ADR Care Homes Limited

Keneydon House

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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Keneydon House provides accommodation and personal care for up to 21 people, some of whom live with dementia. The provider is not registered to provide nursing care. The home is located over two floors. Bedrooms are sited on both floors and accessed via stairs or a stair lift. There are external and internal communal areas on the ground floor for people and their visitors to use.

Our last inspection took place on 11 March 2016. As a result of our findings we asked the provider to make improvements to their staff recruitment procedure and to display our ratings on their website and in the service. We received an action plan detailing how and when the required improvements would be made by and these actions have been completed.

This unannounced inspection took place on 16 January 2017. There were 13 people receiving care at that time.

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

The provider had made improvements in the service's recruitment procedures and staff were only employed after the provider had obtained satisfactory pre-employment checks. There were sufficient staff to meet people's assessed needs. Staff were well trained, and well supported by senior staff.

There were systems in place to ensure people's safety was managed effectively. However, these were not always updated to reflect people's current needs.

People were not always supported to manage their prescribed medicines effectively. Medicines were stored safely. Staff were aware of the procedures for reporting concerns and of how to reduce the risk of harm.

People's health, care and nutritional needs were effectively met. People were provided with a balanced diet and staff were aware of people's dietary needs.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and report on what we find. We found that there were formal systems in place to assess people's capacity for decision making and applications had been made to the authorising agencies for people who needed these safeguards.

People received care from staff who did not always have a good understanding of the MCA and DoLS. This meant that people's decisions may not always be respected.

People received care and support from staff who were kind, patient and caring towards the people who lived at the service. People felt they were treated with respect. However, people's dignity was not always upheld. People and their relatives had opportunities to comment on the service provided and people were involved in every day decisions about their care.

Staff understood and met people's care needs. However, people's care plans were not always up to date and reflective of people's current needs. This meant that up to date information may not always have been available for staff to refer to.

There was a varied programme of entertainment for people to join in with. However, not all people were supported to spend their time in meaningful ways.

People knew who the registered manager and senior staff were, and were happy to speak with them regarding any issues. People had access to information on how to make a complaint and were confident their concerns would be acted on.

Records were not always up to date or accurate and could not be relied on to demonstrate the care that staff provided.

The service did not have an effective quality assurance system. Systems were not in place to ensure sufficient food was delivered to the service regularly and supplies were supplemented by staff.

We found three breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People were not always supported to manage their prescribed medicines safely.

There were systems in place to ensure people's safety was managed effectively. However, these were not always updated to reflect people's changing needs.

Staff were only employed after satisfactory pre-employment checks had been obtained. There were sufficient staff to ensure people's needs were met safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not have a good understanding of the MCA and DoLS. This meant that people's decisions may not always be respected and their liberty may have been restricted.

People received care from staff who were trained to meet the needs of the people they provided care to.

People's health and nutritional needs were effectively met.

Is the service caring?

Requires Improvement

The service was not always caring.

People's dignity was not always upheld.

Staff treated people with respect.

People received care and support from staff who were kind, caring and patient.

People and their relatives were involved in every day decisions about their care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Staff understood and met people's care needs.

Event type activities were offered but there were limited opportunities for people to carry out activities of daily living or maintain their interests.

People had access to information on how to make a complaint and were confident their concerns would be acted on.

Is the service well-led?

Requires Improvement

The service was not always well led.

People could not rely on the service's records because they were not always up to date or accurate.

The service did not have an effective quality assurance system.

People were enabled to make suggestions to improve the quality of their care.

Keneydon House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This unannounced inspection took place on 16 January 2017. It was carried out by one inspector 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 the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used this information to assist with planning the inspection.

We also looked at all the information we held about the service including notifications. A notification is information about events that the registered persons are required, by law, to tell us about.

We asked for feedback from the commissioners of people's care and Healthwatch Cambridge.

We reviewed previous inspection reports and the Provider Information Record (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.

During our inspection we spoke with three people able their experience of living at Keneydon House. We also spoke with three relatives, a volunteer and seven staff. Staff members included the registered manager, a team leader, two senior care assistants, two care workers and a cook. Throughout the inspection we observed how the staff interacted with people who lived in the service.

We looked at seven people's care records, staff recruitment and training records and other records relating to the management of the service. These included audits and rotas.

Following our inspection we received feedback from two health care professionals who visited the service. During our inspection the registered manager agreed to send us further information including meeting minutes and survey results. However, we did not receive this information.

