Oak House Homecare Ltd

Olivemede

Inspection report

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Date of inspection visit:
22 March 2016

Date of publication:
12 April 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Olivemede is registered to provide accommodation for up to 33 people who require nursing and personal care. At the time of our inspection there were 31 people living at the service. The service is located in the village of Yaxley and is close to local shops, amenities and facilities. Accommodation is provided on two floors. Bedrooms are single rooms with en suite facilities and access to the accommodation is provided by stairs and a lift to the first floor.

This unannounced inspection took place on 22 March 2016.

The service had a registered manager. However, they had left their post in March 2016. 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.

Staff were knowledgeable about identifying and reporting any incident of harm should this ever occur. People were cared for and looked after by enough staff to support them with their individual needs. However, not all incidents had been reported to the CQC, and without delay. This limited the response external organisations could take if this was then required.

Satisfactory pre-employment checks were completed on staff before they were employed and allowed to work with people who used the service.

People were supported to take their medicines as prescribed and medicines were safely managed. Not all staff had been regularly assessed as being competent to safely administer people's prescribed medicines. This put people at risk of not being safely administered their medicines. An effective induction process was in place to support new staff.

Risk assessments to help safely support people with risks to their health were in place and these were kept under review according to each person's needs. However, we found that there were no risk assessments in place to safely support people in the event of an emergency. This put people at risk especially people those who relied on two members of staff to help them to mobilise.

The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The registered manager and staff were knowledgeable about when an assessment of people's mental capacity was required. Appropriate applications had been made by the provider to lawfully deprive of their liberty. People using the service who currently met the criteria to be lawfully deprived of their liberty had applications and authorisations in place. However, not all staff had an understanding of the MCA and how a DoLS would be determined. This meant that there was a risk that people could be provided with care that was not in line with the relevant codes of practice.

People had sufficient quantities of their preferred food and drink choices including various snacks during the day. This included the provision and choice of appropriate diets for those people at an increased risk of malnutrition, dehydration or weight loss. However, there were missed opportunities for people to be as independent as they could have been at mealtimes.

People were supported to access a range of health care services and their individual health needs were met.

People were cared for and supported with their needs by kind and attentive staff. People were given as much opportunity as possible to be involved in planning and reviewing their care needs. People's privacy and dignity was respected by staff.

Information was made available for people or their relatives who may have needed access to independent advocacy. People were given various opportunities to help identify and make key changes or suggestions about any aspects of their care. However, the investigation into their concerns, suggestions and complaints did not ensure that the potential for recurrence was minimised.

A range of audit and quality assurance procedures were in place. However, these were not always as effective as they should have been. The provider had not always notified the CQC about important events that, by law, they are required to do so.

We found a number of breaches of the Health and Social Care Act 2008 (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.

Risk assessments were not always in place and up to date to support people in the event of an emergency.

People were administered their medicines as prescribed. However, not all staff had been regularly assessed to safely administer people's medicines.

Recruitment procedures and the number of suitable staff in post helped ensure that people's needs were met promptly.

Is the service effective?

Requires Improvement

The service was not always effective.

People were asked to consent to the care they were provided with. Staff respected people's decisions. However, not all staff had a complete understanding of the Mental Capacity Act 2005.

People were not always supported with their independence as much as they could have been.

Staff sought and followed the advice from health care professionals who visited the service. People's health, nutritional and hydration needs were met.

Is the service caring?

Good

The service was caring.

People were provided with care that was compassionate and considerate of their privacy and dignity.

Staff understood people's preferences and people were supported with their right to a family life and stay in touch with those people who were important to them.

People were encouraged, and involved in making decisions

about aspects of their care that was important to them.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Opportunities were missed to support people with their care in an individualised way.

People's complaints, suggestions or concerns were not always fully investigated or resolved in a way that would limit the potential for recurrence.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider had not always notified the Care Quality Commission about important events that by law, they are required to do so.

Quality assurance and audit processes and procedures were not as effective as they should have been.

People and staff were involved in the development of the service. There were arrangements in place to listen to what people, relatives and staff had to say.

Olivemede

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 22 March 2016 and was undertaken 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. Their area of expertise was in caring for older people and those living with dementia.

