HC-One Limited

# Brooklands Care Home

## Inspection Report

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# Summary of findings

## Overall summary

Brooklands Care Home is a care home for older people in Grimsby with good access to local transport and amenities. At the time of our inspection 47 people were living at the home. During our visit we spoke with eight people who used the service, one relative and eight members of staff.

The home provides care and support to older people and has a separate unit specifically designed to support people with dementia. The home is located in a residential area with parking to the front of the property. Accommodation is on two floors and there are two passenger lifts.

Mental capacity statements and best interest assessments were in place where required, for people who were unable to make decisions for themselves. Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS) is law protecting people who do not have mental capacity, which means they may not be able to make some decisions for themselves.

Each person's care plan had a personal profile which described their personal preferences in relation to religion, food, drink, and daily routines. We saw this had been reviewed monthly. This allowed staff to pick up on changes in people's behaviours which may indicate anxiety, pain or distress.

The care plans we reviewed showed people's individual health care needs were addressed. Each person was registered with a GP and had an allocated member of staff who coordinated their care. Each care plan we viewed had been signed by the person it concerned which confirmed their involvement in their care.

The eight members of staff we spoke with demonstrated a good understanding of people's care and support needs and clearly knew people well.

We looked around the home and identified a number of concerns regarding the condition of some of the bathroom areas which were in poor state of décor and repair. The inspection team felt that we would not wish any of our relatives to use these bathrooms. The loose floor seals and damaged plasterwork meant there was an infection control risk as it was not possible to clean these areas effectively.

We also identified seven bathrooms/toilets that had no lock. Five of the doors without locks had holes through the door where the locks had once been. This meant people could be observed whilst going to the toilet. This meant people's privacy and dignity was compromised.

Following our observations of these bathrooms we have decided to issue a Compliance Action as we consider there has been a breach of Regulation 15 of the Health and Social Care Act (2008). Further information about this Compliance Action can be found at the end of this report.

We saw adequate leadership at all levels. At the time of our visit the service had a registered manager in place. The registered manager was supported by two senior care assistants. Since the home provided nursing care a total of 13 registered nurses were used on the staff rota. The registered manager promoted a positive culture that was person centred, open, honest and inclusive.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Are services safe?**

We looked around the home and identified a number of concerns regarding the condition of some of the bathroom areas. Whilst three bathrooms had recently been refurbished to a high standard, five others were in poor state of décor and repair. All had flaked paint, damaged floors, loose floor seals and damaged plaster work. The inspection team felt that we would not wish any of our relatives to use these bathrooms. In addition the locks to some bathrooms had been removed which meant people's dignity and privacy was affected. The inspection team felt some of the bathrooms were not fit for their purpose.

Following our observations of these bathrooms we have decided to issue a Compliance Action as we consider there has been a breach of Regulation 15 of the Health and Social Care Act (2008). Further information about this Compliance Action can be found at the end of this report.

We saw mental capacity statements and best interest assessments were in place where required, for people who were unable to make decisions for themselves. Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS) is law protecting people who do not have mental capacity, which means they may not be able to make some decisions for themselves.

The members of staff we spoke with were aware of their individual responsibilities to report any incidents or concerns and understood their employer's whistle blowing procedures.

Each person had their needs assessed on admission to the home. Each assessment contained information from the person and their families about their needs, choices and health problems.

We saw each person had a personal profile which described their personal preferences in relation to religion, food, drink, and daily routines. We saw this had been reviewed monthly.

The care plans we reviewed showed people's individual health care needs were addressed. Each person was registered with a GP and had an allocated member of staff who coordinated their care.

We noted the home was generally kept clean and tidy. However, the building was not always free from mal odour. We observed members of staff wearing appropriate personal protective equipment such as disposable gloves and aprons. Members of staff we spoke with demonstrated their knowledge of infection control procedures.