Requires Improvement

Is the service safe?

Our findings

At our inspections on 11 March 2016 we found that people were not protected because robust recruitment procedures were not in place. This was a beach of the Regulation 19 (1) (a) and (3) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection in March 2016 the registered manager told us they had made improvements to the recruitment procedure by 3 May 2016.

During this inspection on 16 January 2017 we found that sufficient improvements had been made to ensure the provider had robust staff recruitment processes in place. Staff members told us that the required checks were carried out before they started working with people. These included written references, proof of recent photographic identity as well as their employment history and a criminal records check. One staff member told us and records showed that, these checks were "all back" before they started working at the service. This showed that systems were in place that ensured that staff were only employed once the provider was satisfied they were suitable to work with people who used the service.

Although protocols were in place for medicines prescribed to be given 'when required' these did not always contain sufficient information for staff to follow. One person was prescribed two different medicines for a health condition. One of these medicines had been prescribed to be given as a variable dose when the person required it. Although the protocols and person's care plan explained the reason the medicines were prescribed, they did not instruct staff on how to decide when to give each medicine, or the dose. In addition, the protocol provided no instruction as to when staff should seek medical advice if the medicine did not work. A staff member explained to us the circumstances when they understood the medicine should be administered to the person. However, records showed this medicine had been given every day regardless of whether these circumstances were satisfied or not. The staff member and registered manager were not able to explain this. We found there were clear protocols in place to guide staff for a second person who was prescribed pain relief to be given 'when required'.

People's medicines administration records [MARs] showed that people had mostly taken their medicines as prescribed. However, of the two people's medicines records we looked at we found that one of one person's medicines had not been signed to show it had been taken the night before our inspection. The registered manager investigated this during the inspection and ascertained the medicine had been administered, but the record had not been signed to show this.

In addition we found further discrepancies in records relating to medicines. For example, one person was prescribed a medicine to be administered 'when required'. Staff had recorded when they had administered the medicine on both the person's MAR and on a form that contained the protocols for administration. However, the dates and times of administration did not correspond on these documents on three occasions in a seven day period. This meant that neither document contained a complete record of when the person was administered this medicine. Further, the form with the protocols showed that a staff member had administered the medicine to the person. However, the staff member told us this was not their signature

and they had not made the record. We also noted that during our inspection the quantity of medicine held at the service for this person, did not correspond with the service's record. The registered manager and staff were not able to explain these discrepancies.

The registered manager told us they audited the medicines monthly. The record of the last audit showed that no concerns or discrepancies were identified. This meant that the audits were not effective because they had not identified the issues we found during our inspection. This meant we could not be confident people were receiving their medicines as prescribed.

This was a breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were satisfied with the way staff supported them to take their prescribed medicines and said they received these in a timely manner. One person said, "They bring me my tablets. I take antibiotics with water. I get them on time you know." Another person told us, "[Staff] bring [my medicines] to me…They make sure I take it."

Staff told us that their competency for administering medicines was checked regularly. We found that medicines were stored securely and at the correct temperatures.

Systems were in place to identify and reduce the risks to people who used the service. In the PIR the registered manager told us, 'All of our premises are risk assessed, each resident has their own specific risk assessments in their care plans that cover any risks they are likely to face, these are reviewed on a monthly basis, or if any changes occur.' We found that care plans contained a range of assessments that evaluated risks. These included risks such as poor skin condition, nutrition, and falls. These assessments gave staff clear direction as to what action to take to minimise the risks. However, these had not always been reviewed as people's needs or circumstances changed. For example, one person's mobility needs had been assessed and guidance was in place for staff on how to assist the person to move safely around the service. However, staff told us the person's mobility needs had recently changed. The registered manager confirmed it was no longer safe for the person to use the stair lift to access the upstairs of the service. However, the person's risk assessment and care plan had not been updated to reflect this change.

People receiving the service said they felt safe. They told us this was due to staff checking on them regularly, assisting them with personal care and helping them to move around the service. One person told us, "I feel quite safe here." A relative said, "I always felt [my family member] was safe here [at Keneydon House]." Information was available for people and their relatives that explained how they could report any concerns they had.

Staff told us they had received training to safeguard people from harm or poor care. They showed they had understood and had knowledge of how to recognise, report and escalate any concerns to protect people from harm. One member of staff said that if they suspected a person had been subjected to abuse they would go "straight to a senior [staff member]." Staff told us they felt confident that the registered manager would act on any concerns they raised.