Before the inspection we looked at the number and type of notifications submitted to the Care Quality Commission. A notification is information about important events which the provider is required to tell us about by law. We contacted commissioners of this service prior to our inspection for their views.

During the inspection we spoke with nine people living at the service, a relative, a visiting hair dresser, the provider, a deputy manager, one senior member of care staff, three care staff, the chef and a domestic member of staff. We also spoke with two external auditors, a visiting GP and community nurse.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed people's care to assist us in understanding the quality of care people received.

We looked at four people's care records and the minutes of residents' and staff meetings. We also looked at medicine administration records and records in relation to the management of the service such as health and safety checks. We also looked at staff duty rosters, staff recruitment, supervision and appraisal process records, training records, compliments and quality assurance records.

Requires Improvement

Our findings

We found that there were no risk assessments in place to support people in the event of an emergency situation such as a fire. Other information such as the staff responsible for coordinating actions in the event of an emergency was also out of date. Equipment that was required in the event of a loss of lighting, such as a torch, was also missing from the fire marshal's equipment box. In addition, not all staff knew where the fire fighting appliances were located and in one situation staff had to reach over a food heating trolley to access this equipment. The provider did not ensure that people who use services were as safe as they could have been. This put people at risk of harm in the event of an emergency.

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

We found that risk assessments for people, including those for people at an increased risk of falls, choking or malnutrition, were in place and were up to date. This included the provision and use of mobility equipment as well as ensuring that staff had the rights skills for safe moving and handling.

Staff told us, and we saw from records viewed, that staff were trained and knowledgeable in recognising and reporting any incidents of harm to people. This included what types of harm people may experience and the action they would take in reporting any such events to the appropriate authorities including the local safeguarding authority. Information about how to recognise and report incidents of harm was publicly available throughout the service for people, staff and visitors. Accidents and incidents were investigated and action was taken to prevent recurrence. For example, referrals were made to the most appropriate health care professional when required. This included the person's GP, the falls team or speech and language therapist.

People told us that they received their medicines on time and they were aware of the medicines that they were prescribed. We observed staff administering medicines. Staff explained what the medicines were for and then made sure the person took all their medicines correctly. One person told us that they had to have tablets daily. They explained, "They [staff] always stand by you when they're [administering the medicines] to make sure you've taken them." We also saw them asking one person if they would like some pain relief, which the person then agreed to. Staff had been trained in the safe administration of medicines. However, competency assessments had not been completed to ensure staff were following the correct procedures when administering medicines. This had been for a period exceeding 12 months. This put people at risk of not being safely administered their prescribed medicines. We observed that medicines administration and

management was in line with current guidance such as secure storage and accurate recording. Guidance and protocols were in place for people's pain relief as well as for those medicines which had to be administered at a particular time and in a particular way.

One person said, "If I ever need help after a fall I am sure the staff would help me." We saw that staff were patient to those people who required more time with their support, such as those people who required the assistance of two staff or whose mobility was impaired.

The building was light and airy with wide corridors and handrails at each side for people to use to move around the building. The presence of staff around the service helped ensure that people were kept as safe as practicable. People we spoke with all told us that they felt safe. Several people were seen to use walking frames to move around. One person told us, "Oh, I couldn't do without that." Another person said, "I absolutely do feel safe. If I need the loo, two staff help me every time." A relative spoke highly of the service, saying, "[Family member] has not had any falls but they had [health condition] which was starting to affect their mobility." Another person told us, "Oh yes, I have had some falls but they were all my own fault." We saw that where actions were required, such as referrals to the falls team or the introduction of equipment such as sensor mats, that these had been acted upon. Another person told us, "I use a walking frame and they [staff] make sure I use it all the time." We saw that this was the case. We saw that people had call bells in their rooms that were easily accessible. One person told us that they had used the call bell at night time and the care staff came quickly. Another person also confirmed that staff responded very quickly. To alert staff to people's movement sensory mats were in place which were in people's best interests. This was to help ensure the risk of people experiencing a fall was minimised.

Equipment and services were maintained to help ensure that the service and environment was a safe place to live and work in. This included checks for lifting equipment, infection prevention and food hygiene. We also observed that staff supported people to use equipment in a safe manner.

