

Yorkvalley Limited

Haven Lea Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Good ●
Is the service safe?	Good ●
Is the service effective?	Good ●
Is the service caring?	Good ●
Is the service responsive?	Good ●
Is the service well-led?	Good ●

Summary of findings

Overall summary

This inspection was carried out over two days on 02 and 06 December 2016. The first day of the inspection was unannounced.

Haven Lea Residential Care Home is registered to provide accommodation and personal care for up to 26 adults. The service is located in the Whiston area of Merseyside and is close to local public transport routes. Accommodation is provided over two floors. These floors can be accessed via a stair case or passenger lift.

The service has a registered manager who was registered with the Care Quality Commission in October 2016. 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 last comprehensive inspection of the service was carried out in December 2015 and we found that the service was not meeting all the regulations. We asked the registered provider to take action to make improvements to the management of people's medication. The registered provider sent us an action plan following the inspection detailing how and when they intended to make the improvements. During this inspection we found that the required improvements had been made.

The required improvements had been made to the way people's medication was being managed and recorded. The registered provider had developed their medication policy to bring it in line with national guidance and current legislation. Systems for recording quantities of medication received into the service and medications returned to the supplying pharmacist had been improved. The allergy section of people medication administration records (MARs) had been completed to show any known or unknown allergies. Staff responsible for the management of people's medication and associated records had completed training and competency checks to ensure they were suitably skilled for the task.

We have made a recommendation about making the environment more dementia friendly. The environment had been improved since the last inspection, including some re decoration and the replacement of old, and tatty furniture and fittings. However there was a lack of stimulus and signage to help orientate and stimulate people living with dementia. On the second day of the inspection the registered manager evidenced that they had researched dementia friendly environments. Items to improve the environment for people living with dementia had been purchased and plans had been made to make further improvements to the environment to make it more dementia friendly.

We have made a recommendation about the complaints procedure. The procedure did not include the details of the registered provider or any external body such as the local Ombudsman. This meant people did not have the information they needed to escalate their complaint should they wish to.

The recruitment of new staff was robust. Applicant's suitability to work at the service was assessed based on information which they were required to provide. This included details about their previous employment history, skills and experience. Before an offer of employment applicants were also subject to a series of pre-employment checks on their suitability, including reference checks and a check with the Disclosure and Barring Scheme (DBS).

People were kept safe from abuse and harm. People told us they felt safe at the service and that staff treated them well. Staff had completed training in relation to keeping people safe, including safeguarding and emergency procedures. Staff knew the different types and potential signs of abuse and what their responsibilities were for reporting any incidents which impacted on people's safety. Equipment was checked to ensure it was clean and safe to use and it was stored away when not in use to avoid the risk of trips and falls. Risks to people in relation to the environment and their individual care and support needs had been assessed and planned for.

The environment was generally clean and tidy throughout. A recent visit by the local authority infection control team had identified some concerns in relation to the prevention and control of infections. However, the registered manager demonstrated that they had taken action to make improvements and they had put plans in place to make further improvements. Disposed clinical waste outside the premises was not stored safely because the lock on the bin was broken. The registered manager acted upon this immediately. A new lock was fitted to the bin by the second day of our inspection and a system was put in place to check it was in good working order and being used appropriately.

The right amount of suitably skilled and qualified staff were on duty to meet people's needs and keep them safe. People told us that they thought there was enough staff on duty to keep them safe and this was echoed by family members.

People were happy with the food and drink available at the service, they told us they enjoyed the meals and had always been offered plenty to eat and drink. People's nutritional and hydration needs were assessed and an appropriate care plan was put in place for those whose needs required one. The care plans detailed things such as food textures, consistency of fluids and assistance and equipment people needed to eat and drink. People who required it had their weight, food and fluid intake monitored. Staff had access to guidance to help them recognise when a person required input from an external professional such as a dietician and/or speech and language therapist and referrals were made promptly.