# Summary of findings

People were given their medicines as prescribed and relevant staff had attended training about safe handling of medicines.

**Are services effective?**

People living in the home and their relatives told us they had a care plan which they had been involved in creating. We observed members of staff gave people choices about what they wanted to do, where they wanted to sit, and what they wanted to eat.

Plans were put in place for people who were expected to require end of life care. This ensured they were made as comfortable as possible and assisted with pain. All care plans contained an end of life wishes section which allowed people's needs and choices to be recorded.

Records showed people were supported to have a healthy diet. We observed the lunch time meal and saw that people were given a choice of what to eat and drink. The meals were well presented and we observed staff assisting people to eat. We saw people's weights had been monitored regularly.

**Are services caring?**

We observed members of staff providing care with compassion and respect. We saw staff sat with people talking about things that were important to them. They spent time watching their body language and facial expressions to understand how they were feeling. Members of staff spoke about how they ensured people's dignity was maintained, for example, when using a hoist.

Members of staff had received specific training in dementia care and were able to tell us how they had put this into practice.

**Are services responsive to people's needs?**

People's capacity to make decisions for themselves was considered under the Mental Capacity Act (2005). When people did not have capacity, decisions had been taken in the person's best interest and this had been recorded.

We saw people were encouraged to maintain relationships with friends and relatives. The registered manager told us friends and relatives were free to visit at any time of the day. We spoke with one relative who was complimentary about the care people received in the home.

The home employed an activities coordinator for 22.5 hours a week. However, the coordinator had many other roles in the home which meant people did not have access to meaningful activities on a regular basis. Some people told us this meant that days could be long with little to do.

# Summary of findings

People living in the home were aware of how to make a complaint. Information was provided in the foyer of the home and also in the 'service user guide'.

**Are services well-led?**

We saw varying levels of leadership throughout the home. At the time of our visit the service had a registered manager in place.

The manager showed us minutes from staff meetings that showed learning from mistakes and incidents took place such as group learning from safeguarding incidents.

People were able to express their views and these were listened to. We saw records from the regular residents' and relatives' meetings which showed the manager had acted on people's views.

We looked at the complaints received by the home and saw these had been acknowledged, investigated and responded to appropriately. Learning from issues raised in complaints had taken place at staff meetings.

We saw people's dependency was assessed regularly and the registered manager explained how this was a determining factor for staffing levels during the day and at night. The registered manager told us staff were encouraged and supported to undertake nationally recognised qualifications in care so that staff were able to adequately meet the needs of people.

Audits on the quality of the service provided were carried out monthly by the registered manager and the regional quality assurance manager. We saw that when issues were identified action plans were put in place to address them.

# Summary of findings

## What people who use the service and those that matter to them say

We spoke with eight people who lived at Brooklands Care Home. In addition we spoke with one relative who visited the home at the time of our visit, eight members of staff and one visiting healthcare professional.

When we asked people about whether they felt safe and cared for comments included:

"I feel safe here."

"The staff are very caring"

"I feel that I am well looked after here."

One person commented on the activities within the home, "The days can be long; the activities are not as good as they used to be."

When we asked relatives about the care, they said, "The care is absolutely wonderful; there has been a marked improvement in my mother's care since she moved into Brooklands last year" and "Absolutely wonderful."

We asked a visiting healthcare professional about the levels of care, they commented, "There is good care here, people are looked after well and there is good communication between the staff and other agencies." Further comments included, "The staff knowledge of tissue damage and end of life is pretty good; there are not usually any problems", "People seem to be well hydrated and fed well" and "The staffing levels are OK, I certainly think they have enough most of the time."

# Brooklands Care 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 regulations associated with the Health and Social Care Act 2008. It was also part of the first testing phase of the new inspection process CQC is introducing for adult social care services.