The provider had recently introduced a dependency assessment tool to help determine the number of staff to safely meet people's needs. This was reviewed regularly and always after a person had been to hospital where their care needs may have changed. We saw that this and the number of staff on duty meant that people's care needs were met. Staff, people living in the service and our observations confirmed that there were sufficient numbers of staff on duty to ensure that people remained safe. We noted that people's request for assistance were responded to promptly. One member of staff said, "We cover for each other if this is required and the [deputy] manager pitches in as well if needed." The deputy manager advised us that if there was a shortage of staff due to unplanned absences, the provider's regular bank staff would be used. They also explained that in response to a change in people's care needs, additional staff were being recruited.

Staff told us, and we found, that there was a robust recruitment and induction process in place. We found that checks included requests for two written employment references, evidence of any criminal convictions and recent photographic identity. Where staff had been deemed unsuitable to continue working at the service, we found that the provider had followed clear staff disciplinary procedures. Care staff confirmed to us the records that they had been required to provide, as well as their job interview before they were offered employment. This demonstrated that staff who were employed had undergone rigorous checks that deemed them suitable to work with the people who used the service.

Our findings

Staff confirmed that they were supported with training, and that new staff received a formal induction and that shadowing opportunities with experienced staff were arranged. We found that staff completed their induction prior to working on their own. Training which the provider had deemed mandatory included subjects such as safeguarding people from harm, moving and handling and infection control. One staff member said, "I started here recently and I am being supported. I get all the support I need from the deputy manager, senior care staff or more experienced staff. Everyone [staff] has been very supportive."

The provider and deputy manager were keen to develop all staff's knowledge. This was with any additional training needs such as gaining health care related qualifications. Staff had enrolled in the Care Certificate (This is a nationally recognised qualification in care and includes additional requirements for staff competency in basic life support and dementia care) of which two had completed this qualification. All staff confirmed that they felt that the support mechanisms available in the service helped them to provide people's care needs safely and effectively. One senior staff told us that they had to complete regular training and updates. They said, "We [staff] have all had to complete some units of the Care Certificate around dementia care and the Mental Capacity Act [MCA] but we could do with more detail around the MCA and DoLS." The provider confirmed that he would act on this request.

People were provided with a choice of food, snacks and drinks and people who required special diets were provided with these. For example, for those people with food allergies, reduced sugar, or soft food diets, were offered a choice of appropriate food and drinks. However, we saw that staff did not always respect people's abilities to be as independent as possible when eating and drinking. People did not benefit from being able to physically see and smell their choice of food. Although people were asked for their choice of food and snacks during the day, the opportunity for them to be more independent was limited by the way meals were served pre plated and people were not offered a physical choice of snacks.

One person confirmed, and we found, that the staff came round during the morning to ask people to choose what they wanted for lunch. The person could not remember what they had chosen but said, "The food is like a first class hotel." They went on to tell us that, "Breakfast is at 9am but you can choose to have it earlier if you want." A relative told us, "It would be much better for [family member] if the staff used pictures of the meal or even a sample so they could chose at the time of the meal." Some people were offered aprons but it was disappointing, to us, that others did not have serviettes. This became more obvious at the end of the meal when several people were asking for tissues to wipe their hands and faces. There was a box of tissues

available on a trolley but individual serviettes would have made it easier for people without having to ask. The provider told us that they were looking at ways to improve people's mealtime experience with a more dining room focused service.

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 are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and DoLS.

Staff had received training on the MCA and DoLS. We found that some staff lacked an embedded understanding of these subjects. This put people at risk of receiving care that was not in line with the appropriate MCA and DoLS codes of practice. Some people using the service had been assessed as lacking mental capacity to make decisions with or without support from staff. Appropriate applications had been made to, and in one case authorised by, the local authority to lawfully deprive people of their liberty. Where appropriate these had been acknowledged. Records viewed showed us when and whether people could or couldn't make specific decisions. For example, the type of soap they preferred and the clothes they liked to wear.