Care plans clearly set out people's needs and how they were to be met. Care plans were reviewed regularly and updated when required to reflect any changes to people's needs. A daily record was maintained of the care and support people received and they showed that care plans had been followed in accordance with people's needs, wishes and preferences. Staff interaction showed they had a good understanding of people's needs, likes and dislikes. Staff used their knowledge of people to help generate conversations of interest and people reacted positively to this.

People's privacy, dignity and independence was respected and promoted. Staff were patient when assisting people and they spoke with people in a kind and caring manner. Staff sat down next to people, maintained eye contact when speaking with them and they showed interest in what people had to say. Staff knocked on doors before entering bedrooms and bathrooms and waited to be invited in. Staff knew and respected people's preferences such as their preferred titles and gender of carer when receiving personal care.

Staff received appropriate training and support for their roles. New staff were inducted into their role over a twelve week period and throughout induction staff underwent regular supervision and assessments of their

learning. Induction and ongoing training for all staff included topics such as safeguarding, infection control, safe people handling and dementia care.

Staff, people who used the service and their family members made positive comments about how the service was managed. They said the registered manager had made a lot of improvements at the service since they became the manager. The registered manager was described as being supportive and easy to approach.

There were systems in place to check on the quality of the service and to make improvements. Checks were carried out at various intervals on things such as people's care records, medication and the safety of the environment. Action plans were developed to address any identified areas for improvement.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good 

The service was safe

The required improvements had been made to ensure that people's medication was safely managed.

Robust recruitment procedures were followed and there were sufficient staff to keep people safe.

People were protected from abuse and avoidable harm because staff knew how to recognise and respond to concerns about people's safety.

Is the service effective?

Good 

The service was effective.

The environment would benefit from further improvements to make it more dementia friendly.

People received care and support from staff who received appropriate training and support for their roles.

People's dietary and healthcare needs were planned for and met.

Staff had a good understanding of the principles of the Mental Capacity Act 2005 and the associated Deprivation of Liberty Safeguards (DoLS).

Is the service caring?

Good 

The service was caring.

People were cared for by staff who were patient, kind and caring.

People's privacy, dignity and independence was respected and promoted.

Staff knew people well including their preferences, choices, likes and dislikes.

Is the service responsive?

Good ●

The service was responsive.

The complaints procedure lacked information about the process for escalating complaints.

People's needs were assessed, planned for and regularly reviewed.

People's needs were understood and met by staff.

Is the service well-led?

Good ●

The service was well led.

There was a registered manager at the service.

The registered manager took prompt action to mitigate risks and make improvements to the service following checks carried out by other agencies.

There were systems in place to monitor and improve the quality of the care people received.

Haven Lea Residential 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 legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place over two days on 02 and 06 December 2016, the first day was unannounced. One adult social care inspector carried out the inspection.

During the inspection we spoke with seven people who used the service and four family members. We spoke with the registered manager, and staff who held various roles including care staff, kitchen staff and domestic staff.

We looked at areas of the service including the communal lounge and dining room, bathrooms, bedrooms, the kitchen and the laundry.

We observed the interaction between staff and people who used the service and reviewed a number of records, including care records for three people who used the service and the records for three of staff. Other records we looked at which related to the management of the service included quality monitoring audits and safety certificates for equipment and systems in use at the service.

Before our inspection we reviewed the information we held about the service including notifications that the registered provider had sent us, information received from the local authority and Healthwatch and the Provider Information Return (PIR). The PIR is a form that asks the provider to give some key information about the service, including what the service does well and any improvements they plan to make.

Is the service safe?

Our findings

People said they felt safe living at Haven Lea and that the staff treated them well. People told us they would tell someone if they were mistreated or felt unsafe in any way. Their comments included; "I felt scared living on my own but now I don't, I feel really safe here", "I'm not worried about a thing. I am treated very well" and "I couldn't feel any safer". Family members told us that they had no concerns about their relative's safety and the way they were treated. One family member said, "I always leave here reassured that [relative] is in safe hands" and another said "The staff treat [relative] very well indeed, we couldn't ask for better".