The registered manager and staff considered ways of planning for emergencies. Each person had a recently reviewed individual evacuation plan within their care plans. This helped to ensure that appropriate support would be given in the event of an emergency, such as a fire at the service.

Prior to our inspection we received a concern that there were insufficient staff at the service. The registered

manager investigated this and found there were sufficient staff to provide safe care.

During our inspection people told us there were enough staff to meet their needs. One person told us, "I have to call the staff to help me. I ring the bell and they come quickly." Another person said, "If I ring the bell [staff] will respond quickly even if it is to say they are busy at the moment and will come back."

Staff also told us there were sufficient staff to ensure people were safe. They, and the registered manager, told us that staff absence was covered by existing staff working extra shifts. Staff also told us that the registered manager assisted with care if a staff member was absent at short notice and their shift could not be covered. We observed that care was provided in a timely way and an unhurried manner.

Requires Improvement

Is the service effective?

Our findings

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

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

The registered manager told us they had submitted DoLS applications to the local authority for six of the thirteen people living at the service. The registered manager and staff told us they had received training in the MCA and DoLS. However, staff were not clear whether any DoL authorisations had been applied for. The front door required a code to be tapped into a key pad in order to open it from the inside. The registered manager confirmed people did not have access to this code. Five of the six staff members said they would not open the front door if any of the people living at the service wanted to go out unescorted. They said this was because they did not believe the people would be safe alone. Staff told us this included those people who, staff and the registered manager confirmed, had not been assessed as lacking the mental capacity to make this decision. One staff member told us, "I wouldn't be happy for any of the [people using the service] to go out [alone]. I would phone a relative to see if they could take them." We received similar responses from three other staff. Senior staff were not clear whether people's relatives had legal authorisation to make decisions on behalf of their family members and this information was not always on people's records.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they liked the staff and felt they were competent. One person said, "[Staff] know what they are doing." Another person told us, "The staff are a good bunch, [I've got] no worries."

In the PIR the registered manager told us, 'When new recruits start working in the home they start the care certificate straight away... there is also a detailed in depth induction programme to follow for the first 4 weeks that covers our policies and procedures.' The Care Certificate was developed jointly by Skills for Care, Health Education England and Skills for Health. It applies across health and social care and sets a minimum standard that should be covered as part of induction training of new care workers.

Staff told us that when they first started working at the service they received induction training and 'shadowed' a more experienced staff member until they felt confident and were deemed competent to provide care. Records showed, and one staff member told us, their training included moving and handling, medicines management, end of life care and fire safety. Another member of staff told us the training they received, "made a massive difference" to what they looked for when providing care to people. They said, "I

know to watch for pressure sores ... [people's] skin can break down so easily."

Staff were supported to achieve qualifications appropriate for their roles. Staff had completed level two or three NVQ's in health and social care and one staff member told us they were working towards level four. All are nationally recognised qualifications.

Staff members told us they felt well supported by senior staff. Staff received annual appraisal and formal supervision bi-monthly. They said that this was useful and provided them with an opportunity to discuss their support, development and training needs. They said they valued the formal supervision meetings with senior staff. One member of staff told us, "It's nice, you can sit on your own and have a good old chat and get feedback. Our seniors are brilliant."

People told us they liked the food provided and that there was always enough to eat and drink. One person said, "I am happy with what's on offer." Another person told us, "There is always enough food. I can't fault the quantity." People told us there were no menus available, but that they were offered a choice for meals and where these could be taken. We saw a whiteboard in the dining room advertised what was for breakfast and tea, but did not state what was available for lunch.

Most people chose to eat their main meal in the dining room. Meals were plated up in the kitchen and carried to the dining room. No covers were over the food and one person told us that the food was "not always as hot as it should be." We noted that one person's hot meal was placed on the table approximately five minutes before they sat down to eat. There was little conversation between people or with staff over the lunchtime period to help this become a social occasion.

People were supported to have enough to eat and drink. In addition to meals, we saw that a range of drinks and snacks were available. Staff offered people assistance with their meals and drinks, where they needed this. Efforts were made to maximise each person's independence. For example, one person used a guard on their plate to prevent food falling off the edges. We saw that staff gave each person the time they needed and did not try to rush them.

