Tinkers Hatch Limited

Tinkers Hatch

Inspection report

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12 October 2017

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Tinkers Hatch is a privately owned care home for up to 32 adult people with learning disabilities and/or physical disabilities. People lived in the 'main house' which accommodated up to 23 people, 'the cottage' which accommodated up to six people, a unit for up to two people and a unit for one person. At the time of inspection there were 29 people living at Tinkers Hatch.

There was a registered manager in post. 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 associated Regulations about how the service is run.

We identified a number of areas of record keeping that needed to improve to document more clearly the running of the home. For example, in relation to recording people's contributions to staff recruitment and in relation to fire drills. We saw some practices did not demonstrate a caring approach was always used. There were also some shortfalls in the management of medicines prescribed on an 'as required basis.'

We also saw very positive practices during our inspection. People's needs were effectively met because staff had very good training opportunities that enabled them to gain the skills they needed to do so. Staff were supported well with thorough induction, training, supervision and appraisal. People were supported to have choice and control of their lives and staff supported them in the least restrictive way possible.

Whilst most people had good communication skills, others needed support with communication and were not able to tell us their experiences, so we observed they were happy and relaxed with staff.

People had enough to eat and drink and had been involved in menu planning. Everyone was supported to maintain good physical and mental health. Appropriate referrals were made to health care professionals when needed and there were very good links with local health care professionals.

Staff had a good understanding of the care and support needs of people and had developed positive relationships. People told us they were happy with the support they received and with their day to day activities. They told us they knew who to talk to if they had any concerns or worries. There was a friendly and relaxed atmosphere in the home.

Staff had a good understanding of people as individuals, their needs and interests. Some people attended the onsite day centre, activities were also provided within the home daily. Good use was made of local facilities and amenities and external entertainment was provided regularly. People were supported individually to have their needs met.

There was good leadership in the home and the registered manager had an open door policy which staff valued. There was a good handover between shifts and staff were kept up to date on the running of the

home.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe

The management of medicines prescribed on an as required basis were not always safe.

Staff understood the procedures to safeguard people from abuse.

There were enough staff to meet people's needs safely.

Is the service effective?

Good

The service was effective

There was a very good training and supervision programme to ensure staff developed and maintained their knowledge and skills.

The registered manager and staff had a good understanding of mental Capacity assessments (MCA) and Deprivation of Liberty Safeguards (DoLS).

People were given choice about what they wanted to eat and drink and received food they enjoyed.

People were supported to have access to healthcare services and maintain good health.

Is the service caring?

Requires Improvement

The service was not always caring

Staff did not always treat people with respect and dignity

Staff knew people well and treated them with kindness and warmth.

Staff adapted their approach to meet people's individual needs and to ensure care was provided in a way that met their particular needs and wishes.

Is the service responsive?

Good

The service was responsive

People received support that was responsive to their needs because staff knew them well.

People were supported to take part in activities of their choice.

People's support plans contained guidance to ensure staff knew how to support people.

Is the service well-led?

Requires Improvement

The service was not consistently well led

Record keeping did not always clearly demonstrate the running of the service.

There was good handover system between shifts.

There were good systems to keep staff up to date with the running of the service.

Tinkers Hatch

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 checked 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.

We visited the home on the 10 and 12 October 2017. This was an unannounced inspection. The inspection team consisted of an inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who used this type of service.

During the inspection, we spoke with nine people who lived at the home, one visitor, the day care manager, administrator, a carer, two team leaders, the registered manager and deputy manager. We spoke with or received correspondence from five visiting health or social care professionals.

Some people were unable to speak with us. Therefore we used other methods to help us understand their experiences. We used the Short Observational Framework for Inspection (SOFI) at lunchtime on the second day of our inspection. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We considered information which had been shared with us by the local authority, looked at safeguarding concerns that had been raised and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. We also contacted the local authority to obtain their views about the care provided in the home.