During the last inspection we found that people who used the service did not have their medicines managed safely. This was a breach of Regulation 12(2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection we found that improvements had been made.

People's medicines were managed safely. Since our last inspection medication administration records (MARs) had been updated to indicate whether or not the person had an allergy. Having this information can reduce the risk of medicines being given to someone with an allergy. Since our last inspection the systems had improved for checking medication received into the service and for recording medication that was returned to the pharmacist. The amount of medication held for each person was recorded on their MAR including any stock carried forward. A register was in place which recorded each item of medication returned to the supplying pharmacist. The register included the date the medication was returned and the reason why, and the record was signed by the pharmacist to confirm receipt of it. This helped to ensure that quantities of medication were accounted for.

Medication was stored securely and administered to people safely. A copy of the registered providers policy and procedure for the safe handling of medicines was available to staff in the medication room along with other related guidance. The policy and procedure which had been developed since our last inspection contained up to date information in line with national guidance. Senior care staff were responsible for managing people's medication and they had completed medication training and underwent regular competency checks to ensure they were suitably skilled for the task. Medication was stored in secure cabinets in a dedicated room which was kept locked when unattended. Each person's medication was individually labelled by the supplying pharmacy and a MAR for each person included each item of prescribed medication, instructions for use and the time it was to be administered. Any handwritten information entered onto MARs was signed by two staff to ensure the accuracy of the information.

A Fridge was used to store medication which needed to be kept cool to ensure its effectiveness, this included ointments and eye drops. Refrigerated items were dated to show when they were first opened. The temperature of the fridge was checked daily and recorded to ensure it was at a safe temperature for storing items of medication. Controlled drugs (CDs) were stored securely in an appropriate cabinet and records of the administration of CDs were properly maintained. We checked a sample of CDs and found stocks tallied with the records kept.

Prior to our inspection we received the outcome of an audit carried in August 2016 by the local authority

medication management team. Although some areas of improvement were identified the overall findings were a significant improvement on the previous audit carried out. Our checks during this inspection showed that the registered provider had actioned the areas of improvements given following the most recent audit carried out by the local authority medication management team in August 2016.

The registered provider had a recruitment and selection policy which was accompanied by a procedure which described a robust process for recruiting new staff. Records for new staff that had been recruited since our last inspection showed that the procedure was followed correctly. Prior to an offer of employment candidates completed an application form, attended an interview and underwent a series of pre-employment checks. For example, suitable references were obtained and a check was carried out with the Disclosure and Barring Scheme (DBS). A DBS check consists of a check on people's criminal record and a check to see if they have been placed on a list for people who are barred from working with vulnerable adults.

Equipment used at the service was regularly checked, serviced and maintained to ensure it was safe to use. This included gas and electricity systems and appliances, firefighting equipment, lifting hoists and specialist beds.

People were protected from abuse and the risk of abuse. People knew what was meant by abuse and they were confident about telling someone if they were mistreated. Staff had completed safeguarding training and they had access to the registered providers and the relevant local authorities safeguarding policies and procedures. Staff described the different types and indicators of abuse and they clearly explained what they would do in the event that they witnessed, suspected abuse or if a person made an allegation of abuse. The registered manager kept a record of all allegations of abuse. This showed that they and other senior staff had taken appropriate action by promptly informing the relevant agencies such as the local authority safeguarding team and the Care Quality Commission (CQC). The records evidenced that action had been taken to reduce further risks to people.

Risks to people's health and safety were assessed as required and risk reduction methods were put in place to ensure people's safety was maintained. For example, people who were at risk of falls during the night had a sensor mat next to their bed to alert staff of their movements. Other equipment including hoists and wheelchairs were used to transfer people who were unable to weight bare. This helped to minimise the risk of falls which may result in harm or injury occurring.