People's individual dietary needs were catered for. The catering staff had information about these so that they were able to prepare food to meet people's individual dietary needs. This included, for example, soft and pureed foods for people who had difficulty with swallowing. People who were at risk of unintentional weigh loss were offered fortified foods such as milk shakes. One relative told us, "[My family member] is much better here [at Keneydon House]. When I found out [my family member] had a [health condition] I told the [staff] and they adjusted [my family member's] diet and now [my family member] is eating really well. [My family member] used to be in hospital every two or three weeks and now [my family member] hasn't been for six weeks." Another relative said, "[My family member] put on weight when [my family member] was here. [My family member] was eating really well, much different to when [my family member] was at home."

People had access to health care professionals and were supported to manage and maintain their health. People were supported to access healthcare appointments. One relative told us, "[Staff] took [my family member] to the dentist in a wheelchair." People were seen by appropriate health care professionals including GPs, speech and language therapist [SALT], chiropodist and a community psychiatric nurse.

Staff showed us they used a pain assessment tool prior to administering pain relief. They told us this helped to assess the level of the person's pain and provide additional information to healthcare workers.

A healthcare professional told us that staff always followed their guidance and provided them with "good

information" about people. They told us, "[The staff] have managed very, very well."

Requires Improvement

Is the service caring?

Our findings

People's dignity was not always upheld. For example, on our arrival a person was wearing a clothes protector while eating their breakfast. Staff did not assist the person to remove this protector when the person finished their breakfast and they continued to wear it until after they had eaten their lunch. Further, although the person spilled food, one staff member ignored the food and it was not cleaned up until the end of the meal.

People felt staff treated them with respect. They told us that staff knocked on doors before entering rooms. People said staff asked them if they needed help before assisting them. One person told us, "They ask me if I need help… I can live how I want." A relative said, "[My family member] does what [they] want so [staff] give [my family member] a choice. They told [my family member] to treat it as if [they] are living in a hotel." Staff explained what they were going to do before providing care. We saw staff assisting people to move using equipment. They took time to explain what they were going to do and what they wanted the person to do.

People and their relatives were complimentary about the staff. One person said, "They treat me alright." Another person told us, "They are all kind." A volunteer who regularly visited the service said, "[The staff] treat them as individual people. They're very understanding carers. The biggest part is the staff all know them. They're like a family. There's a closeness there." A relative said, "[Staff] treat [people] like their own granny and granddad." Written compliments also praised staff and referred to staff members 'caring attitude' and 'warmth towards the [people using the service].'

Staff told us they would be happy with their family member's being cared for at this service. One staff member said this was because all the staff "really care." Another staff member told us, "I think this is a really lovely home. [The staff are] a bit older and understand. There's a lot more to care than a cup of tea and a chat. I'd live here if I was older."

Our observations showed the staff were caring and patient towards people. We saw staff talking to people in a calm and kind way. Staff knelt down to speak to people at eye level and used eye contact. They checked on how people were feeling at various times of the day. They used people's names and terms of endearment "darling", "love", "sweetheart" which people responded to positively. People's care was planned to help reduce their anxiety. One person's care plan advised staff that the person sometimes shouted when they because anxious. The care plan advised staff to 'take me to a quiet room…to have a chat. This helps me to calm down and not get agitated.' Staff confirmed they were aware of this.

Staff helped people to be comfortable. We saw one staff member stroking a person's arms when they became upset and anxious. Another staff member spotted that one person had slumped in their chair and assisted the person to a more comfortable position.

Care plans reminded staff to maintain people's privacy and dignity. For example, a care plan instructed staff to make sure the curtains were closed when providing personal care 'to promote dignity and respect.' Another person's care plan explained how a person reacted when they were embarrassed so staff

understood and could minimise this.

Relatives were involved in decisions about people's care. They confirmed they were welcomed into the service and were kept informed on changes to their family member's well-being. People said they had been asked questions about their care needs when they first moved to the service, but they could not recall being consulted about their care plans after this. However, people felt staff did listen to their views about how their care was provided. Relatives told us staff had discussed their family member's care with them, including after their family member was discharged from hospital.

Requires Improvement

Is the service responsive?

Our findings

People and relatives felt that staff understood and responded to people's needs. One person told us, "If you ask [the staff] to do anything, they will." During our inspection we saw staff respond to people's requests for assistance. For example, one person wanted to go to bed at 3pm because they were not feeling very well. A care worker assisted the person into their nightwear and into bed and took them a cup of tea.

