Shelphen Care Limited

Northgate House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 15 March 2016 and was unannounced.

Northgate House is a care home in Market Weighton, which provides care for up to 25 older people who may be living with dementia. At the time of our inspection there were 17 people using the service. Accommodation was on two floors and most of the upper floor was accessed by a chair lift. There was a registered manager for the service, but on the date of our visit the registered manager was on a period of extended leave, and an acting manager was overseeing the home. 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.

Mental capacity assessments and Deprivation of Liberty Safeguards (DoLS) applications had not been submitted to the local authority for everyone who we were told needed them and not all staff had completed training in the Mental Capacity Act (2005). The registered provider had started to complete mental capacity assessments and DoLS applications, but we have made a recommendation that the service acts promptly to complete these to ensure they are meeting all the requirements of the Mental Capacity Act (2005). This was a breach of Regulation 13(5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

We found that the provider had robust recruitment processes and completed appropriate checks before staff commenced employment. There were sufficient staff to meet peoples' needs.

The provider had a safeguarding policy in place and we were told this would be updated. Staff were aware of the signs of abuse and knew how to report this. People who used the service felt safe at the home and were confident that they would not be harmed.

The provider completed assessments to identify potential risks to people using the service and risks to staff. The risk assessments we saw were reviewed monthly and were up to date.

The provider had a system for recording and responding to accidents and incidents. There had been a significant number of falls at the home over the previous year, but we saw the provider had completed comprehensive risk assessments and implemented measures to minimise the risk of falls occurring. Specialist guidance and support had also been sought from the falls prevention team and physiotherapists for individuals where this was required.

We saw evidence that people using the service signed their care plans and staff demonstrated an understanding of the importance of gaining consent before providing care to someone.

The decor in the home was tired and the building was in need of renovation to improve the environment for

older people including those with dementia. The registered provider was fully aware of the issues with the decor and layout of the building and told us they had plans for extensive refurbishment and re-design of the premises. We have made a recommendation that the provider commences their planned renovation work at the earliest opportunity, taking steps to improve the design and decoration of the premises in line with the needs of people using the service.

People were supported to maintain good health and to access health care services when they needed them. Visiting healthcare professionals commented positively about the care provided by staff at the home. People were also supported well with their nutritional needs.

People using the service told us that staff were kind and caring, and the interactions we observed were positive, friendly and respectful.

Most people we spoke with felt they had choice and control about their care and that staff respected their wishes. Care files demonstrated the involvement people wished to have in their care planning. Peoples' privacy and dignity was also respected.

Everyone using the service had a care plan and we saw that these were detailed, person centred and had been reviewed regularly. Staff demonstrated a good knowledge of peoples' needs.

There were opportunities for people to comment on their experience of the service, as we saw evidence of regular residents' meetings and satisfaction surveys. There was also a complaints procedure and people knew how to complain.

Staff received an induction, training, supervision and appraisals. Staff meetings were held and staff told us they felt supported by the management.

There were a range of quality assurance audits in place, and regular equipment and environmental checks; most of which were accurately completed.

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.

There were systems in place to protect people. Staff were aware of signs of abuse and knew how to report concerns. Risks to people were appropriately managed.

There were robust recruitment processes and appropriate checks completed before staff commenced employment. There were sufficient staff to meet peoples' needs.

Systems were in place to ensure that people received their medication safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Mental capacity assessments and Deprivation of Liberty Safeguards applications had not been submitted to the local authority for everyone who we were told needed them.

The decor was tired and the building was in need of renovation to make it a more pleasant and appropriate environment for older people including those with dementia.

People were supported to maintain good health and access health care services when they needed them. They were also supported with their nutritional needs.

Is the service caring?

Good

The service was caring.

People told us that staff were caring and they had positive relationships with the staff who supported them.

People using the service were involved in decisions about their care and most felt that their views were acted on.

People we spoke with felt staff respected their privacy and dignity.

Is the service responsive?

Good

The service was responsive.

Peoples' needs were assessed and care plans were in place to enable care workers to provide personalised care. People were involved in contributing to their care plans.

The service had a system in place to manage and respond to complaints and concerns.