We visited this service on 23 April 2014. We used a number of different methods to help us understand the experiences of people who lived in the home. These included talking with people and observing the care and support being delivered. We also looked at documents and records that related to people's support and care and the management of the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

The inspection team consisted of a lead 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. The expert by experience gathered information from people who used the service by speaking with them and with the care staff. Both the lead inspector and the expert by experience observed the environment and the support provided.

At the time of our inspection 47 people were living at the home. During our visit we spoke with eight people who used the service and one relative. Prior to the inspection we spoke with a representative from the local clinical commissioning group who provided positive feedback about the service. We also contacted a representative from the local Healthwatch.

Upon arrival at the inspection the provider gave us access to their completed 'provider information return'. They told us they had submitted this to the Commission electronically.

# Are services safe?

## Our findings

We looked around the home and identified a number of concerns regarding the condition of some of the bathroom areas. Whilst three bathrooms had recently been refurbished to a high standard, five others were in poor state of décor and repair. All had flaked paint, damaged floors, loose floor seals and damaged plaster work. The inspection team felt that we would not wish any of our relatives to use these bathrooms. The loose floor seals and damaged plasterwork meant there was an infection control risk as it was not possible to clean these areas effectively. Whilst the bathrooms posed a risk to infection control and prevention we the inspection team decided these rooms were not fit for their purpose as people could not be kept safe from harm. We asked about the home's plans for the refurbishment of these rooms and were told there were no plans in place currently to address this issue.

Furthermore, we identified seven bathrooms/toilets that had no lock. When we asked the registered manager about this we were told they had been removed whilst the doors were painted. However, people living at the home told us they had not been present for, "A long time." Five of the doors without locks had holes through the door where the locks had once been. This meant people could be observed whilst going to the toilet. This meant people's privacy and dignity was compromised. The registered manager assured us these holes would be covered without delay.

Following our observations of these bathrooms we have decided to issue a Compliance Action as we consider there has been a breach of Regulation 15 of the Health and Social Care Act (2008) as the inspection team decided these rooms were not fit for their purpose. Further information about this Compliance Action can be found at the end of this report.

The service had a clear policy and procedures in place that provided staff with guidance to follow if an incident of abuse was reported or suspected. In discussion with members of staff, they demonstrated a good understanding of their responsibilities in terms of safeguarding people from abuse and communicated a desire to ensure the safety and wellbeing of people who used the service.

The eight members of staff we spoke with were aware of their individual responsibilities to report any incidents or concerns and understood their employer's whistle blowing procedures. Members of staff said they were confident managers would deal with any such concerns effectively and support them as whistle blowers. Records showed that staff had undergone safeguarding training which equipped them with knowledge of how to identify abuse and report it.We looked at the care records and saw mental capacity statements and best interest assessments were in place where required, for people who were unable to make decisions for themselves. Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS) is law protecting people who do not have mental capacity, which means they may not be able to make some decisions for themselves. The registered manager showed us records of a DoLS application and the best interests meetings that took place in support of the application. We also saw a copy of the notice and records of the best decision meeting when the DoLS authorisation ceased to be in force. However, the registered manager was not aware of the recent Supreme Court ruling relating to DoLS and we suggested they contact the local authority for clarification.

We observed people having access to the secure garden area and various parts of the home without restriction. People who lived on the Brooklyn Wing, a separate unit designed for people with dementia, were protected from people entering the unit without authorisation by a key code entry system. Two people told us members of staff would take them outside into the garden if they asked.

We saw the manager completed a monthly audit of accidents and incidents including any falls people may have had. We reviewed the minutes from staff meetings and notes from individual staff supervisions. We saw any accidents or incidents had been talked through openly with members of staff in order to promote continual improvement and learning. We saw the home had a 'falls team' which met monthly to consider any concerns about people. The meeting addressed whether people were safe in their rooms and in other areas of the home as well as whether they may have had an infection or dietary issues.