During the inspection we reviewed the records of the home. These included staff training records and procedures, audits, three staff files along with information in regards to the upkeep of the premises. We also looked at five care plans and risk assessments along with other relevant documentation to support our findings. We 'pathway tracked' people living at Tinkers Hatch. This is when we looked at their care documentation in depth and obtained their views on how they found living at Tinkers Hatch. It is an

important part of our inspection, as it allowed us to capture information about a selected group of people living there.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at Tinkers Hatch. One person told us they felt safe because, "I like all the staff." They said staff checked on them at night to make sure they were ok." A number of people were able to tell us what they would do if the fire alarms sounded. One person told us, "We have fire training. I know where all the points are and where the assembly area is. If you are ill you can stay in bed if you need to, for as long as you need, staff keep coming in to check you." Despite these positive comments we found practices that were not always safe.

One person had an air mattress. These need to be set in line with people's individual weights and according to the manufacturer's instructions. There was no effective system to monitor settings. The registered manager told us the settings were monitored by a visiting health professional. However, this person's mattress had been set at 80Kgs but should have been set at 60Kgs and this left them at increased risk of pressure damage. The registered manager acted promptly and sought advice which confirmed the correct setting and agreement was reached the home would monitor the settings in future. A new form was devised to ensure the settings were recorded as having been checked daily.

The procedures for the management of medicines prescribed on an 'as and when required' basis (PRN) were not always robust. One person was prescribed two different medicines for constipation. There was guidance within the care plan about which medicine to use first and when to use the second medicine. We were told there was an expectation staff would read the care plan before giving PRN meds but on the medication administration record (MAR) it was noted on one occasion the second medicine had been used first. There was no evidence staff always checked if a second dose was required as prescribed. By the second day of inspection the PRN protocol had been adapted to ensure staff asked the person if they needed this medicine.

Another person was prescribed medicine PRN for agitation. The care plan included advice on when to give the medicine. However, the guidelines implied the medicine should be given if the person requested it. A staff member described the steps they would take to support this person to settle before giving this medicine. However, these steps were not described within the care plan. Immediately following the inspection a revised guideline was sent to us. This included input from the person who was prescribed the medicine on key phrases to be used to support them to be calm. The above areas are areas that require improvement.

With the exception of the PRN medicines all other medicines were given safely. Medicines administration records (MAR) showed people received their medicines as prescribed. Staff could not give medicines unless they had been trained and there was a policy to support staff to safely give medicines. There was a safe procedure for storing, handling and disposing of medicines.

We had been told there had been a number of medicine errors in the past 12 months. The registered manager felt they had got to the root of the problem, most were signing errors and there had been a marked reduction in the past three months. The home's pharmacy had recommended additional monitoring and a

new form had been devised to start this process.

Staff had an understanding of different types of abuse and told us what actions they would take if they believed people were at risk. All staff had received training in safeguarding. They told us if an incident occurred they reported it to the management team who were responsible for referring the matter to the local safeguarding authority. One staff member said. "I wouldn't hesitate." Where appropriate, matters had been reported to the Local Authority for further advice and support.

Some people needed regular reassurance from staff and there was always a staff member available to provide reassurance and guidance, where appropriate. Risks to individuals were well managed. Where risks were identified there were appropriate risk assessments and risk management plans. This helped people to stay safe while their independence was promoted as much as possible. Incidents and accidents were reported and investigated. Staff told us they felt confident to report any incident, and knew the registered manager would deal with it appropriately. Records confirmed when incidents occurred, there were support systems for the people involved and detailed records were kept that described the incident.

There were enough staff working in the home to meet people's needs safely. There were clear on call arrangements for evenings and weekends and staff knew who to call in an emergency. Staff told us there were enough staff to meet people's individual needs. We were told agency staff were used if there was a shortage but they always tried to use staff who knew the home so there was consistency for people.