People could be assured that the staff would take action to reduce and prevent any risks that were associated with their health. One person told us, "The doctor comes if required – they [staff] won't let anything slide." This was referring to the way the staff identified any medical or health issues. A relative told us that a doctor came in to the service every week to monitor people's health. A visiting GP confirmed to us that they had never provided health care advice which had not been adhered to. A visiting District Nurse said, "One thing Olivemede [staff] are good at is letting us know about any changes to people's health." One person said, "If I need the doctor they [staff] call one for me or I can see when they visit for one of their visits." Where people were at an increased risk of ill health due to their nutritional needs, appropriate monitoring and health care arrangements were in place. This included regular health care professional visits such as a dietician or District Nurse to monitor people's health. This was to help ensure that people's diet met their health needs.

Good

Our findings

All people, relatives and health care professionals spoke highly about the care provided at the service. A visiting district nurse said, "Of all the homes I visit the care at Olivemede is second to none. The staff are just so very caring in everything they do." Our observations confirmed that this was the case. One example we saw was staff supporting people with their pain relief. The staff sought assurance that the person was well and also that their foot wear was correctly fitted. Once the person sat down with staff support, the staff made sure the person was not in pain. On another occasion we saw staff bend down so that they could easily be seen by the person. The staff asked, "Is there anything I can get you and how are you today?" Relatives were complimentary about the compassionate care provided by the staff team. Other ways included domestic staff, who had appropriate training, assisting with the meal preparation and serving as well as helping people with their mobility around the home if this was required.

We saw two members of staff assisting a person to manoeuvre from their wheelchair to a walking frame and then onto a lounge chair. The staff spoke to the person in a gentle reassuring way and encouraged them to move their feet to sit down. They then checked if the person wanted a blanket to keep their legs warm. One person said, "They're [staff] nice to us here." And, another explained, "It's a marvellous place, the staff are good and the food is very good."

However, we also saw that despite the numbers of staff that there was limited interaction between them and the people living at the service. Staff seemed to be concentrating on managing tasks rather than spending any meaningful time with people. This put people at risk of isolation. One person told us, "I do get bored sometimes." For some periods of the day we saw that people were left in a lounge for over an hour with no staff interaction.

People were supported with their faiths and religious beliefs if they preferred this. One person told us that they liked to have Holy Communion as it was something they had done all their lives. They told us, "Just because I am in a [care] home it doesn't mean I have to change my ways."

People confirmed to us that they got on really well with staff and felt that staff always aimed to meet their expectations about the aspects of their lives that were important. For example, by being cared for in a dignified manner. We observed the interactions between people and staff and these showed us how well staff knew the people they cared for. A relative explained to us, "I'd give them [the provider] 10 out of 10 [for care] and tell others to bring their family members here." They told us that this was because the care provided by the provider and its staff was undertaken in consideration of the things that were important to

people. For example, during the morning one person noticed a spillage mark on their jumper. Care staff asked them if they would like to go and change into a clean jumper but the person decided not to.

Staff promoted people's dignity. For example, by only discussing personal issues with the person they referred to. Other ways included covering people up as much as possible when providing personal care. One person told us that there was one male carer. Initially they were very dubious about having a man to care for her but now "he's one of the nicest [staff]." Our observations showed us how staff spoke with people by their preferred name, in a calm and clear manner. During the morning we saw that when the deputy manager came into the lounge she engaged in polite conversation with each person, asked how they were and made sure that people had the things they needed such as a walking frame, magazine or clothing for when they were going out. We observed how care staff spoke discreetly with people when asking if they needed any assistance with their personal care needs. On another occasion we saw that staff made sure that a person's clothing was as comfortable as possible before helping them. This demonstrated to us that all staff considered people's privacy.

People, relatives and the deputy manager confirmed that there was never any restriction on visiting or being visited. One person said, "I have regular visits from my family. Not as often as I would like but they come when they can." Care records were held securely and staff ensured that these were only reviewed or read in private. We saw that pet dogs visited and there were resident pet birds. These visits and pets were the subject of much jovial discussion and people showed their happiness, excitement and pleasure at these.

We found that people had relatives, friends and representatives who acted as an advocate for them if required. Advocacy is for people who cannot always speak up for themselves and provides a voice for them. The deputy manager and staff were aware of organisations which offered this service if required. This showed us that people's wishes, needs and preferences were respected if people were not able to speak up for themselves.

Requires Improvement

Our findings

Although there were planned activities, such as Bingo and religious services, these were limited to small groups of people. This was because other social stimulation was not provided to people on a one to basis.