Is the service well-led?

Good

The service was well led.

The service promoted a positive and person centred culture by providing a range of opportunities for people to provide feedback on the service they received.

The acting manager was accessible and visible to staff and to people who used the service. They provided staff with the support they needed to deliver the service.

The service had quality assurance systems in place.

Northgate 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 inspection took place on 15 March 2016 and was unannounced. The inspection team consisted of two Adult Social Care Inspectors.

Before the inspection we looked at information we held about the service, which included notifications sent to us. Notifications are when registered providers send us information about certain changes, events or incidents that occur. We also requested feedback from East Riding of Yorkshire Council's contracts team about the home, and they did not have any significant concerns about Northgate House at the time of our visit. The registered provider was not asked to submit a provider information return (PIR) prior to the inspection; this is a document that the registered provider can use to record information to evidence how they are meeting the regulations and the needs of people who live at the home.

As part of this inspection we spoke with four people who used the service, three care staff, the cook, the acting manager, a senior manager from the company and two visiting professionals. We looked at three people's care records, two care worker recruitment and training files and a selection of records used to monitor the quality of the service. We conducted a short observational framework for inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who may be unable to share their views and experiences. We also carried out a tour of the premises.

Good

Is the service safe?

Our findings

We asked people using the service about how safe they felt and they told us "Yes I feel safe here, I have no fears" and "I am confident that no one would harm me".

The provider had policies and procedures in place to guide staff in safeguarding vulnerable adults from abuse. We noted that the policy was not dated and required reviewing as it contained outdated references. When we discussed this with the acting manager they told us they would bring this to the attention of the registered provider and address this.

The service had a copy of the Local Authority's multi-agency safeguarding policy and procedures available for staff reference. Staff received training in safeguarding vulnerable adults from abuse; we saw records of safeguarding workbooks, produced by the local authority, which had been completed by staff since April 2015.

No safeguarding referrals had been made in the previous year, but the provider had a system in place to manage safeguarding concerns should these arise. Care staff we spoke with understood the different types of abuse that could occur and were able to explain what they would do if they had any concerns. One member of care staff told us "I would report it to a senior and the head of care. The seniors make an alert". There was also a whistleblowing policy for staff to use if they wished to raise any concerns.

The registered provider completed assessments to identify potential risks to people using the service and care staff. We reviewed care files for three people living at the home and saw that there was an appropriate range of risk assessments in place in relation to people and the environment, such as risk assessments for manual handling, falls, pressure care, nutrition and choking. The risk assessments we saw were reviewed monthly and were up to date.

The registered provider had a system for recording and responding to accidents and incidents, in order to keep staff and people using the service safe. We saw records of accidents and incidents in 2015 and 2016. We noted that there were a significant number of accidents and incidents at the home; 85 recorded in 2015 and seven in 2016 up to the date of our inspection. Many of these recorded incidents were relatively minor with no injuries sustained. We reviewed the care files of two residents who had had a high number of falls, and found that there were detailed person centred risk assessments in place for these people in relation to falls. There were also detailed mobility and falls care plans in place, which were regularly reviewed and up to date.

Where someone had fallen there were records of half-hourly or hourly observations completed on the person for a 24-48 hour period, to monitor their well-being following a fall. The provider also completed an additional falls prevention and screening tool when someone had fallen and these were appropriately completed. We also saw evidence that the home had made referrals for specialist support from relevant professionals for one resident in relation to their falls, from a physiotherapist and the falls team. Records showed that the home had measures in place to minimise the risk of any further falls within the limitations

of the current building.

Pressure sensor mats were also in use for people at identified risk of falls, to alert staff when these residents were out of bed. One resident had a bedroom close to the top of a flight of stairs and they had a sensor mat next to their bed, so that staff were aware when the person was out of bed and mobilising in their room. This helped to reduce potential risks presented by the location of the room.

We saw records of health and safety and environmental checks, including an up to date gas safety certificate, fire certificate, hoisting equipment checks, electric stair lift servicing records and PAT test certificate. The registered provider also had a contract in place for pest control checks and for the appropriate disposal of waste.

