Allambie Enterprises Limited

Allambie House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Allambie House is registered to provide accommodation and personal care for up to 30 older people. This can be people who have a learning disability, physical disability, dementia or sensory impairment. At the time of our visit there were 25 people living in the home.

The inspection visit took place on 4 October 2016 and was unannounced.

During our last inspection on 12 February 2015, we found the provider was not fully meeting the standards required. We identified a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was in relation to safeguarding people from abuse and improper treatment. We rated the service as "Requires Improvement" overall. We asked the provider to make improvements and they sent us an action plan stating they would take the necessary action to comply with the legal requirements. During this inspection we found improvements had been made by the new registered person and new manager.

The new registered person had been in place since June 2016. The manager had been in post for approximately two months at the time of our visit and was not registered with us. However, the provider was aware of the need to ensure any manager of the service was registered and plans were in place to address this. 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.

Staff understood their responsibilities to keep people safe and protect them from harm. They had completed training so they knew the procedures to follow if they had any concerns. People told us they felt safe living at the home and we saw people shared positive interactions with staff when supported.

Where there were risks associated with people's care, risk assessments had been completed with instructions to staff about how to minimise them to keep people safe. However, some risk assessments had not been updated to ensure information about how risks should be managed was clearly identified.

The provider carried out a range of recruitment checks to make sure that staff employed to work at the home were safe and suitable to work with people. New staff were provided with an induction to the home and completed induction training to prepare them for their role. Refresher training was provided to all staff on an ongoing basis to keep their skills and knowledge updated. We found some staff had not completed all of their training, but this was ongoing to ensure they met people's needs safely and effectively.

The provider and manager understood their responsibility to comply with the requirements of the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS). Staff knew to seek people's consent before giving care and to support people's independence where possible. Work was ongoing to update care plans to ensure people's needs and wishes were fully identified and met.

Staff were caring in their approach towards people and aimed to provide care in accordance with people's choices and preferences although sometimes this did not happen. People were provided with a choice of meals and drinks but some people felt meals could be improved, such as, there being more variety. People were supported in a range of social activities within the home and there were some also provided outside of the home when possible.

Each person had a care plan that contained information about their needs and how they needed to be supported. Some of the care plans were in the process of being reviewed and updated to contain more detailed information about people to support staff in delivering person centred care.

Staff told us they felt supported by the provider and manager and were positive about working at the home. There were audit checks undertaken to monitor the quality of the service and to plan improvements to ensure people received the quality of care and services they expected. Some policies and procedures for the home were in need of updating. This included the complaints procedure as people were not aware of this so they knew how to raise concerns if they needed to.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The services was safe.

People told us they felt safe at the home and staff knew what to do if they suspected abuse. Risk assessments identified risks associated with people's care and staff were aware of the actions they needed to take to minimise these risks. Staff had been recruited safely and there were enough staff to meet people's care needs.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff training was in progress to ensure they had all of the skills and knowledge needed to meet people's needs at the home. Staff understood their responsibilities in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. People had choices of food and drinks but there were some identified areas for improvement. Staff referred people to healthcare professionals when needed.

Is the service caring?

Good

The service was caring.

Staff were friendly in their approach and people said staff were kind and respectful towards them. Staff supported people to be as independent as possible and helped them to maintain relationships that were important to them.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People were given opportunities to participate in a range of social activities within the home and work was ongoing to develop these further. Care plans were being reviewed to ensure they contained up-to-date information and provided staff with the information required to support people with person centred care. The service had not recently received any complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

There was a manager in post and staff felt well supported by the manager and provider. Checks and audits of the quality of service were being developed so they were fully effective. People did not always feel involved in decisions relating to the quality of service but were positive in their comments about the home.

Allambie 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.

The inspection visit took place on 4 October 2016 and was unannounced. The inspection was undertaken by one inspector, an inspection manager 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.

We reviewed the information we held about the service including the statutory notifications the manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law.

The provider had not 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. We discussed this with the manager and they informed us this had been due to technical difficulties which they had not been able to resolve. They gave a commitment to ensure that any further requests were addressed in good time.

During our inspection visit we spoke with nine people, two relatives, three care staff, the activity co-ordinator, the manager and the two owners of the home (the provider). We also carried out observations in the communal areas and, with their permission, visited people in their bedrooms to obtain their views of the home.

We reviewed four people's care plans and daily records to see how their support was planned and delivered. We reviewed two staff files to check that staff were recruited safely and trained to provide care and support appropriate to each person's needs. We reviewed management records such as checks the staff and manager made to assure themselves people received a quality service. This included notes of meetings held with staff and people who lived at the home and accident and incident records.