Environmental risks were also assessed and planned for within the service and staff followed them to ensure people's safety was maintained. For example, equipment to help people with their mobility was stored away when not in use to minimise the risk of trips and falls. Fire exits were kept clear from any obstructions and signs were used to alert people and others to potential hazards such as wet floors.

People received care and support from the right amount of suitably skilled and experienced staff. Rotas showed there was four care staff including a senior carer on duty throughout the day and two care staff at night. Other staff on duty throughout the day included the registered manager, an administrator, domestic and kitchen staff.

Procedures were in place to protect people in the event of an emergency. Staff had completed training in emergency procedures such as first aid and fire awareness and they were aware of their responsibilities to work as a team to keep people safe in the event of an emergency. Emergency equipment such as first aid boxes and firefighting equipment which was located around the service and staff knew where to locate it. Emergency grab bags were located near to fire doors on the upper and ground floors. The bags contained

essential items of equipment such as a first aid box, blankets and torches for use in the event of an evacuation. Personal emergency evacuation plans (PEEPs) were in place for each person who used the service. The PEEPs were regularly reviewed to ensure they included up to date information for staff about how they needed to evacuate people in the event of an emergency such as a fire.

During our inspection the registered manager informed us that earlier in the week an audit had been carried out by the local authority infection control team. At the time of our inspection the written report was not available however the registered manager informed us that the verbal feedback they received at the time of the audit highlighted a number of concerns. The manager had however actioned some of the concerns which included a lack of appropriate bins at the service for the disposal of clinical waste and the cleanliness of bed mattresses. New clinical waste bins and replacement bed mattresses had been obtained and put in place. We contacted the infection control team who confirmed that they were working closely with the registered manager to improve infection control practices and procedures at the service.

On the day of our inspection the environment was generally clean although carpets along the corridors leading to people's bedrooms were heavily stained. The registered manager confirmed that alternative washable flooring had been ordered for the corridors and was expected to be laid early in the new year. The clinical waste bin situated outside the service did not have a lock on. This posed a risk to members of the public because the clinical waste contained in the bin was not secure and could be accessed. We raised this with the registered manager and they immediately contacted the suppliers of the bin who confirmed they would attend to the lock. This had been actioned by the second day of our inspection.

Is the service effective?

Our findings

People told us they received care and support from staff that were good at their job. Their comments included; "They [staff] all seem to know what they are doing and are very careful when helping me" and "I've no complaints about any of them [staff] they do a great job". Family members told us that they thought the staff were well trained and competent in what they did.

Improvements made to the environment since our last inspection have enhanced people's living environment. For example, the registered provider had purchased new curtains, easy chairs and dining room furniture which replaced old ones which were stained, tatty and worn. New lighting had been installed in the main lounge making it brighter. A selection of bedrooms had also been redecorated and refurbished and there was an ongoing programme to decorate and refurbish all other bedrooms. However, some people who used the service were living with dementia and most parts of the environment were not dementia friendly. Although bathrooms and toilets displayed pictorial signage there was little clear signage around other parts of the service to help and aid orientation of people living with dementia. The environment lacked items of interaction or stimulus which could be used to support reminiscence and wayfinding such as memory boxes, pictures of the local areas and favourite pastimes of people who lived at the service. There were no items of familiarity in place to support people living with dementia to understand what a room, cupboard or space was used for. An example of this may be where pictures of food and drink around the environment are used to help people to identify their bedrooms, lounge and dining areas. This meant that people could be at risk of increased confusion and their independence being limited as the environment did not specifically cater for them.

The registered manager confirmed that they had discussed with the registered provider improvements needed to the environment to make it more dementia friendly and plans had been agreed to make the improvements. On the second day of our inspection the registered manager demonstrated that they had carried out some research about dementia friendly environments. They had purchased some items including coloured toilet seats and wall art for bathrooms to enhance people's orientation and provide stimulation.

We recommend that the registered provider refers to best practise guidance on dementia friendly environments.