Each person had their needs assessed on admission to the home. Each assessment contained information from the person and their families about their needs, choices and health problems. Information was also provided by health

# Are services safe?

and social work professionals such as district nurses, GPs and social workers. This meant the staff at the home had the appropriate information about people's health and wellbeing at the time of admission.

We reviewed six people's care plans. We saw each person had a personal profile which described their personal preferences in relation to religion, food, drink, and daily routines. We saw this had been reviewed monthly. This allowed staff to identify any changes in people's behaviours which may indicate anxiety, pain or distress.

The care plans gave guidance to staff about how to manage behaviours which may challenge the service. Information was provided to staff about how to recognise changes in people's behaviour such as walking without a purpose, collecting and handling objects, and repetitive/ staccato speech. In addition, information was provided on techniques staff should employ to manage any distress or agitation the person may experience such as distraction techniques.

The care plans we reviewed showed people's individual health care needs were addressed. Each person was registered with a GP and had an allocated member of staff who coordinated their care. Each care plan we viewed had been signed by the person it concerned which confirmed their involvement in their care.

Each person had a set of risk assessments which identified hazards people may face and provided guidance to staff to manage any risk of harm. Care plans and risk assessments were reviewed monthly to ensure they were current and relevant to the needs of the person. We saw reviews were meaningful and informative. People at high risk of choking had an eating, drinking and swallowing assessment which informed the care plan. For example, one person with dementia was at risk of choking because they were unable to chew their food and pockets of food would remain in their mouth after eating. The care plan gave clear instructions to staff on how to assist this person to negate this risk.

We observed staff using the hoist with some people to ensure they were transferred safely. Staff spoke to each person throughout the procedure reassuring them and explaining what was happening. We saw staff used the hoist in a calm and patient manner.

Arrangements were in place made to administer medicines safely. We saw people were given their medicines as recommended by the manufacturers especially with regard to food. Appropriate arrangements were in place to make sure that medicines were obtained in a timely way. Relevant staff had attended training about safe handling of medicines.

We saw that medicines were stored safely. People were given their medicines as prescribed. The records about the management of medicines showed they were handled safely. Information was available to guide staff how to administer medicines which were prescribed to be given "when required". Appropriate arrangements were in place for the recording of medicines. It was possible to tell from the records that medicines, including creams, had been given as prescribed and that all medicines in the home could be accounted for.

The registered manager had in place a system to audit medication and actions were taken to resolve any concerns found as a result of the audits.

We noted the home was kept clean and tidy. However, the building was not always free from mal odour. We saw monthly audits were carried out on infection control. One member of staff commented, "It's a big place to clean but I think it's pretty good myself. We are all trained well in infection control."

We observed members of staff wearing appropriate personal protective equipment (PPE) such as disposable gloves and aprons. Members of staff we spoke with demonstrated their knowledge of infection control procedures. We noted each bathroom and hand basin was equipped with disposable hand towels and cleansing gels and soaps. Records showed members of staff had been trained in infection control annually.

# Are services effective?

(for example, treatment is effective)

## Our findings

We saw people's bedrooms were comfortable and personalised. People we spoke with told us they liked their rooms. We saw people had brought in their own furniture to make their room more like it had been in their own home. People had pictures and photographs on the doors to their rooms to help them identify their own rooms and bathrooms and toilets had pictorial signs to help people find their way around the home. This meant people with dementia who might have difficulty finding their own room were able to maintain some independence.

People living in the home and their relatives told us they had a care plan which they had been involved in creating. People told us they were involved in regular review meetings which they found meaningful and helpful. One relative said, "Yes, I was involved at the very beginning by writing XXX's personal history." This meant the staff could get to know them.

The care plans we reviewed showed people's individual health care needs were addressed. Each person was registered with a GP and had an allocated member of staff who coordinated their care. Information about each person's 'keyworker' was displayed in their room together with a photograph. Each care plan we viewed had been signed by the person it concerned or their representative to confirm their involvement in their care.