Good

Is the service safe?

Our findings

People felt safe living at Allambie House because staff knew about their needs and how to support them. People told us, "It's alright here, I feel safe, it's a safe place" and "Quite safe here, I'm more than happy with staff." Most people said they never used the call bell, however, those that did told us it was responded to in a timely manner. Some people were cared for in bed and some people chose to stay in their rooms rather than sit in the communal areas. Staff told us they made regular checks of people to manage their care and ensure they were safe.

The manager and staff were aware of their responsibilities to manage any risks to people's health and safety. Staff told us they had received training in protecting people from the risk of abuse and understood their role in ensuring the safety of the people who lived in the home. Staff told us they would report any concerns relating to people's wellbeing to the manager to ensure they were managed appropriately. One staff member told us, "I would report any incident to the manager and I know she will handle the situation." Another told us, "I am confident everything is put in place to keep people safe."

People felt there were enough staff on duty to meet people's needs and keep them safe. They told us, "Yes, seems enough (staff), quite a lot of staff coming and going" and "Never had a problem with staff. They deal with me straight away."

On the day of our visit we saw there were enough staff to support people's needs to keep them safe. The manager worked in a supernumerary capacity (in addition to the care staff team) and the two owners were also in the home to support the manager. We saw staff were not rushed when they were providing care. The manager explained that staffing levels had recently reduced because the number of people in the home had reduced. However, they explained the dependency of people had been taken into consideration to ensure care was not compromised and their needs were met.

Staff confirmed that staffing levels enabled them to provide the support people needed. One staff member told us, "We normally have three carers and one senior. Normally it goes smoothly and there is enough staff on." At night there were two care staff on duty. Night staff told us this was sufficient unless there was an emergency situation. We raised this with the manager who told us they were 'on-call' during the night and always available for staff to contact for support in an emergency situation. We were told there were plans for the on-call system to be reviewed to extend this to other management staff. This would ensure that the responsibility was shared and emergency situations were effectively managed at all times.

Staff told us when they were recruited they went through an induction process and commenced training to prepare them for their role. They said they were not allowed to start work until their recruitment checks had been completed. Records showed that staff were recruited safely, which minimised risks to people's safety and welfare. The provider carried out police checks and obtained appropriate references to ensure staff were safe to work with people who lived in the home.

Prior to people coming to live at the home, the manager undertook assessments of people's care needs.

This ensured any risks associated with their care were identified and their support needs determined to ensure these could be met. For example, some people needed equipment to help them move around safely, others needed support to manage their skin care so they didn't develop sore areas.

Care records contained specific care plans about managing risks. For example, one care plan detailed how many staff were required to support the person during transfers such as from their bed to a chair and what moving and handling equipment staff were to use to do this safely. In another, we noted the person was at risk of poor food and fluid intake and was cared for in bed. The risks associated with this had been assessed and reflected in the person's nutritional care plan. There were instructions for staff to monitor the amount of drinks the person consumed to make sure this was sufficient. When we spoke with staff about this person, they were aware the person only liked specific foods and drinks and understood the need to encourage the person to eat and drink enough to maintain their health. Records confirmed the amount of drinks the person consumed and we noted the person's weight was stable. This demonstrated the risks associated with the person's nutrition were being sufficiently managed. However, we did note that actions within one person's nutritional risk assessment were not followed and that some risk assessments for people were not updated. These issues were discussed with the manager and are detailed further in the 'Effective' and 'Well Led' sections of this report.

Medicines were stored safely and securely and there were checks undertaken to ensure they were kept in accordance with manufacturer's instructions and remained effective. A medicine administration folder contained the medicine records for each person and included their photograph to reduce the chances of medicines being given to the wrong person. Administration records showed people received their medicines as prescribed.

Where people were allergic to specific medicines, this information was recorded on the medicine administration records (MAR's) to reduce the risk of these medicines being prescribed by a health professional. Where people had been prescribed medicines to be given 'as required' (PRN) there was a protocol in place stating how the medicine should be managed. For example, where pain relief tablets had been prescribed there were clear instructions about how these were to be managed to prevent the risk of too many tablets being given which could impact on the person's health. One exception related to a person who had a PRN protocol for a medicine they no longer took as it had been replaced with a different medicine. There was no new PRN protocol for the new medicine. This was discussed with a senior staff member who stated they would address this straight away.