New staff commenced a twelve week induction programme when they first started work at the service. On commencing their induction staff were provided with a tour of the premises, introduced to the registered providers policies and procedures and learnt about the organisation and the expectations of their role and responsibilities. Before being included on the rota new staff worked under the supervision of more experienced staff and completed training in key topics including safeguarding and health and safety. The induction was monitored either by the registered manager or a senior member of staff and at regular intervals assessments of staff knowledge and performance were carried out and recorded as a way of monitoring their progress.

Following induction all staff entered onto an ongoing programme of training specific to their job role,

including refresher training in key topics such as infection control, safer people handling, health and safety and dementia care. Staff were required to complete a competency check following the completion of each training course to ensure they had achieved the necessary learning from the training. A record of staff training was kept and the registered manager kept an overview of it which enabled her to plan for future training.

Staff received support and supervision for their roles. Staff said they felt well supported by the registered manager and other senior staff and that they were confident about approaching them at any time for advice and support. There was a system in place for formally supervising staff on a one to one basis, however the registered manager confirmed that she had fell behind in conducting these. The registered manager advised that she was in the process of providing training to senior staff to enable them to assist her in conducting more regular formal supervisions with junior staff. Care staff were given opportunities to progress into more senior roles. Senior carers who had been promoted told us they were provided with appropriate support and training for their new role.

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 people lack mental capacity to make particular decisions, any decisions 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 2005. The application procedures for this are called Deprivation of Liberty Safeguards (DoLS). We checked that the service was working within the principles of the MCA 2005 and found that they were. The registered manager and staff were aware of the principles of the MCA and they knew that everyone was assumed to have capacity unless they had been assessed otherwise.

Throughout the inspection we heard staff asking people for their consent before providing care and support. People's liberty was only restricted when there was no other means of keeping them safe. Staff were aware that any such restrictions should be properly authorised and always be the least restrictive option. A lock on the front door was used to prevent people leaving the service. This was because it was unsafe for most people to leave without someone with them. The registered manager had made applications to the local authority to deprive some people of their liberty in order to keep them safe. Copies of the applications and authorisations which had been granted were kept in people's individual care files. Appropriate care plans had been put in place for restrictions placed upon people.

Where people had been assessed as not having the mental capacity to make decisions, meetings had been held in order to decide what was in the person's best interest. Records showed that discussions had been held between staff, relatives and health care professionals about what was in the person's best interests.

People's nutritional and hydration needs were assessed using a recognised tool. People who required it had care plan in place for eating and drinking. Care plans described the support people needed to eat and drink including how to manage any risks identified. For example, where a person was at risk of choking the required texture of their food and consistency of fluids was detailed in their care plan. The detail of any specialist equipment people needed to promote their independence at meal times was also detailed in their care plan and people were provided with it. People who were at risk of dehydration were provided with regular drinks and staff encouraged their intake of fluids. Drinks were offered to people both during and in-between meals and jugs of juice and glasses were available in the dining room for people to help themselves. People that were unable to access drinks independently and those who occupied their rooms where provided with regular drinks and offered snacks.

People told us that they enjoyed the food and that they got plenty to eat and drink. One person said, "I've never ate so much since being her. I eat things I never did before like curry and pasta and it's all lovely". With their prior consent we joined a group of people for a meal at lunchtime on the first day of our inspection. Meals were served to people individually and they were well presented and served hot. The cook held information about people's dietary needs, likes and dislikes and they prepared meals in accordance with them. For example meals were prepared low in sugar content for people with diabetes and a vegetarian option for one person who did not eat meat. Soft foods were provided for people who were at risk of choking and each element of the meal was served separately on the plate to promote taste and maintain the presentation of the meal.

Is the service caring?

Our findings

People told us that the staff were kind and caring and that they respected their privacy and dignity. One person said "They [staff] treat me like royalty, they are very caring and kind to me" and another person said "They [staff] are so patient and kind". Family members commented that their relative was well cared for and treated with dignity and respect. Their comments included, "[relative] is very well cared for here, I've nothing but praise for all the staff. They care about [relative] a lot" and "They [staff] treat [relative] like family".