There were also several memorabilia type pictures on the corridor walls and some books in the communal rooms but there was very little else to enable care staff to engage more easily with people with limited verbal communication. Where music was being played there was little done by staff to promote people's enjoyment. A relative explained that she thought there were not enough activities being provided for people who had limited independence and this was evidenced when we saw people sitting around for over an hour with little to occupy them.

There were missed opportunities for people to be more involved in their care. For example, where people could be more independent with their care such as helping folding napkins or pouring their own gravy. Whilst some effort had been made to provide information for people such as a daily noticeboard with the day, season and weather this wasn't up to date on both floors. This could cause confusion to people especially those living with dementia.

Prior to living at the service people's initial care needs were assessed and reviewed. This was to help ensure that the service and its staff were able to safely meet people's care needs. This was also used as an opportunity to identify key information about people such as their pastimes and life histories. This information then formed the foundations of people's care and care plans and was used by staff to help them understand what really made a difference to people. As well as information about people's preferences, memorabilia, and clear signage around the service helped people, and those living with dementia, orientate themselves better.

People were given various opportunities to contribute to the assessment and planning of their care needs. This included both formal and informal reviews of care such as conversations about people's day to day lives as well as information from relatives and family members. One person told us that they remembered being involved with their care plan. And, a relative said they had been involved and that a review had been instigated by staff when a change in their family member's condition was highlighted.

People's individualised care was focused on what they wanted. For example, one person asked to go out and staff responded by getting the person's coat and helping them get dressed appropriately before then going out. Another person told us how they had enjoyed going out, "Yesterday, they [care staff] took me out

in my wheelchair for a walk to the wood." Another person explained that they preferred to sit in their room; "I'm not a mixer, I prefer my own company." We also saw that some people enjoyed reading many novels in their room which they preferred.

A hairdresser visited the service twice a week and we saw that several women were making use of this facility. The hairdresser told us that they saw several people every week whilst others choose to come less regularly. Just before lunch we saw staff in the downstairs lounge encouraging a small group of people to think of male and female's names beginning with various letters of the alphabet.

People were actively encouraged to make choices, give their views and raise concerns or make suggestions before they had the potential to become a complaint. One person told us that they weren't keen on the meals provided at teatime and the staff had asked what the person preferred. The person explained that they'd really like treacle on bread which the staff provided and added, "They [staff] are really good at dealing with [different] food requests." We saw that staff responded to people's individual requests such as those for a smaller portion for lunch or food that was appropriate to their dietary needs. However, the actions taken for these events were not investigated or checked to make sure that they were effective or if the changes were a long term or temporary solution. This limited the provider's ability to identify what worked well and where long term improvements may have been required.

People and their relatives knew how to make a complaint and staff knew how to respond. Information in the form of a service user booklet was provided on how to raise a concern or complaint. This included how to escalate complaints to the Local Government Ombudsman for social care and the CQC. One person told us, "I don't have anything to complain about. It's [care] all fine." A relative told us they had raised concerns with the management and was happy that they were always dealt with to their satisfaction. Other complaints had been investigated and responded to. This had been in line with the provider's policies and to the satisfaction of the complainant.

Requires Improvement

Our findings

We found from records we held that notifications involving people's safety had not always been reported to the Care Quality Commission as required by law. This put people at risk of harm and limited the information available to external organisations in responding to the safety of people using the service. This put people at risk of not being as safely supported as they could have been.

This was a breach of Regulation 18 of the care Quality Commission (Registration) regulations 2009.

We found that in response to recent concerns about people's care at the service, the provider had brought in external assistance. In addition, the deputy manager from another of the provider's services was providing assistance. This was to help identify, implement and act upon improvements that were required and to support the provider and staff with these. Examples we saw of this were the introduction of effective audits for the service's general environment and medicines administration. Actions such as accurate recording of people's intervention charts and the secure storage and recording of medicines had been acted upon. However, we found that the provider's audits had not always been effective in identifying the omissions we identified. These included the appropriate procedures to support each person in the event of an emergency.

All staff and visiting health care professional commented favourable at how the improvements in the service were beginning to take effect. One of the external auditors told us. "It has been good to see the changes take effect and how much better the whole service is becoming." The deputy manager and provider confirmed to us that this was the case. Other examples of improvements made included access to up to date guidance for medicines administration as well as having an action plan with clear lines of responsibilities and dates for these actions to be completed. A relative also told us that they felt that the change in management was much better – "The atmosphere is much better here now."