We reviewed six care plans. We saw each person had a personal profile which described their personal preferences in relation to religion, food, drink, and daily routines. We saw this had been reviewed monthly. Comments from members of staff included, "We try to give people choice as much as we can" and "It's all about giving people independence here, we give people as much choice as possible really."

Two people's care records included a 'do not attempt cardiopulmonary resuscitation' (DNACPR) form in place. We saw records of the discussion between the person, their relatives, and their GP which showed the person had made an informed decision about their treatment. We saw people's care files included advanced care plans which contained information about their wishes about the end of their life. This showed the service had taken steps to respect people's dignity.

We observed members of staff gave people choices about what they wanted to do, where they wanted to sit, and what they wanted to eat. We observed people who were still in bed being asked if they wanted to get up or stay in bed. One person told us that they were supported to be as independent as possible and able to go out in their electric mobility scooter in to the town with the use of a taxi which the staff arranged for them.

We asked the registered manager about end of life care at the home. They told us about the preparations they had made for people who were expected to require end of life care such as ordering anticipatory medication to ensure they were comfortable and assisted with pain.

People living at the home had access to health care professionals when they needed them. Records showed people had access to domiciliary dental care, opticians, chiropodists, occupational therapists, and dieticians. Four people we spoke with were visited by a district nurse each day.

We spoke with a McMillan nurse who was visiting someone who lived at Brooklands. They told us they had been visiting weekly for some time and that they were impressed with the professionalism of the staff. They said staff sought advice appropriately regarding palliative care and commented, "There is good care here, people are looked after well and there is good communication between the staff and other agencies" and "The staff knowledge of tissue damage and end of life is pretty good; there are not usually any problems."

Members of staff were supported through a programme of staff training, supervision and appraisal. These ensured staff were supported to deliver care safely to people. Core training for all staff included the administration of medicines, moving and handling, fire safety, infection control and food hygiene.

Records showed people were supported to have a healthy diet. Risk assessments and other guidance was in place that gave staff information on how to meet people's individual needs. We saw one person's care plans included information from the speech and language therapist on the required texture of their meals to aid swallowing.

We observed the lunch time meal and saw people were given a choice of what to eat and drink. The meals were well presented and we observed staff assisting people to eat. This was done without rushing and at the person's own

# Are services effective?

## (for example, treatment is effective)

pace. We observed people were given plate guards and adapted cutlery if appropriate. We saw people were offered alternative meals if they did not like those provided on the menu.

A handwritten menu was displayed on a whiteboard in the dining room. However, when we spoke with people many said they were unable to read the board or didn't understand it. When we asked the registered manager about this they told us that people were physically shown a choice of meal as it was served so that they could choose at the time of eating. On the day of our inspection this did not happen on the Brooklyn wing. This meant the people with dementia on this wing were being given a choice that they may not be able to understand.

The home had appointed one member of the care staff to act as a 'dignity champion'. The staff member told us they coordinated people's completion of the support plan documentation about their social and personal history. However, we did not find any evidence to support dignity being discussed at staff meetings.

We saw people's weights had been monitored regularly. When people's weight had decreased, appropriate risk assessments had been put in place and people were weighed more frequently. This helped to ensure people maintained healthy weight. We saw when necessary, appropriate referrals had been made to dieticians.

We reviewed how the staff protected people from developing skin damage and how they cared for people who had pressure sores. We found people who had been assessed as being at high risk of developing skin damage, as a result of being nursed in bed for example, had charts in place showing they had been re-positioned and checked every two hours. In cases where people already had skin damage the home had put in place a wound care management book for each person. This included weekly photographs of the wound in order to track improvement. This was accompanied by a weekly pain assessment which the registered manager was required to 'sign off'. Pain assessments provide information to staff on how to identify if people are in pain and are especially important for people living with dementia who may not been able to communicate when they are in pain.