People's care plans were person centred, focused on what people could do, and provided staff with a good level of information about how to meet people's needs in a way they preferred. Care plans covered such needs as continence, mobility and fluid intake. These were regularly reviewed. The registered manager showed us that improvements had been made to care plans where people's behaviour may challenge others. These now provided staff with information on possible triggers, the form the behaviours took, and how to support the person to reduce their anxiety. However we noted that one person's care plan had not been updated to reflect that their mobility needs had changed and they could no longer access their first floor bedroom.

Another person's care plan relating to fluid intake and output stated, 'I would like staff to record my output in the mornings when they get me up and evidence this in the input and output chart.' And 'I have an input and output chart in place to monitor my catheter.' Staff generally recorded this information. However, some entries were made without amounts. In addition, there was no evidence that these charts were being monitored and senior staff confirmed there was no information to guide staff as to the person's daily target intake and output. A senior staff member advised us people's target intake was "about a 1000mls a day". They acknowledged this may vary but could not provide us with any additional information in relation to individual people's target fluid intake.

Two staff told us they did not read people's care plans. However, all staff told us that that senior staff communicated people's changing needs to them verbally so they were kept up to date with people's current care needs. People, their relatives and a healthcare professional said they felt staff understood and met people's care needs. One person told us, "I feel well looked after."

People told us they could have a bath or shower if they wanted. One person told us, "I can have a bath or a shower if I want but they help me get a good wash." Another person said, "[Staff] give me a good wash each morning. I could have a shower in the afternoon when they are not so busy." However, staff confirmed there was no system for ensuring that people were offered a bath on a regular basis. A staff member told us, "It is left to [each person] to request a bath or shower but I sometimes suggest that they may want one."

From discussion and observations we found the registered manager and staff had a good knowledge and understanding of the care needs and preferences of the people receiving this service. Staff encouraged people to do as much for themselves as possible. A healthcare professional told us, that staff had helped the person to improve their mobility and encouraged them to participate in activities. They said this had helped improve the person's general well-being.

Event type activities were offered but staff did not always encourage people to carry out activities of daily living or maintain their interests. The provider employed an activities co-ordinator who had put together a programme of events for people to join in with. Visiting entertainers were advertised and people told us they enjoyed these. One person told us, "The music is quite good. I have a sing-along to Elvis. I also get a paper or a magazine." A relative said, "They got the local primary school to come in and sing wartime songs and then they asked [people] about the war. They came back at Christmas and sang carols. I think that was great." A healthcare professional told us, "Instead of just observing [people, there is] a lot of entertainment which the ladies and gentlemen love."

People had mixed views as to whether they were sufficiently supported to maintain their interests. One person told us, "I sit in my chair and watch TV or read…I don't get bored but I get lonely, you are still cut off…I've only been out twice since I've been here." Another person said, "I do get bored."

During the morning of our inspection there were railway magazines on the table in the middle of the lounge. No one showed any interest in these. One staff member spoke with people about their hair and asked if they would like their nails done. Everyone declined and staff made no further effort to engage anyone in any other activity. Background music played for most of the morning in this lounge. During the afternoon there was an entertainer which people enjoyed. Some people sang and or clapped along.

People and their relatives said that staff listened to them and that they knew who to speak to if they had any concerns. Everyone we spoke with was confident the registered manager or another member of staff would listen to them and address any issues they raised. One person commented, "I would say if I wasn't happy with anything." Another person said, "I am not worried about anything."

Information about how people could complain, make suggestions or raise concerns was available throughout the service. Staff had a good working understanding of how to refer complaints to senior managers for them to address.

The registered manager told us that they had not received any complaints since our last inspection.

Requires Improvement

Is the service well-led?

Our findings

At our inspection on 11 March 2016 we found that the provider had failed to display the ratings on their company website and in the service. This was a beach of the Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection in March 2016 the registered manager told us improvements in this area were made by 3 May 2016.

Prior to our inspection on 16 January 2017, we found the provider displayed our rating on their website. During this inspection we found that sufficient improvements had been made and our ratings were also displayed in the service.

Records were not always up to date or accurate. For example, a person's care plan and risk assessment had not been updated to reflect the change in the person's needs. Records relating to medicines were not always accurate. Fluid intake charts did not always show the amounts consumed, did not show target intake and showed no evidence of having been totalled and monitored. Care records did not accurately reflect when people had been assisted to bath or shower. This meant that records could not be relied on to demonstrate the care given.