On the notice boards we saw that the minutes of a previous residents meeting held on 7 March 2016 were displayed and another was planned for 30 May 2016. We saw that these meetings gave people the opportunity to comment on the quality of various aspects of their care. One relative told us that they were not aware of any relatives meetings but they would welcome them if they were arranged. The provider explained that relatives' meetings were planned to be held and the way these were to be provided was also being considered. For example, as a group, individually or by e-mail or telephone if relatives preferred this. The relative also expressed a wish for a notice board to be put up with photographs and names of all the staff in the building which they thought would be very useful as there had recently been a lot of staff

changes.

People's, staff's and health care professionals' views about developing and improving the service were sought in the most appropriate way. This included residents' meetings, staff spending time with community nurses, GPs and people and their relatives as well as the planned implementation of a relatives' quality assurance survey. One comment from a visiting GP was that, "They [staff and management] are always very well prepared in providing people's health care records." A district nurse said, "The new care plans are so much better now and people's health care information and risks are much easier to find."

All staff commented that they had noticed and been aware of changes which were for the better of the service and its staff. One care staff said, "It is much better now as we know who is responsible for what and when things have to be completed by." The staff also explained how well the domestic and catering team all worked together. The provider kept themselves aware of the day to day staff culture. This was by regular contact with the deputy manager and senior care staff. Staff confirmed that the support they now received enabled them to do their job effectively. For example, with support from external organisations, mentoring and support to staff about improvements to the service such as changes in the way incidents were managed.

Staff meetings and handover meetings were held regularly and staff were able to make suggestions and improvements to the way care and support was provided. These included, but were not limited to the way people's food and fluid intake was recorded. We saw that these were now being completed with more detail. Staff told us that as well as daily hand over meetings they also ensured comments from people were recorded in daily notes. Where issues affected people's care, staff were made aware of these, such as ensuring that medicines were signed for at the time they were administered. We found that action had been taken to make the necessary improvements.

Links were maintained with the local community and included various trips out to local lakes, parks, shops and walks around the local area. One person told us, "I love going to see the chickens, love birds and the pet cats and dogs that visit.

Staff spoke confidently about the provider's key values of putting people first and treating each person as an individual. One said, "The reason I like working here is because of the difference I see every day [in people] and putting a smile on people's faces as well being a caring person." One person said, "All the staff are lovely and they [management] are around most days." All staff confirmed that they liked working at the service. One said, "The reason I came to work here is because it has had a good name for the care its staff provides." Relatives told us that they were always asked, when they visited, if everything was alright and if there was any aspects of their family member's care that needed addressing. This was as well as being given information in the form of a monthly newsletter. We saw that this included important information and events that had taken place, or were planned, such as celebrations for people's birthdays.

From our observations throughout the day we saw that the deputy manager, senior care and care staff understood their role and the key risks and challenges in running the service. For example, whilst a registered manager was not in post and the changes that were being implemented to people's benefit. For example, a daily walk around by management to check that staff were adhering to the required standards of care provision. The deputy manager and external auditors confirmed that these checks were due to start the week after our inspection. We also found that the provider was working with the services' commissioners with improving the service. This showed us the service sought to improve the quality of service it provided to help ensure the quality of care provided was to the right standards.

Staff were regularly reminded of their roles and responsibilities at supervisions and staff meetings. Staff told us they felt very confident that they would be supported to escalate any issues or concerns they became aware of if this was required. One care staff said, "I would have no hesitation in reporting any concerns if I ever saw them. I firmly believe in putting people first and ensuring they are safe." One person said, "I feel confident now if I had any concerns that staff would respond appropriately."

The service had been awarded a rating of five out of five for food hygiene [this is the highest award]. Part of this assessment includes the management of food hygiene. We saw that the current systems in place had helped ensure a good standard of food and kitchen hygiene.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not always notified the Commission about important events that, by law, they are required to do so.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not always done all that was reasonable practicable to mitigate risk. Risk assessments were not always in place to support people with their safety in the event of an emergency. Regulation 12 (2) (b)