Staff told us that one person had their medicines crushed so they could swallow them. We saw a letter that showed the GP had been approached to check this was safe practice and this process had been agreed. The manager told us this had also been discussed with the pharmacist, but there was no written confirmation from them that this was safe and did not impact on the effectiveness of the medicine. The manager told us this would be followed up.

Only senior staff members who had completed training in the safe management of medicines gave people their medicines in the home to ensure medicines were safely managed.

The provider had taken measures to minimise the impact of unexpected events such as fire risks. People had individual evacuation plans on their files so it was clear to staff and the emergency services how they would need to be supported in the event of an emergency.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in February 2015 we found the provider had not taken the necessary actions to comply with the Mental Capacity Act (MCA). The provider had not applied for the necessary authorisations where people were deprived of their liberty in regards to restrictions placed on their care. This was a breach of Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2014 – 'Safeguarding service users from Abuse and Improper Treatment'. During this inspection we found actions had been taken to make the necessary improvements.

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

The manager understood their responsibility to comply with the requirements of the MCA and the need to ensure care plans ensured staff worked in a person centred way, promoted independence and provided support in the least restrictive way. The manager told us work on care plans was ongoing to ensure people's needs and wishes were fully identified and met.

Staff had received training in the MCA and worked within the principles of the Act. Staff understood the importance of supporting people to make as many of their own decisions as they were able to. One staff member told us, "We have to assume everyone has capacity as a starting point. We don't take away people's independence; we support people to make decisions by getting the right people involved."

People told us that staff usually asked them first before providing care. One person told us, "They ask me first, most of the time." Another told us, "They do knock and ask to do what's needed."

The MCA and Deprivations of Liberty Safeguards (DoLS) require providers to submit applications to a supervisory body for authority to deprive a person of their liberty. Applications had been submitted where potential restrictions on people's liberty had been identified. Where DoLS were in place, applications for their continuation had been submitted to help ensure these were authorised and the requirements of the legislation continued to be met. However, some of the authorisations had run out, the manager told us she had notified the local authority and was awaiting confirmation of continued authorisation.

People said they felt staff had the skills required to meet their needs. They told us, "I'm happy with their knowledge and ability, they talk to me nicely" and "They seem to know what they are doing. They seem to ask each other if they are not sure."

Training was planned to support staff development and to meet people's care and support needs. Staff had

completed training in a number of areas and this was ongoing ensure their skills were kept updated. Training included safeguarding adults and health and safety. A staff member told us, "We have training every other week now; this has improved with the new owners."

We identified that night staff were not trained in administering medicines. This meant if people needed PRN medicines such as pain relief during the night, staff were not able to administer it. We discussed this with the manager who said staff training would be addressed.

New staff followed the provider's induction programme when they started working at the home to prepare them for their role. The manager told us the training was based on the 'Care Certificate' and we saw records confirming training modules in progress or that had been completed. The Care Certificate helps new staff members to develop and demonstrate they have the key skills they need to provide quality care.

Our observations throughout the day showed staff had learned from training they had completed on how to support people safely and appropriately. For example, we saw how staff prompted and guided a person to stand from a chair in a safe way. We also saw staff wore gloves and other protective clothing to help prevent the spread of infection within the home.

Staff told us they attended supervision meetings with the manager to discuss their role and training. This was so any staff development needs could be identified and acted upon. One staff member told us, "I think supervisions are useful, they help me to grow, getting feedback is good and helps me to do my job properly." The manager confirmed staff supervision meetings took place where they discussed staff wellbeing and training needs. Records of supervision meetings with staff were maintained to confirm those that had taken place and any issues discussed.

People were able to have a choice of meals but some people felt the meals could be improved and there could be more variety. One person commented the wanted "more spicy Indian food". One person told us, "The food is nice, I think." Others told us, "The food is okay, reasonable, they gave me a choice today" and "I'm not happy with the food." The provider told us people had been involved in making decisions about the meals provided and some suggestions had been implemented.

The meal at lunch time was a social part of the day when a group of people sat down to eat together. On the day of our inspection there was a choice of two main meals but some people had not eaten their meals. We were told these people would not always eat a main meal but would eat snack foods instead. Although the cook knew about these people and what they liked, we did not see that snack meals of people's choice were provided. The manager said with the change of season, the menus were due to be reviewed and told us they would involve people in decisions about what meals to include on the menu.