Staff were aware of what to do in the event of an emergency, such as a fire. There was a list on the wall in the office of resident room locations and mobility needs in the event of an evacuation, but people did not have detailed personal emergency evacuation plans (PEEPS) in place. PEEPS are used to record the assistance people would need to evacuate the premises in an emergency, including any impairment they had, the support they would need from staff and any equipment they would need to use. We discussed this with the acting manager who agreed to complete these for individuals.

The registered provider had a safe system for the recruitment of staff. We looked at recruitment records for two care staff. There was a small number of gaps where paperwork had not been signed, however appropriate checks were completed prior to staff commencing work. These checks included seeking references and completing a Disclosure and Barring Service (DBS) check. DBS checks return information from the police national database about any convictions, cautions, warnings or reprimands. DBS checks help employers make safe recruitment decisions and prevent unsuitable people from working with vulnerable groups.

We looked at whether there were sufficient staff available to meet the needs of people living at the home. The acting manager completed an assessment of the person's needs prior to them moving in to the home. This was to ensure the service could meet their needs. We looked at staff rotas for the two months prior to the inspection. The rota showed four care staff during the day in addition to the acting manager, and three care staff in the afternoon/evening and at night. The registered provider employed an activities coordinator for three hours each day, a cook every day and a member of domestic staff on weekdays. We were told that despite there only being 17 people living at the home at the time of our inspection the registered provider had maintained the same staffing levels they had when the home was at full occupancy for 25 people.

We talked to staff and people using the service about the availability of sufficient staffing to meet peoples' needs. One person using the service told us "There are enough staff yes. I never have to wait when I pull the call bell". Another person told us that there was not enough staff to take them out as often as they would like and that sometimes staff were a bit hurried. Staff told us the staffing levels were "Good, generally okay. We are a little bit shorter on an afternoon sometimes, but there are not many residents at the moment and everything gets done". Another told us "There are enough staff: three is usually enough but we can have four".

There was a call bell system for the service; people could use this to call for assistance from staff. We saw call bells were within reach of people and one person who used the service confirmed to us "I have a bell to call for help if I need it".

The registered provider had a medication policy in place and senior staff that had responsibility for

administering medication had received training on medication management. We observed staff supporting people appropriately with their medication and recording on Medication Administration Record (MAR) charts that they had given people their medication. Medication was stored in a locked trolley and there was a lockable medication cupboard, which contained an appropriate controlled drugs cabinet. Some prescription drugs are controlled under the Misuse of Drugs legislation (and subsequent amendments). These medicines are called controlled medicines or controlled drugs.

We looked at the MAR charts for three people who used the service, and found that these were appropriately completed. We checked the stock balance for a selection of medications and these all tallied with the information in the MAR charts. Care files contained a medication care plan, with key information and preferences in relation to the persons' medication needs.

The acting manager completed medication audits every two weeks, and regular spot checks on medication stock levels. We also looked at a copy of a medication audit completed by the home's pharmacist the day prior to our inspection. We noted there were three recommendations arising from this audit, but no significant concerns identified. The acting manager told us they would address the recommendations.

This showed that there were systems in place to ensure people received their medication safely.

On the day of our inspection we noted some infection control and prevention risks, such as an open bin in a toilet, which was not an appropriate foot pedal operated bin with a lid, and the inappropriate storage of clean linen on the floor in one room. The acting manager agreed to correct these issues on the day of our inspection. The fabric of the building was tired and in need of extensive refurbishment, which meant that it was more difficult to see the visible benefits of the cleaning that was taking place. Various hand rails were also worn which meant they were not impervious to bacteria. However, there were cleaning schedules in place and records of the cleaning that had been done. The registered provider had also taken steps to manage risks presented by the building, until planned renovation work begins, such as securing the join in a carpet on one corridor.

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 MCA requires that as far as possible people make their own decisions and are helped to do so when needed. Where people lack mental capacity to make 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 process for this in care homes and hospitals is called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the provider was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The acting manager told us that there were nine people living at the service that they believed lacked capacity to consent to their care and treatment and for whom they would be completing mental capacity assessments and DoLS authorisation applications. We saw that the acting manager had started work on this documentation for some of these people but this had not yet been finished and therefore the applications had not been submitted at the time of our inspection. This meant that people were potentially being deprived of their liberty without authorisation. This was a breach of Regulation 13(5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations. The acting manager told us that they would finish completing these mental capacity assessments and DoLS applications as a high priority.