There was a relaxed and friendly atmosphere at the service. There was much laughter and banter between staff, people who used the service and visiting family members. People and family members told us this was usual. One person's family member told us that their relative particularly enjoyed the banter with staff and that it cheered up their relative. Another family member told us that their relative had a really good sense of humour and enjoyed the interaction with staff as it kept their relative in good spirit.

People's likes dislikes, personal preferences and preferred routines were recorded in their care plan and staff knew them well and respected them. For example, staff knew how important it was for one person to spend a lot of time in their bedroom with all their possessions around them. The person's care plan stated that the person needed space around them to call their own and that it encouraged a feeling of security and homeliness for the person. Another person's care plan stated that they liked their lamp left on at night and the person confirmed staff ensured this.

Conversations which took place between people and staff showed that staff had good knowledge of people's past lives, family relationships and people's interests. A member of staff initiated a conversation with a person about their past life and the person reacted positively and went on to talk about their favourite past times.

People were treated with dignity and their independence and privacy was promoted. Care plans were written in a way that promoted and encouraged people's independence and dignity. For example they included phrases such as 'assist' 'encourage', 'be patient', 'gently prompt' and 'prefers'. Observation of staff practice and discussions held with them demonstrated that they promoted people's independence where ever possible and promoted people's dignity. Staff were patient and encouraging when assisting people to mobilise. For example, when assisting a person to walk staff were heard advising a person not to rush and to take their time. Staff knocked on doors before entering people's bedrooms, bathrooms and toilets and they asked people if it was ok to enter. Staff sat next to people and maintained eye contact when holding conversations with them.

Staff were patient and supportive at meal times allowing people to eat at their own pace and offering assistance when required. Staff sat next to the person they were assisting and avoided any interruptions from others. Dining tables were attractively laid with table cloths, condiments and a centre piece. Most people chose to sit in the dining room for their meals, however those who chose to, ate in their rooms. On entering the dining room people sat in their chosen place and they were offered a drink. People were reminded of their choice of meal before it was served to them and staff offered an alternative to people who

changed their mind about their meal choice.

Care plans included people's preferred names and their preferred gender of carer when receiving personal care. Staff knew people's full titles and what they preferred to be called and they were aware of those people who stated a gender preference when receiving personal care.

Family members told us they were welcomed whenever they visited their relative. They said staff always greeted them and offered them with refreshments. One family member told us they had recently been invited to have a meal with their relative and that staff set up a table in the conservatory so that they could eat together in private. Another family member said they also had been invited for a meal with their relative. Family members said they could visit their relative at any time during the day or night without question. A family member explained that they visited their relative several times each week and had always found the atmosphere to be friendly and welcoming.

Some people had a 'do not attempt resuscitation' (DNAR CPR) order in place which had had been authorised by their GP. These are put in place where people have chosen not to be resuscitated in the event of their death or in cases where they cannot make this decision themselves, where the GP and other individuals with legal authority have made this decision in a person's best interests. DNAR CPR certificates were placed at the front of people's care file so it was clearly visible. Staff knew which people had a DNAR CPR order in place and they understood what their responsibilities were in the event of a person's death.

People's personal records were kept confidential. Personal records were stored in locked cabinets when not in use. Staff knew the importance of this and of their responsibility to share information only on a need to know basis.

Is the service responsive?

Our findings

People told us that they received all the right care and support by staff that were good at their job. People's comments included; "They [staff] are very good indeed, they see to everything I need", "I can't fault them in any way. I get to see my doctor when I need to" and "I've no complaints at all". Family members told us that they thought that staff had a good understanding of their relatives needs and that staff were good at recognising any concerns and acting upon them. One family member said, "They are marvellous with [relative]. They know when [relative] is upset and anxious and how to settle her".