Records confirmed where people were at risk of poor nutritional health the advice of health professionals was sought such as a Speech and Language Therapist (SALT) or dietician to help ensure these risks were managed. Staff were aware of people's nutritional needs and knew who needed their food to be cooked so that it was soft and easy to swallow to prevent the risk of them choking. However, we noted one person who should have been provided with a pureed meal at lunchtime did not receive a meal that was fully pureed. The carrots on their plate had not been pureed which could have placed the person at risk of choking. A care staff member thought this did not present a risk to the person. However, when we advised the manager about this, they told us the person had been given the wrong meal by mistake and the carrots should have been pureed. The manager said immediate action would be taken to make information clearer to staff to ensure this did not happen again.

We could not be sure that people were always supported to drink enough to maintain their health. Some people in their rooms told us they had two drinks a day when the staff "came around". We saw that some people had access to drinks in their rooms and others did not. However, in the communal lounge we saw staff offered people drinks and provided them on request. We saw one person ask if they could have a drink with two sugars and a staff member went immediately to get this drink. Two other people also requested drinks which were provided. One person said "Ooh that's nice of her, oh it's lovely." We saw some people had spouted beakers to help them drink independently.

People who needed assistance to eat were supported by staff. At lunchtime we saw a staff member sat down at the same level of the person they were assisting to eat. The staff member took their time so the person was not rushed and ensured each spoonful was given at a pace the person was comfortable with. The staff member also offered encouraging words.

Staff ensured arrangements were made for people to see health professionals when there were changes in their health that required attention. The provider also worked with healthcare professionals to manage people's ongoing health needs. For example, during our visit a district nurse visited to attend to one person's wounds to check this was healing and the treatment provided was effective. People told us if they had health problems staff arranged for them to see the doctor. One person told us, "Last week I didn't feel well, the carer called the doctor, he came the same day." Another person told us, "The carers make all my appointments with the doctor and the rest, it all seems efficient."

Good

Is the service caring?

Our findings

People were positive in their comments about the staff. One person told us, "Their kindness is wonderful, the people here are lovely, it's homely… they come and speak to me at night, nothing is too much trouble."

People were supported to maintain relationships with those who were important to them. Relatives were welcomed into the home and we saw them visiting people during the day. One relative told us, "It's quite friendly here."

Relatives spoke positively about the staff team. They said staff knew people well and understood their needs. One relative told us, "Yes, definitely caring, they are quite chatty with [person]."

Some people had developed positive relationships with staff due to the staff having worked at the home for a number of years. We saw the positive impact this had made for one person who at our previous inspection had limited living space in their room due to the arrangement of their possessions. With the agreement of the person, a staff member who knew them well had helped the person to decide what to keep and what they wanted to put into storage. The improved space in the person's room, and the ability to clean all areas, made it a more pleasant and safe environment for the person.

Staff told us they worked in a caring environment. One staff member told us, "Everyone pulls their weight here, it seems nice and I have worked with all of the people (other staff)." We observed that staff were caring in their interactions with people and provided help and assistance to people in a patient, calm and reassuring way. For example, one person spilt their coffee on a picture on their table and was anxious about this. A staff member assisted in a kind and warm way and reassured the person so they did not become upset.

People told us that staff were respectful and maintained their privacy and dignity. Comments included, "They couldn't be better. More than respectful, no concerns at all" and "They are okay, never disrespectful." Overall, we saw staff treated people with respect when supporting them and understood the importance of maintaining people's privacy and dignity. However, we saw two occasions when doors to people's rooms and toilets were open when they were in a state of undress and staff had not noticed this. Also, we observed during the day that one care staff member did not knock the door before entering a person's bedroom. They did not address the person by name or wait to be invited in by the person. We told the manager about this so that appropriate action could be taken.

Confidentiality was maintained in that information held about people's health, support needs and medical histories was kept secure. The provider told us the CCTV cameras in the home were not operational which meant people's privacy and dignity was not compromised.

Requires Improvement

Is the service responsive?

Our findings

Overall, people felt that their needs were met and staff respected their independence. One person told us, "I go out sometimes with friends. I can go to bed anytime. The carers make all my doctor's appointments and the rest. It all seems efficient." Another person told us, "I can't say I can grumble. If they can't help me, they would find someone who can. I'm quite happy with all of them (staff)."

There were some people at the home that smoked and there were mixed views about them being able to do this when they wanted. One person told us, "I smoke outside …. when I want." Another person told us they would like to be able to access staff quicker when they wanted to smoke as sometimes they had to wait to be supported. We noted they waited for around 40 minutes to be supported to have a cigarette during our visit.