We looked at the registered manager's audits for falls and medicines management for December 2016. The falls audit recorded that there had been no falls. However, we found one person had fallen and suffered a minor injury to their arm. The medicines audit had not identified any of the discrepancies and shortfalls in the information recorded in people's medicines records that we found. This meant that the audits were not effective because they had not identified the issues we found during our inspection.

This was a breach of Regulation 17 (1) (2) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People received sufficient food. However, we found systems were not in place to ensure sufficient food was delivered to the service regularly. One person told us, "I like salad but they run out of it at the end of the week." Food had been delivered to the service during our inspection. However, no salad had been delivered. Another person said, "They sometimes run out of things at the end of the week. Nothing big, but say marmalade and things like that."

Staff members told us the weekly food delivery often did not contain sufficient food for the people living at the service. They said that they often brought additional food into the service to ensure that people had enough to eat. They told us they were not always reimbursed for this. One staff member told us, "I feel we don't get enough shopping for [people using the service] ... It's the things that [people] enjoy: biscuits, marmalade, cakes, that we don't get… When I'm old I'll want biscuits and cake. It happens almost every [delivery]... Today there's no biscuits [delivered]. Very often there's no washing powder... People don't go without because [staff] bring things in. If it wasn't for us, [people] would suffer." Other staff also made similar

comments. The weekly food order was delivered on the day of our inspection. We saw that there was insufficient desserts, cakes and biscuits to last until the next order arrived the following week.

The registered manager showed us the menus and the record of food that had been served at the service over the past week. Only one main meal had been prepared in line with the menu. The registered manager and staff told us this was because the food on the menu had not been delivered.

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

The registered manager was aware of her responsibilities. They were aware that they were legally obliged to notify the CQC of incidents that occurred while a service was being provided. Our records showed that the registered manager and provider had submitted to the CQC notification about specific events in a timely manner.

We received positive comments about the management of the service from people and visitors. They knew who the registered manager and senior staff were, and were happy to speak with them regarding any issues. One person told us, "I see the [registered] manager walking through [the service]." A relative said, "I would speak to [the registered manager]. She is approachable, they all are. I would recommend it here." Another relative told us, "[The registered manager] has tried to improve things like the entertainment [and] decoration. She got the leak in the roof repaired. I would recommend [the service]." A healthcare professional told us they felt the service has been well managed "since the [current registered manager] has been there."

Staff had mixed views about the effectiveness and support they received from the registered manager. Staff received regular formal supervision and attended staff meetings. One staff member told us, "[The registered manager is] quite approachable. I wouldn't be afraid to talk to her." Another staff member said, "It's so nice here. [The registered manager] is lovely." A third staff member told us, "[The registered manager] does her best but [the director] doesn't support her." However, another staff member said, "I wish [the registered manager] would listen to her staff a bit more. What's missing here is being able to talk to the [registered] manager." They felt meetings and supervision were not effective because people did not feel able to put their views to the registered manager. They told us staff attended meetings "but no-one speaks up. It's generally about the [people] who are not well."

In the PIR the registered manager told us, 'We … have audits that cover all areas of the home from infection control to fire safety these are carried out on a monthly basis.' The provider's representative carried out a monthly audit of the service. This included comments from people using the service and staff, checks of records and the premises. Where improvements were identified, an action plan was in place. For example, the recruitment of a staff member by 10 December 2016 and that staff appraisals would commence in January 2017. Each audit contained a review of the previous months actions.

The registered provider and registered manager sought feedback from people formally, through meetings and reviews, and more informally through day to day conversations. One person told us, "I go to residents meetings." Another person said, "I see the [registered] manager most weeks… She has never not done anything I asked her to do." A relative commented that meetings were always held during the day so some relatives were not able to attend them. The registered manager told us they carried out regular surveys to ascertain people's views. The results of these were not made available to us.

The registered manager told us that she was keen to continually improve the service. The provider's audit showed maintenance was planned and we saw that a bathroom had recently been turned into a wet room which staff told us was well used. Staff told us there was opportunities to develop and said they had completed training in end of life care. A healthcare professional told us "The [registered] manager…always attends the professionals meetings that are held and are quick to uptake information provided. This showed that there were plans for developing the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's rights to make decisions were not always respected and staff did not have a good understanding of the MCA and DoLS. Regulation 11.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not always supported to manage their prescribed medicines safely. Regulation 12 (2) (g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Records were not always up to date or accurate. Regulation 17 (1) (2) (d).