# Are services caring?

## Our findings

We reviewed the home's equality and diversity policy which included information for staff about different faiths and cultures and the potential implications for care and dietary requirements.

We observed members of staff providing care with compassion and respect. We sat in the dining room during the lunchtime meal and saw staff were patient and had kind words to say to people. Whilst using the short observational framework for inspection (SOFI) we saw staff interacting with people on a regular basis. People were not left for more than 10 minutes without some form of interaction from a member of staff, talking about things that were important to them, for example. This meant people were kept stimulated and involved with what was going on around them.

Members of staff had received specific training in dementia care and were able to tell us how they had put this into practice. We saw members of staff took time to understand the needs of people who were not able to communicate as well as others, particularly in the dementia unit. Our SOFI observation confirmed they spent time watching their body language and facial expressions to understand how they were feeling. One member of staff told us, "We know people's facial expressions and we know when they are not happy about something." The members of staff we spoke with were all able to explain in detail about people's needs and behaviours including their facial expressions if they were in pain or needed the toilet.

We reviewed the records of when people took a bath or shower since during our visit some people had told us they were only able to take a bath once a week. One person said, "My bath day is Sunday but I would like another one during the week but there are not enough staff to do this." The records showed most people had a bath or shower only once a week but the registered manager and nurse told us this was not to do with the staffing levels and people could ask to take a bath or shower whenever they wanted.

People's human rights, privacy and dignity were maintained and promoted. We saw staff knocked on people's doors before entering rooms. People appeared well dressed and well looked after and told us they chose what to wear each day.

One person's relative described the care provided as, "Absolutely wonderful."

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

People's capacity to make decisions for themselves was considered under the Mental Capacity Act (2005). The Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS) is law protecting people who do not have mental capacity, which means they may not be able to make some decisions for themselves. When people did not have capacity, decisions had been taken in the person's best interest and this had been recorded.

We saw that independent mental capacity advocates (IMCAs) had been used on occasions to speak up on the person's behalf. Information about IMCAs was made available in the home and the 'service user guide'.

The manager was able to describe the principles behind DoLS and understood their responsibilities to make an application when they considered this to be in the person's best interests.

We reviewed six care plans and saw each had been evaluated monthly. This ensured the home responded to any change in people's needs.

We saw people were encouraged to maintain relationships with friends and relatives. The registered manager told us friends and relatives were free to visit at any time of the day. On the day of our visit we only saw one relative who was complimentary about the care people received in the home.

The home employed an activities coordinator for 22.5 hours per week. The activities coordinator also undertook other tasks in her other roles as the moving and handling train the trainer, dignity champion, minibus driver and NAPA coordinator. NAPA is the National Association for Providers of Activities for Older People of which the home is a member. They told us they trained all the staff in moving and handling, carried out all the risk assessments in the care plans, took people to GP appointments, held relatives meetings as well as checking the safety of the slings and hoists. People told us that as a consequence of these other responsibilities activities were afforded a lower priority than in the past. The inspection team felt that whilst activities were appropriate to the needs of people, they did not happen regularly enough. We did not see any plan of regular activities; this was confirmed by people we talked with whose comments included, "There used to be a lot of activities happening but not so much anymore" and "There are long days sometimes, it would be nice to have something to do." We reviewed the logs of people's activities and saw records of some people participating in only one activity per week whilst others participated in none. One member of staff told us, "People are left with nothing to do for quite a lot of the time, when you consider we have two floors and a separate dementia unit there really isn't that much happening."

On the day of our inspection we observed an activities session in the dementia wing using a memory ball. The activity was well planned and received by the people who participated.

People living in the home were aware of how to make a complaint. Information was provided in the foyer of the home and also in the 'service user guide'. People told us they knew how to make a complaint if they were not happy with the service or care they received. We noted there was an easy read version of the complaints procedure available using pictures and simple text. This meant that people were given information on how to make a complaint in a suitable format if they had difficulty in reading and understanding relatively large amounts of text.