People's needs had been assessed before they lived at Allambie House and details obtained during this assessment process had been transferred into individual care plans for people. Care plans detailed people's care needs and how they needed to be supported. For example, one person had dementia and was unable to speak English which meant they were at risk of becoming socially isolated. We saw the manager had addressed this issue by speaking with the person's family about obtaining a "tablet" loaded with the person's favourite music and photographs to reduce the risk of this happening. Another person who was at risk of urine infections due to having a catheter, had a specific plan about how this should be managed to help reduce the risk of them developing an infection.

Some people told us they had not discussed their care plans with staff on an ongoing basis to ensure staff continued to be aware of their individual choices and preferences. One person told us, "They discussed my care plan with me, I haven't signed it." Others told us, "I don't know about a care plan. We don't talk about my care," and "I haven't got a care plan." Relatives also said they had not participated in any "care reviews" so that they were involved in ongoing decisions about their family member's care.

When we looked at people's care plans, we noted some of the reviews had not been updated. This meant it was not clear the information they contained was accurate so that people were supported appropriately and in accordance with their preferences. We found that one person was not supported in accordance with their preferences. For example, the person ate alone in the lounge at lunchtime and they told us this was not their choice. They explained they had painful legs and were worried they may get knocked if they sat at a table. They told us they did not like to be left to eat alone. We did not see that other options had been explored for this person. We mentioned this to the manager so that they could look into how this person's mealtime experience could be a more positive one. In regards to care plans not being accurate, one care plan we viewed stated the person was at high risk of poor nutrition but the assessments within the same care plan stated they were at medium risk which was conflicting.

Prior to our inspection we had been informed that some people who were cared for in bed were being supported with personal care at an early hour of the morning which was not their preference. During our visit, we spoke with the night staff and were able to confirm this was the case. Staff told us they supported

people at an early hour and this was their usual routine as opposed to this being something that people had requested. This was not considered to be person centred and we advised the manager of this so the necessary action could be taken to ensure people were supported at times of their choice.

We were made aware by the manager that care plans were in the process of being reviewed which included updating them with people's individual choices and preferences. This included plans to compile 'life story' books with the help of people and relatives which detailed information such as names of people's family members, special occasions, their likes and dislikes and information about people's interests.

Staff used summary care plans to help them understand people's daily needs and meet them effectively. These enabled staff who were not familiar with people's needs to access key information about their care quickly. More detailed care plans were available within the manager's office for staff to access as required.

Staff told us communication in the home was good as information about people was handed over at the beginning of each shift so that they knew how to respond to changes in people's health. One staff member told us, "We have a handover it's useful to know how the residents are doing."
Staff had also recently completed training in regards to 'communication' to help them understand the importance of promoting people's individual choices. One staff member, "We always promote people's choices, for example, 'Do you want a wash now or later' and we go back later."

People told us they had access to social activities and work was ongoing to ensure these were person centred and in accordance with people's interests. Comments from people included, "I have been asked, and am going to have a game of scrabble with a carer this afternoon" and "We do quite a lot of games and things, I did some today." A relative told us, "Whenever I come, I see activities going on in the lounge." They told us this included someone who came into the home to play music.

The activity co-ordinator explained how some people liked specific activities such as going shopping and sitting to have a chat. They told us they carried out activities with people "most days" and tried to ensure that the activities provided were what people enjoyed. They told us, "Every day I start with exercise to music and we do quizzes about who is singing (when playing music)". They went on to tell us they had art sessions and had involved some people in cooking sessions. On the day of our visit, people were colouring pictures of their choosing and were talking with one another about enjoying this activity. One person told us, "My main interest is this colouring book, not a lot else." The activity co-ordinator said they also played games such as bowling, bingo and dominoes. Two people liked to go to the local park and we were told they were taken there when the weather was good. However, one person told us, "I would like to go out more."

People in their bedrooms were also involved in social activities. The activity co-ordinator told us they frequently visited people in their rooms to talk to them. They told us, "Some are sleepy, [person] is very confused, I sit next to them and do massage on their hands and chat with them, if they don't answer, I don't worry." A relative confirmed that staff chatted to their relative who was cared for in bed. They told us, "[Person] is not mobile and can't do activities. They do have quite good conversations with [staff member] in their room."

There was a "Compliments, Concerns and Complaints" procedure within the home but people and relatives told us they had not seen it. We found that the procedure did not contain all of the essential information to support people should they wish to raise a concern. This included information of the Local Authority complaints process should people wish to access this. This was discussed with the manager and provider who said this would be addressed. However, people and relatives spoken with told us they had no complaints. They told us, "I've not made a complaint, quite happy. We haven't seen any complaints

information" and "No, I haven't needed to (view complaints procedure). We haven't been told about complaints information. I haven't got anything to complain about. Quite the opposite." The manager told us no complaints had been received recently by the home.

