into my room, [staff] come straight away."

We looked at processes in place to gather feedback from people and listen to their views. Records showed that meetings were held for people living in the home, although they were not regular. These meetings mostly discussed the meals and it was evident that people were able to share their views regarding this. Records showed that the chef asked people what they enjoyed on the menus and what they would like to see in the future. The records reflected that people's individual needs and preferences were discussed, with one person requesting that the bread be toasted on both sides when making cheese on toast. We spoke with the registered manager regarding the frequency of the meetings and they told us they had an open door policy and people came to them to raise any issues when they had them, so they did not feel more regular meetings were necessary. People we spoke with agreed that they could raise any concerns with the registered manager whenever they needed to.

Relatives we spoke with told us they completed quality assurance questionnaires and we saw that the results from these surveys were on display within the home and most responses were positive. It was clear that the registered manager had addressed any comments that required action to be taken. For example, there was a comment regarding the cleanliness of the front door and we saw that this had been cleaned.

People had access to a complaints procedure and this was displayed within the home and within the service user guide provided to people when they moved into the home. The registered manager maintained a log of all complaints received as well as any actions taken and the outcome from them. People living in the home told us they had not had cause to make a complaint. Relatives told us they knew how to raise any concerns they had. One person told us, "The only thing was the lighting in [family members] room wasn't right. The next visit it was sorted." We found that complaints were investigated and managed appropriately and in line with the provider's policy.

Requires Improvement

Our findings

During the inspection we looked at how the registered manager and provider ensured the quality and safety of the service provided. A quality service manager was employed by the provider and they visited regularly and supported the registered manager with the completion of audits.

We viewed completed audits in areas such as accidents, care plans, medicines, infection control, personal care records and the health and safety of the environment. Audits we viewed included a sheet to record any actions that were required on completion of the audit; however no actions had been identified within these audits. A quarterly home manager's audit had been completed in September 2016 and March 2017. This covered areas such as risk assessments, training, moving and handling, fire safety and health and safety performance and the same areas requiring improvement had been identified on both of these audits. Although some of the actions had now been completed, not all of them had been. For instance, a list of first aid trained staff was not displayed in the home.

We found that actions identified through external audits were in the process of being addressed, such as those identified in a recent infection control audit. The registered manager had an action plan that they were working through and we could see that a number of actions had been met.

Although audits had been completed, we found that they did not identify all of the concerns highlighted during the inspection, such as those regarding consent and accurate assessment of risk. This meant that systems in place to monitor the quality and safety of the service were not always effective.

We recommend that the provider reviews the systems in place and updates its practice accordingly to ensure systems to monitor the quality and safety of the service are effective.

The home had a registered manager in post. We asked people their views of how the home was managed and feedback was positive. Comments included, "[Registered manager] is always out and about and is very approachable" and "We looked round numerous homes, but when we saw this one and spoke to [Registered Manager] we were welcomed with open arms." Staff we spoke with agreed and told us the registered manager was always there to support them and that they could raise any issues with them.

Relatives told us they felt the home was managed well. One relative said, "I think because there are only 17 people living here, you get that bit extra" and another relative said, "The atmosphere is smashing." A third relative told us, "It's great. I'd definitely recommend it. I have been on line and said how good it is. I told a

friend and she brought her mother here." Staff told us they enjoyed working in the home, that there was good team work and everybody was, "Like family."

Staff were aware of the home's whistle blowing policy and told us they would not hesitate to raise any issue they had. Having a whistle blowing policy helps to promote an open culture within the home. Staff told us they were encouraged to share their views regarding the service.

There were policies and procedures in place to guide staff in their roles and staff we spoke with were aware of these policies and their responsibilities within them.

Records showed that feedback was gathered from staff regarding the service through staff meetings, although they did not take place regularly and not all staff we spoke with were aware of them. One staff member told us they felt involved in the running of the service and that they were asked for their views and felt listened to. For example they had been asked for their view as to which bath chair would be most beneficial before one was purchased. Records showed that the registered manager held meetings when there was information to convey to staff, such as the outcome of recent audits or completed surveys.

The registered manager had notified the Care Quality Commission (CQC) of most events and incidents that had occurred in the home in accordance with our statutory notifications. We found however, that not all incidents that had been referred to the local safeguarding team had been sent to CQC. We discussed this with the registered manager who told us they thought only those referrals that were progressed to safeguarding investigations should be sent to CQC, but that they would in future, notify CQC of any safeguarding referrals made, as required.

Ratings from the last inspection were on display within the home as required.

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 12 HSCA RA Regulations 2014 Safe care and treatment Care plans were not in place for all identified health needs to guide staff how to support people with these needs. Risk assessments were not all up to date to enable risk to be monitored and mitigated.