# Are services well-led?

## Our findings

We saw varying levels of leadership throughout the home. At the time of our visit the service had a registered manager in place although they informed us they were due to retire in the summer. The registered manager was supported by two senior care assistants and a registered nurse on each shift. We were not able to confirm there was a cohesive structure for communication between the senior staff, one of whom said, "Sometimes we are not sure which areas of responsibility we have day to day."

The registered manager told us they promoted a positive culture that was person centred, open, honest and inclusive. Members of staff told us they felt empowered to act professionally and make day-to-day decisions. The registered manager told us they valued the input of the staff and worked hard to maintain a good level of morale. From the eight members of staff we spoke with four indicated they felt valued and four said they did not. One staff member said, "Some of the staff don't feel appreciated, this is a busy place and sometime staff are just left to it. The important thing though is that the residents are looked after which they are, some of us just feel we have more to offer." Another member of staff said, "The manager runs a tight ship, walks the floor, and is strict but fair with the staff."

We saw there was a whistle blowing policy in place; members of staff confirmed they were aware of the policy and would feel able to use it without fear of any adverse redress.

The registered manager showed us the annual schedule of audits. We saw recent audits included those for: care plans; moving and handling; falls; medication; tissue viability; and nutrition. We were shown the monthly audit of accidents which listed people's falls. We saw actions plans had been created as a result of this audit which protected people from further harm and analysed any trends. We saw the manager had signed to indicate when actions, such as updating risk assessments, had taken place.

The manager showed us minutes from staff meetings that showed learning from mistakes and incidents took place. One member of staff told us, "We do discuss any mistakes or problems in the staff meetings and in supervisions. If we did make a mistake there would be no problem in owning up to it." We noted staff meetings openly discussed topics such as medication; training; and infection control.

We reviewed the home's emergency plans. We saw the provider had put in place contingency plans for incidents ranging from the failure of the lifts through to actions required as the result of a fire.

People were able to express their views and these were listened to. We saw records from the regular residents' and relatives' meetings which showed the registered manager had acted on people's views. There was also a weekly manager's surgery for people and their relatives to express their views. People told us they felt able to make comments to the registered manager and the provider and knew these would be acted on.

Complaints were handled using a computerised system that was monitored by the provider's head office. We looked at the complaints received and noted one complaint was regarding the state of the toilets. We reviewed how complaints had been handled and saw complaints had been acknowledged, investigated and responded to appropriately.

The manager showed us the results from three recent satisfaction surveys. The first was issued to people who used the service in January 2014. It showed three people out of the nine respondents did not know who their key worker was. The second survey was to relatives in February 2014. It indicated people thought the staff were polite and courteous and the cleanliness of the home was good. All six respondents said they had been invited to attend their relatives' care review and felt able to approach the manager with any concerns. The third survey was issued to professional visitors in March 2014. All seven respondents indicated the home was clean and tidy and that they were provided with all the necessary information about people who lived in the home when they came to see them. From all three surveys action plans had been created and we saw issues had been addressed.

We saw people's dependency was assessed regularly and was a determining factor for staff levels during the day and at night. We were told that staffing levels were adjusted when people's needs changed or when occupancy levels changed. The registered manager told us the home did not

# Are services well-led?

employ any agency staff and shortfalls as a result of sickness or holidays were covered by other members of staff. This meant people were not left without sufficient staff to care for them.

The registered manager told us staff were encouraged and supported to undertake nationally recognised qualifications in care. Records showed 86% members of the staff had gained such a qualification at level two. Of this 25% had achieved level 3 in care. We saw staff had been encouraged to attend specialist training other than courses the provider considered to be mandatory, such as dementia care, mental health awareness, and end of life care.

This section is primarily information for the provider

# Compliance actions

## Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Safety and Suitability of Premises.<br><br>People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance. Regulation 15 (1) (c). |