We found evidence of a mental capacity assessment for one individual. The home's new pre admission assessment documentation contained a mental capacity assessment, and this documentation had been used for one person who had recently returned to the home after being in hospital.

We saw evidence that people using the service had signed their care plans and staff demonstrated an understanding of the importance of gaining consent before providing care to someone. Where people had a Power of Attorney (POA) this was clearly recorded in their care file, and staff were aware of this. A POA is a person appointed by the court or the office of the public guardian who has a legal right to make decisions within the scope of their authority (health and welfare and/or finances).

Staff we spoke to had a basic understanding of the principles of the MCA. However, not all staff had completed MCA training and the acting manager had not completed MCA training. The acting manager confirmed to us that they, and two other senior staff, were booked on DoLS training the week following our inspection, and were booked on Mental Capacity Act training in the month following our inspection. The acting manager also told us that they would ensure all staff completed the MCA training provided by the local authority.

We asked people using the service if they felt staff had the knowledge and skills to support them well. People told us "Staff do everything they can to help me" and "The girls are very good". Nobody raised any

concerns with us about staff lacking the skills or knowledge to carry out their roles.

We saw that staff had a range of training to help them carry out their roles effectively. This training included moving and handling, infection control, health and safety, medication handling, fire safety, food hygiene and safeguarding vulnerable adults. The majority of the staff team had also completed dementia training, diabetes awareness and pressure area care training. Senior staff also completed first aid training. Records showed when staff had completed training and the date when they would be due to refresh their training. Some of the training was delivered in-house, some by distance learning courses and some via courses run by the local authority. The acting manager told us staff were very enthusiastic about going on training and developing themselves and a staff member said "I am hoping to do my NVQII and NVQIII as soon as possible, so that I can progress on to being a senior in the future".

We saw evidence of staff induction records. Staff told us they shadowed other staff for the first week or two weeks and confirmed that their induction covered a range of areas, including fire safety, health and safety, policies and procedures, the location and use of personal protective equipment and an introduction to all the residents.

We saw evidence of staff supervision, covering a range of appropriate topics, along with evidence of staff appraisal and team meetings. This showed that people received care from staff who had the knowledge and support they needed to carry out their roles.

We observed a mealtime at the home and spoke to care staff, the cook and people who used the service about the food at the home and support provided with nutritional needs. Staff had a good knowledge of people's individual dietary needs and food preferences. Staff told us, and we observed, that in the morning staff told each person what is on the menu, and offer them an alternative if they do not like the option that is on the menu. Some people choose an alternative hot food option and others choose to have sandwiches at lunchtime instead, and their choices were accommodated. The food served looked hot and appetising and we heard people who used the service commenting to each other "That's nice… they do get you some nice dinners don't they?". We saw staff members encouraging people to eat and offering a choice of drinks. We also observed staff offering people who used the service drinks and snacks between mealtimes. People using the service told us "Staff come round and tell me what there is to eat. The food is fine, it's hot and there is plenty of it. They know what I like", "The food is nice" and "The food's alright."

We found that the record of residents special dietary needs in the kitchen was not up to date, but the cook had a good knowledge of individual dietary needs and preferences and told us the staff always kept them informed of any changes. They said that they would request an updated chart for the kitchen.

Peoples' care files contained a care plan regarding nutrition. We found that these were detailed, contained information about peoples' preferences and were regularly reviewed. People's weight was also regularly monitored. Staff told us how they supported people if they had lost weight, by offering higher calorie foods and cream in porridge for instance, and by using food supplements where required.