People lived in a safe environment because the home continued to have good systems to carry out regular health and safety checks. All of the relevant safety checks had been completed, such as gas, electrical appliance safety and monitoring of water temperatures. There were robust procedures to make sure fire safety checks were carried out.

Good

Is the service effective?

Our findings

There were very good arrangements to ensure people's health needs were met. People had an annual health check-up with their local GP. One person whose surgery had no permanent GP had a health check up with a local nurse who had a specialism in learning disabilities. Everybody had a health and care passport. These identified the health professionals involved in their care, for example the GP, physiotherapist or dentist. They contained important information about the person should there be a need to go to hospital. People were supported to attend a range of appointments to meet their individual health needs. If a person had an identified condition there was information in their care plan giving advice about the condition and how it might affect the person. A health professional told us, "The home is very good. They are very risk averse. There is good communication. I always work with the keyworker when I visit and they are able to tell me about changes and what might work for a person."

One person had a fear of needles and did not like attending health appointments. To address this fear a staff member had been trained to take bloods and blood pressure readings. The registered manager told us for a period of time this was done in the home and then the person was taken to their local surgery where the same staff member carried out these procedures and gradually over a series of visits the tasks were transferred to the surgery staff who now carried out this role. The person was happy with the new arrangements.

Another person had been assessed as having problems swallowing. The local speech and language team had been consulted for advice and support. There was detailed advice within their care plan about how food should be served and the consistency of food. A health professional told is the home had been "Very good at engaging with a wider team of professionals around someone very complex needs."

Within a healthcare folder there was advice and guidance on a range of conditions and how they might affect a person. There was easy read literature to help explain procedures to people. This included laminated photographs to explain a step by step process to taking bloods and easy read information on particular medicines used. Training sheets were also available on taking blood pressures and how to assess people's weight in relation to their height. The folder was a very useful guide for staff to ensure they had key information but would also be able to explain difficult topics in a way people could understand.

A team leader had a designated role to induct new staff and to support them through the Care Certificate and through further health related qualifications. The Care Certificate is a set of 15 standards that health and social care workers follow. The Care Certificate ensures staff that are new to working in care have appropriate introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. We were told staff chose units to study that met their personal interests and the needs of the home. For example, some staff chose to study units on epilepsy and some autism.

There was a commitment to ensuring staff had the necessary skills to carry out their roles effectively. The training programme and records showed staff had completed all essential training. A number of staff were due to update training in several areas and where this was the case dates had been booked. Staff told us

they received training which included safeguarding, mental capacity and DoLS, infection control, management of medicines and food hygiene.

The home ensured a holistic approach was used to support people. A team leader had completed more advanced training on dementia and was now the home's dementia champion. They told us they had received training via the local authority on all aspects of dementia care for people with learning disabilities. This had included training on nutrition and hydration, meaningful activities, changing behaviours and medicines. Training had also been booked on communication. They told us they attended dementia forums. Through this they had been put in touch with the local in Reach team who they contacted for advice and support for one person who had complex health needs. (In Reach is a local NHS funded team who support providers to avoid unplanned admissions to hospital and avoid transfers to higher levels of care.) As part of that contact further advice was sought from pharmacy to look at prescribed medicines and reductions in medicines were made. The staff member told us they valued the input from all the various professionals and the positive impact this had for the person. A staff meeting had been held with the representative from the in Reach team to look what approaches worked and didn't work and the result was a more person centred approach to meeting the person's needs.

This team leader was also a champion in supporting people with hearing impairments. They told us they had completed training at a local NHS practice on all aspects of caring for hearing aids. They had put together a training pack for all staff so this training could be transferred to others. They supported people with annual audiology reviews and had booked an annual refresher course for next year. The result for people was that any faults in their aids could be addressed quickly without having to wait for appointments and because of the close links with the local practice it meant, where faults could not be addressed at the home, appointments could be arranged easily.

After our inspection we were told another team leader had the role of skin integrity champion. This was a role that was evolving but as part of regular pressure area care they ensured people had regular visual health checks, provided training in pressure care for staff and ensured relevant policies and procedures were kept up to date.