People were provided with information about how to complain. The registered provider had a complaints procedure which was made available to people and others. The procedure explained the steps people needed to take when making a complaint. This included contacting the registered manager in the first instance. The procedure explained that the complainant could contact the registered provider if they were not satisfied with the initial response from the registered manager. However there were no contact details for the registered provider or any other independent external body, such as the local ombudsman. This meant that people did not have information to enable them to escalate their complaint should they need to.

We recommend that the complaints procedure is updated to include all the required information which people need to make a complaint.

People and family members told us that they were confident about complaining should they need to. One family member said that they had raised an issue about the care of their relative informally with the registered manager and because it had been dealt with promptly and to their satisfaction they did not feel the need to take it any further.

The registered provider had a pre admission assessment pack which was completed prior to a person moving into the service. The registered manager or a suitably qualified member of the care team visited people at their place of residence and completed the assessment documentation within the pack. Initial information gathered about the person included personal details, medical history and background information. In addition the assessment took account of areas of need including, personal care, mobility, communication, healthcare and any associated risks. We looked at completed assessments for three people who had moved into the service since the last inspection. The assessments which were completed in detail provided good descriptions of people's needs. They were dated and signed by the assessor and the person it was for, or where appropriate a family member. Assessments which were obtained from other health and social care professionals were used to help plan people's care.

The outcomes of assessments were used to develop a care plan for people's identified needs. Each care plan clearly showed the area of need, the preferred outcome for the person and how it was to be met. Any known risks and how they were to be managed were incorporated into care plans. Care plans were reviewed regularly and updated to reflect any changes, with the involvement of the person it was for and relevant others. Care staff had access to people's care plans and they told us that they were easily available to them,

informative and easy to follow.

Daily records which were maintained for each person showed that people's needs had been met. For example they detailed specific health care needs which staff attended to and they showed that people's preferred routines were followed. Daily records also reported on people's progress and aspects of their care which required observation such as food and fluid intake, mood and behaviour. All contact people had with others including health and social care professionals, family and friends was also recorded in their daily records. Daily records evidenced that staff had responded to any concerns they had noted with regards to people's health and wellbeing. For example, GPs and specialist nurses were called upon when there was a notable decline in a person's condition or when a new concern was identified. People's general health was also monitored and when required they attended appointments with their GP, dentist, optician and chiropodist. A detail of the appointments, the outcome and any further intervention was recorded in people's personal files.

Records were completed for people who required aspects of their care monitoring. Charts were in place for recording things such as people's weight, skin condition, and food and fluid intake. Staff completed charts at the required intervals and the information recorded was used to plan people's ongoing care. Staff understood the reason for monitoring people's care and they knew the signs and symptoms which indicated any concerns which needed to be acted upon. For example, staff knew that if a person had a significant weight loss or if a person's fluid intake declined they would need to act upon it. Records and discussions with staff showed that when a concern was noted in a person's health or wellbeing appropriate referrals had been made to other health and social care professionals such as dieticians, the falls team and specialist nursing teams.

There was no dedicated member of staff employed at the service to organise and facilitate activities for people. The previous activities co-ordinator had recently resigned from their post and at the time of our inspection they had not been replaced. However, the registered provider was in the process of recruiting a replacement activities co-ordinator. In the interim staff did their best to engage people in activities which included art and craft, board games and film shows. Seasonal events and birthdays were celebrated for those who wished to take part. A local school choir and other entertainment had been arranged to take place at the service over the Christmas period in addition to a Christmas party. Overall most people were satisfied with the activities currently available although one person and a family member said more activities were needed.

Is the service well-led?

Our findings

People and family members made positive comments about the registered manager and how they ran the service. Their comments included; "[Registered manager] has made a lot of changes for the good" "Things have improved an awful lot since [Registered manager] came as manager" "She listens and does her best to put things right" and "She is always around and makes time for you".

The service did not have a registered manager at the time of our last inspection however, the manager who was in post at time of our last inspection was registered with the Care Quality Commission in October 2016. People who used the service, family members and staff commented on notable improvements made at the service since the registered manager's appointment. They described her as supportive and approachable and willing to listen.