People were supported to maintain good health and access healthcare services. We saw evidence in care files of contact with other healthcare services, such as the district nursing team, physiotherapists and GPs. Two visiting healthcare professionals that we spoke with both commented positively about the service. One told us "I am very happy with this service. They [staff] always know what changes there are in people. They wait for my weekly visits before calling me in where possible, but would always call me in if really necessary. The staff are quick to notice symptoms and make suggestions about conditions". In addition "They always listen to my advice and act on it. There has never been a pressure sore for anyone here that I've known

about and I've been visiting for two years or so." The other healthcare professional told us "They follow things through; if I ask them to monitor bloods for instance, when I come back they will always have monitored them."

The home was made up of an original building with an extension that had been added at a later stage. Throughout the home the decor was very tired and the building was in need of renovation to make it a more pleasant and appropriate environment for older people including those with dementia. There were corridors with floors that sloped, areas of stairs carpet that were very stained, a number of bedrooms only had skylights so did not have much natural light. Where there was a join in a corridor carpet the registered provider had used appropriate florescent tape to secure the loose carpet for safety as an interim measure, but this meant the environment was not pleasant or homely in all areas of the home. A number of upstairs bedrooms could no longer be used because the stairs leading up to them was not wide enough for a stair lift. One bathroom had a shower that could not be used, because it was not appropriate for the needs of people who accessed the service. The toilet in this bathroom was in use though, and the sink in this bathroom was also used by the hairdresser one day a week for washing people's hair. This bathroom smelled of urine throughout the day of our inspection, which meant the hairdressing facilities were not pleasant for people using the service. The layout of the home was difficult to navigate and there was no evidence that dementia friendly design principles had been used in the design, decoration and adaptation of the premises. This is important because it can help people with dementia to orientate themselves.

The registered provider was fully aware of the issues with the decor and layout of the building and had plans for extensive refurbishment and re-design of the premises. They told us they intended to start renovation work on the current property as soon as the extension they had built had been completed and registered with CQC, so that people could move into the extension and enable the refurbishment to take place.

We recommend that the provider commences planned renovation work at the earliest opportunity, seeking guidance on current best practice, in relation to the specialist needs of people living with dementia.

Good

Is the service caring?

Our findings

People using the service told us "The staff are lovely; they do everything they can to help me", "The staff care about me" and "They are kind staff and they have a laugh with me". This and other comments made showed us that people felt comfortable with staff and that staff had built positive caring relationships with the people who used the service.

The interactions we observed between staff and people who used the service were positive and friendly. One person using the service told us "It's nice here, I have good friends." A visiting healthcare professional also told us "The staff seem caring".

Some people who used the service told us they had choice and control about their care and felt their views were acted upon. One person said "Staff listen to me and to what I am asking for" and another told us "I would be asked for my opinion about any changes". One person said that staff decided what time they got up and went to bed, but thought that they might have been asked about this at some point. Another person told us they were given sugar in their tea and they preferred it without; "You have to drink what you're given". We observed staff offering people choices, such as what they wanted to eat and where they wanted to sit. Staff responded promptly to requests made by people. There was a support plan involvement record within peoples' care files which detailed how the person wished to be involved in the planning of their care.

Nobody using the service had an advocate at the time of our visit, but the acting manager told us that many people had support from relatives or friends and they would support someone to access an advocate if they felt this was needed. One person using the service told us that they had children that lived close by and visited most days, and they had friends who visited. Another person told us "My family visit me sometimes. They are made to feel welcome and can have a cup of tea".

People using the service told us that their privacy and dignity was respected. We were told "They [staff] maintain my privacy when helping me to dress" and "When staff are there with me in the bathroom they are discreet". When we spoke to staff they were also able to explain how they respected peoples' privacy and dignity. They gave examples such as ensuring people were covered when they were bathed in bed, closing curtains when supporting people to change, and asking people about whether they wanted the staff to stay with them when in the bathroom. We observed that when staff were passing on information to each other about people, such as requesting assistance to support someone with personal care, they were discreet and respectful.

Staff told us they promoted peoples' independence by encouraging them to do things for themselves where possible. We saw examples of this in care files, where peoples' strengths and abilities were recorded. There was instruction to staff about which tasks people could do unaided and which tasks people required support with. For example, one person's file stated 'I am able to choose my clothes appropriately to the weather' and 'I will need the assistance of one member of staff to assist me to wash my lower body'.