We were told when agency staff were used a check would be made that staff had appropriate skills and training to meet people's needs. A new app was being developed which would enable the registered manager to check this online before accepting staff.

One staff member had been chosen to attend a two day course on mental health and all team leaders and support leaders were expected to attend resilience training. Minutes of team leader meetings reflected the importance of taking time out following stressful situations to allow staff to talk through the stresses, what went well and what could have been done better.

Staff said they felt well supported with supervision and were comfortable to discuss any concerns or ideas they might have. A staff member told us, the registered manager was very supportive. They said, "If I had a problem I wouldn't wait till supervision I would discuss it with them at the time." Another told us, "Absolutely supported, all the senior managers are supportive."

People who lack mental capacity can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). The procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met and there was appropriate documentation. We were told a number of standard authorisations had been

applied for.

Staff had a good understanding of the MCA and DoLS. Staff told us they had completed online training on the subject. One staff member told us they were also doing a more advance course on DoLS. The legislation provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make decisions for themselves. There was information within care plans about how each person communicated their needs and wishes and staff described how each person made their needs known. Staff knew if people were unable to make complex decisions, for example about medical treatment, a relative or advocate would be asked to support them and a best interests meeting held to ensure all proposed treatments were in their best interests. Some people with specific health conditions had listening monitors in their bedrooms and where they could not give consent to these; best interests decisions had been taken and agreed with relatives and professionals. Following a best interest discussion between a health professional, relatives and the home a decision had been reached that one person should not have a surgical procedure and the reasons for this decision were documented. A professional told us when a best interest meeting was held, "The outcome was very good and we were all happy that everyone was comfortable about the decisions made. I would say that all my dealings with (Tinker's Hatch) have been co-operative and positive."

People had enough to eat and drink. There was a four week rolling menu that was varied, nutritious and well balanced. People had a choice of meal at each mealtime. Those living in the cottage and units had the same main meal as those in the main house. However, within the cottage people made their own breakfast and took it in turn to choose the evening meal each day. Pictorial aids were used for those who needed assistance to make choices. If people did not want the meal choice an alternative was provided. People's likes and dislikes were clearly recorded in their care plans. Staff regularly offered people drinks during our inspection.

One person told us, "Yes the food is good though sometimes the choices aren't good for me. Then they will make something different, you ask and they will make a salad or something. We get lots of choices." Another said, "We had a meeting with (staff) about the teatime meals we want in our house. We will be doing it every week." The menu for the coming week was on notice board in the kitchen, with two names against each meal to show who was to be supported to prepare it. One person told us, "I fry my own breakfast on Saturdays. I like the food and I like cooking it in the cottage."

Requires Improvement

Is the service caring?

Our findings

People were supported by staff who knew them well as individuals and staff were able to tell us about people's needs, choices, personal histories and interests. One person told us, "The staff are on your side, it's a good friendly environment, I think how lucky we are, the staff talk nicely to us. You see awful stories in the news about care homes, it would never happen here." Another person said, "I would always go to (staff member). All the staff are kind to everyone." A relative told us staff were very kind and caring. A visiting professional told us, "The staff team are very knowledgeable about their clients; they are caring and provide time to meet and discuss any issues." Despite these positive comments we found examples of where the care provided was not always caring.

One person had double aspect windows but no curtains. We were told curtains were on order and would be delivered the week after our inspection. We asked about privacy and dignity for this person and were told they had been offered temporary curtains but had refused them as they did not like the colours. We suggested that perhaps an alternative could be provided and this was done before our inspection was completed.

At the meal time in the main house it was noted a client was supported with their meal by a staff member who stood over them. If the staff member sat on a dining chair they would have been too low to give the person eye contact throughout the meal. There was very good interaction between the staff member and the person throughout the meal. However, consideration had not been given to finding a more appropriate seat that could have enabled appropriate eye contact. The above areas are areas that require improvement.