We obtained information from local authority commissioners and other stakeholders prior to this inspection. The information which was based on checks and audits they carried out since our last inspection showed that the registered provider and registered manager had acknowledged and actioned areas for improvements. For example, improvements had been made based on action plans set by the local authority medication management team following an audit carried out in August 2016. Although at the time of our inspection a written report had not been received from the local authority infection control team following a recent audit, the registered manager had made improvements based on verbal feedback given. In addition the registered manager had implemented more robust internal audits for checking on medication and the environment and had made improvements based on the outcomes of them. This meant that risks to people were mitigated in a timely way to ensure their safety.

The registered manager had overall day to day responsibility for the running of the service and they had the support of a general manager and an administrator. The general manager and administrator assisted the registered manager in the development and completion of records required for the running of the service. There was a team of senior care staff who when on shift were responsible for co-ordinating and supervising the work carried out by junior care staff. Senior carers had a good understanding of their responsibilities in the absence of the registered manager. This included when and how to raise a safeguarding concern with the local authority safeguarding team. Senior carers knew of their responsibilities to notify CQC of any allegations of abuse and when to notify us of incidents and events which occurred at the service. Records showed that CQC had been notified in a timely way of significant events which had occurred at the service. This information helps us to decide if we need to take any action to keep people safe.

Although the registered manager had the support of a general manager their role did not include working directly with people who used the service and care staff. The registered manager felt that the role of a deputy manager would strengthen the current management arrangements for overseeing people's care and the supervision and monitoring of staff performance. It was expected that the deputy manager would work opposite to the registered manager, increasing the presence of appropriate management cover at the service. This had been discussed and agreed with the registered provider and at the time of our inspection the process for the recruitment of a deputy manager was underway.

Staff demonstrated they were aware of whistleblowing procedures and they said they would not hesitate to use it if they needed to. Whistle-blowing occurs when an employee raises a concern about dangerous or poor practice that they become aware of. Staff said they had access to contacts details of those they could contact should they need to raise any of these types of concerns, including the contact details for the relevant local authority safeguarding teams.

The registered manager organised and facilitated meetings for staff from all departments. Meetings were organised well in advance and an agenda was developed and made available to staff prior to the meeting. Minutes of the meetings were taken and shared amongst all staff so that those in attendance and those who were unable to attend had a record of the meeting discussions and any actions agreed.

The registered provider had in place a set of policies and procedures relevant to the service. Policies and procedures support effective decision making and delegation because they provide guidelines on what people can and cannot do what decisions they can make and what activities are appropriate. The registered manager was in the process of reviewing and updating the registered providers policies and procedures and at the time of our inspection she had made significant progress. The majority of them had been reviewed and updated in line with current legislation and best practice. The complaints procedure however needs to be further updated to ensure it contains all the required information which people need to make a complaint. Staff had access to files containing the registered providers policies and procedures. At the start of their employment they were issued with a staff handbook which summarised key policies and procedures, including health and safety, safeguarding and confidentiality. Any changes made to the documents were communicated to staff during meetings and staff handovers.

There were systems in place for assessing and monitoring the quality of the service and making improvements. Checks were carried out on people's care records, the environment and staff working practice. The system for carrying out checks on the environment had recently been developed. It included more detailed information about the findings and action which was required to make improvements as previously the records lacked this detail. Improvements identified during checks were addressed in order of priority. For example improvements required to the environment which posed a risk to people's health and safety were acted upon immediately. We saw examples where radiator covers were replaced because existing ones were loose and potentially unsafe.

Accidents or incidents which occurred at the service were recorded and reported in line with the registered provider's procedure. This included the completion of accident/incident forms and copies were held in the person's care records. Accident and incident records were reviewed regularly as a way of identifying any patterns or trends. Where repeated incidents occurred additional measures were be put in place to reduce the risk of further occurrences.