Discussion with the staff revealed there were no people living at the service with any particular diverse needs

in respect of the seven protected characteristics of the Equality Act 2010 that applied to people living there: age, disability, gender, marital status, race, religion and sexual orientation. In the admission documentation in peoples' care files there was a section to identify any diverse needs and these were appropriately completed. We saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this.

We talked to staff about end of life care for people. Staff were able to describe the support provided and how they met peoples' needs. Staff demonstrated compassion; for example, by explaining how they had stayed late after their shift ended to provide additional support when someone was receiving end of life care. A visiting healthcare professional told us "The end of life care here has been very good; when I got here the other day they had already set up mouth care". Information about peoples' advanced wishes was recorded in the end of life care section of their care file.

Good

Is the service responsive?

Our findings

All of the people using the service had a care plan, and we saw that people had signed these to agree to the care and support documented. Files contained a support plan involvement record which detailed how the person wished to be involved in their care planning.

We saw that a pre-admission assessment was completed prior to people using the service. The assessment included details of known risks, such as any history of falls and any health needs for people. There was also an assessment of daily living skills.

We saw that care plans developed by the service were detailed and included lots of person centred information about peoples' strengths, needs and preferences. Care plans included information about people in relation to medication, mobility and falls, breathing, sight and hearing, continence, nutrition, wound care and skin integrity. We also saw information on sleeping, communication, general health and well-being, spirituality and end of life care, social interaction and the environment. Each section was broken down into three areas; the persons' needs, their goals and aims, and their plan of care, which detailed the support they needed from staff. Preferences were indicated throughout, such as an example in one nutritional care plan that stated 'I take my time with food and need time and patience to enjoy my meals. I tend not to like meats as I find it difficult to chew, so prefer not to have any'. Another person's file documented 'I prefer to take my bath in the evenings before going to bed'.

We could see from the records held that care plans were reviewed and updated regularly. The acting manager and staff all demonstrated a good knowledge of the people using the service.

The registered provider completed comprehensive person centred risk assessments for areas of specific risk, such as falls. These included consideration of risk from the person's perspective and asked the following questions: What is important to the person we support? What is important for the person we support? What have we tried, what have we learned? What are we pleased about? What are we concerned about and given what we know, what next? The assessments also considered whether there were any potential deprivations on someone's liberty, any known triggers and what support measures were in place. These person centred risk assessments were completed appropriately and reviewed monthly.

The registered provider employed an activities coordinator, who worked at the home three hours a day. We spoke to staff who told as about the range of activities provided, such as skittles, board games, bingo, crafts, discussion cards, dominoes, quizzes, sing-alongs, armchair exercise and tai chi adapted for people seated. We looked at activities logs kept at the service and these showed the activities taking place. The logs also included one to one support provided for people.

Whilst there was a range of activities taking place and the activities coordinator did take people out, some people indicated that they would like the opportunity to go out more; "I don't get out much" and "I would like to the staff to take me out more, to smell the air and go to the shops". We observed people taking part in activities in one lounge and having their hair done, as well as some individual support provided by staff for

those people who were in their bedrooms, but in the other lounge there was little activity taking place for periods of the afternoon. One person told us there was "Not much to do to pass the time".

There was a complaints policy and procedure in place. Records showed that there were no formal complaints or compliments about the service in the last year. People using the service told us they would be comfortable making a complaint if they were unhappy about something. People told us "I would tell any carer. I've never needed to here though" and "I'm not unhappy about anything". Another person said "I would tell any of the staff if I had a complaint but I haven't needed to".

We saw evidence of residents meetings taking place and residents told us "We have residents meetings now and again. I speak at them". Another told us "There are residents meetings but I don't go to them". We saw minutes of six residents meetings in the year prior to our inspection. People were asked their views about a variety of topics such as activities, laundry, food and cleaning. Feedback from the meetings was generally positive. We noted that a trip that had been discussed on two occasions over the previous year had still not happened. People had commented that they would have enjoyed a trip out. We discussed this with the acting manager who said they were still looking into this.