Requires Improvement

Is the service well-led?

Our findings

People and relatives spoke positively of the home. One person told us, "They are very good; they always do what I want." A relative told us, "It's not formal, the staff and residents seem at ease. I've not heard any raised voices by staff. They seem very clear about what they need to do."

The management team consisted of the manager and the two owners (the provider) of the home. The manager had been in post for around two months at the time of our visit. It was clear that some improvements had been made since the new registered person and manager had come into post. The provider was available within the home to support the manager on most days and the manager told us she felt supported by them. The manager told us they regularly walked around the home to check all was well with people and staff. Some people said they knew the manager and others did not. People commented, "The manager has popped in a couple of times to see me. She said, just ask (if they needed help) and I will sort it." Two people told us, "I don't know the manager" and "I'm not sure who the manager is."

Staff were clear about their roles and what was expected of them. Staff felt valued and supported in their role by the management team. They told us they received guidance and advice when they needed it. One staff member told us, "I have seen changes in a good way since the new owners came. They treat staff very nicely and building wise there are a few changes. The new manager is really good. She respects the staff team's needs and wants as well. She is very friendly with the residents … they really like her."

People told us they did not feel involved in decisions made in relation to the quality of service provided. One person told us, "No, I'm not" (involved in decisions). I haven't done a survey or been to a meeting, I haven't had any details." Another told us, "They haven't mentioned residents meetings or surveys." We saw there had been a 'resident' meeting with people but this had taken place in June 2016. This was prior to the new manager being in post. Meeting notes showed people had been asked what was "good" about the home and what was "not so good". People had asked for more variety of activities and food. During our visit, we found there were some people who still felt these areas needed to be improved. The manager told us they had already taken steps to make some improvements. This included having a hot choice of menu at tea time as opposed to just sandwiches.

Quality monitoring processes were not always effective in ensuring risks were managed effectively. For example, one person was given a meal that was not fully pureed in accordance with their risk assessment which meant they were placed at risk of choking. Risk assessments in care files we viewed had not been kept updated to ensure they were accurate and risks were appropriately managed. We noted that one person had experienced a period of time where they had been unsettled and had presented with behaviours that were challenging to staff and others. We did not identify that any action had been taken to monitor this so staff had the information needed to seek professional support if needed.

An 'infection control' audit had been completed in June 2016 which had resulted in some issues for action being identified but records did not confirm these had been done. We discussed this with the manager so that she could check those actions completed and any that remained outstanding.

Systems and audit processes had not identified that some people were being assisted up early which may not be their choice although the manager told us of plans to review people's care so that this was more person centred.

When we asked people if there was anything that could be improved they told us, "There is only one toilet downstairs so I use the commode, I would prefer to use the toilet, I haven't asked them." Another person told us, "The decor could be improved, also the toilet resources." We asked the manager if there was a maintenance plan for the home so that we could identify if any improvements were planned to the environment. Following our visit, we received a maintenance plan that showed planned improvements to the home, but this did not include an increase in the number of toilet facilities. However there were plans for toilet refurbishments in 2017.

Some of the policies and procedures that we viewed were in need of updating to ensure staff worked to safe procedures and had clear guidance about what was expected of them in their roles. For example, the 'Safeguarding' policy and complaints policy. We also noted that the fire risk assessment was in need of updating and the provider's 'Statement of Purpose' was not fully complete. The provider said the 'Statement of Purpose' was being worked on and would be completed within a month.

We saw that staff had regular meetings with the management team where issues relating to the running of the home were discussed. The notes of the last meeting showed staff had been reminded about the importance of following health and safety procedures and maintaining people's privacy and dignity. Records of the meeting did not show staff opinions had been sought or that staff were given opportunities to be involved in decisions that involved them. However, one staff member told us, "The manager and owner discuss things with us…I feel involved" which suggested some staff were involved in decisions.

Health and safety and environmental checks were carried out at the home and those seen such as gas and electrical checks showed no concerns had been identified. However, we did not see a risk assessment had been completed for hot surfaces within the home. This included the heater used in the dining room as well as any hot pipes around the home to ensure they did not present a risk of burns to people. The provider told us that pipes were being replaced with plastic ones to minimise the risk of burns and acknowledged the need to consider risks associated with hot surfaces.