We looked at a satisfaction survey that was conducted with residents in 2015. There was no date on the survey responses but the acting manager told us it was conducted in approximately August 2015. People were asked a variety of questions and 13 people responded. Responses were generally very positive. There was also a visiting professionals' survey and a relatives' survey. Responses made were generally positive apart from some negative observations about the environment and the decor.

Our discussions with people who used the service, along with residents meetings and satisfaction surveys showed us that people were encouraged to share their experiences and had opportunity to raise any concerns. There was a system in place to respond to complaints.

Good

Is the service well-led?

Our findings

When we spoke to people who use the service they were generally positive about the service provided and people told us "It's nice here" and "We are well looked after".

We saw minutes of residents meetings and the findings of residents and relatives surveys which showed that people had opportunity to raise concerns or suggestions about the service. The findings of these surveys had been collated and analysed. We saw that action was planned to address issues raised, such as renovation and redecoration work. A staff satisfaction survey had also been conducted, which asked staff questions about their induction, staff meetings, training and support, access to policies, knowledge of how to whistle blow, and knowledge of the organisations aims and objectives. The results of this survey were all positive. Staff also told us "I love it here, it's very rewarding" and "We all get on very well and we like coming to work".

This showed us the service promoted a positive and open culture.

There was a registered manager in post at the time of our inspection. The registered provider had notified us that registered manager was on a period of extended leave, and that an acting manager was overseeing the home in their absence. The acting manager had worked at the home for several years as the head of care, so was very familiar with the daily running of the home. Comments from people using the service suggested that they did not have much interaction with the registered manager, but they spoke positively about the acting manager; "[Name] is nice". A visiting healthcare professional told us "[Name] is very hard working and has peoples' welfare at the heart of all they do."

The staff we spoke to said they felt supported by the acting manager; one told us "[Name] is absolutely fantastic; works really hard and does a good job". From our discussions with staff they were aware of their roles and responsibilities.

We saw evidence of team meetings and records of induction, supervision and appraisal meetings with staff, where feedback was given to staff on their performance. Staff told us that rotas were done every two weeks, and they got good notice of any shift changes. There was a management 'on-call' system, so staff could call for support out of hours if needed. The acting manager provided the on-call support, but told us that any times when they were not available alternative management on-call cover was arranged within the organisation.

The acting manager told us they kept abreast of good practice by attending training from the registered provider and from the local authority. They had also started their NVQ level five in management at the time of the inspection.

This showed us that there was good leadership and management of the service.

In addition to user satisfaction surveys there were a range of other quality assurance measures in place. The

provider conducted a yearly provider check on business management, service user care, health and safety management and quality improvement. Some areas of this overall assessment were overdue. There were quality assurance audits, which were conducted six monthly. We also saw a range of monthly and weekly audits. The acting manager audited all care files monthly, and a comprehensive kitchen check was completed monthly. Fire alarm tests, slings, hoists and water temperature checks were completed weekly, and a full health and safety audit was conducted every two months. We did note that an environmental audit did not reflect how tired and dated the decor was. We discussed this with the provider and acting manager, and they acknowledged that the environmental audit was completed positively because the building was as safe and as appropriately furnished as it could be considering the condition of the building at the time of our inspection, and that it was about to be renovated. They agreed to ensure that future audits fully and accurately recognised issues at the home.

We saw that an overall analysis of falls and accidents in the home had been completed up to August 2015, as this was part of the six monthly quality assurance audit, but this analysis did not identify that there was a pattern of unwitnessed falls in bedrooms. When we discussed this with the acting manager they said they would review this and look in more detail for any patterns across the home. This is important because it can help to identify any potential broader contributory factors to falls, such as poor lighting, sloped floors, trip hazards and availability of sufficient staffing.

We asked for a variety of records and documents during our inspection. Overall we found these were well kept and easily accessible.

This showed us that the service had quality assurance systems in place and that the registered provider was able to measure and review the delivery of care, although some of the audits, such as the falls and accidents audit, could have been used more effectively.

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 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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Mental capacity assessments and applications for Deprivation of Liberty Safeguards (DoLS) authorisations had not been submitted to the local authority for people we were told needed them.