When we arrived at 'the cottage' a staff member spoke about one person in a derogatory manner and spoke to another person in a way that did not respect their dignity. We raised this with the registered manager who immediately said they would arrange additional training for this staff member to prevent a reoccurrence. Alongside these negative observations, we also observed a number of positive interactions and that people had a good rapport with this staff member. One person told us they would go to them first if they had a problem.

We also saw numerous examples of good support offered. For example, when supporting people with their meals staff asked people, "Would you like me to chop it for you?" We also saw a staff member sitting with a person and encouraging them to slow down with their meal to avoid the risk of choking.

The registered manager told us a previous staff member had taken photographs of places and local attractions within East Sussex and painted the murals in the corridors and main house. The murals added to the homeliness of the environment and people told us they liked them.

During our inspection we observed people were treated with kindness and compassion. There was a very relaxed and calm atmosphere in the home and cottage and staff had a good rapport with people. People were encouraged to personalise bedrooms to reflect their individual tastes and interests. One person told us

their room was due to be decorated. Advice had been sought about the colour scheme to accommodate their individual health needs. (Particular colours can be used to benefit people with sight loss to enable them to maintain and improve independence). However, this was in conflict with the person's wishes. Work was underway to find a more appropriate colour that would meet their needs and accommodate their wishes.

When one person needed immediate support with personal care a staff member provided a discrete explanation to the person and guided them to a private area where this was provided. Their calm and reassuring approach enabled what could have been a cause for embarrassment for others, to be dealt with quickly and with no loss of dignity.

Staff were able to tell us how they would ensure people's privacy and dignity was maintained. They said they knocked on people's doors and waited for a response before they entered the room. They told us they maintained people's privacy and dignity by always ensuring doors were closed when personal care was given. One person who spent most of their day in their bedroom and enjoyed staff popping in and out regularly, had a 'do not disturb' sign on their door that was used when personal care was provided to avoid being disturbed and to protect their privacy and dignity.

Good

Is the service responsive?

Our findings

People told us they knew who to talk to if they had any worries or concerns. A visitor told us, "I value the flexibility offered at Tinkers Hatch. I just need to email or ring and they will try their best to accommodate my relative's needs. I can relax now. In previous placements I couldn't, but since coming here I now know she is happy." They also told us, "Staff rang the physiotherapist for me and now (my relative) has been given equipment that has improved their mobility." One person told us, "I like games and music particularly. I go swimming on Thursdays; other groups go on different days. They give you lots of choice. You are always asked what you'd like to do and you can always say you don't want to join in something; you're not made to do anything. Sometimes they might push you towards an activity because it might be good for you, but you can always say no."

There was a range of documentation held for each person related to their care needs. They included detailed information about people's medical and support needs. We were told the deputy manager was responsible for updating the care plans. Staff said if they found anything was incorrect or had changed, they would let them know and it would be changed in the care plan. Care plans were reviewed regularly and annual reviews were held which ensured people, their relatives and professionals were kept up to date with the care provided. The records contained detailed information and guidance for staff about people's routines, and the support they required to meet their individual needs. People had the equipment needed to support their individual needs. For example, one person had been given orthotic boots to wear but they did not find them comfortable. As requested by the clinic, staff were encouraging their use for a short time every day to see if the person could get used to them. However, this was proving difficult so they enlisted the support of their local physiotherapist to resolve the problem.

Care plans were written in a person centred way. For example, for one person it stated the person had glasses but refused to wear them. Advice was included to encourage their use but also for staff to be more vigilant about the person's mobility and particularly when they moved from light to dark areas. Some people wrote their care plans with support from staff. One person wrote about the support they wanted to receive with their personal care. Another person wrote about the support they wanted to receive when they were anxious and to keep their bedroom clean. If a person had diabetes, their care plan included specific advice about diabetes and what a normal blood sugar range would be for them. It gave advice about what to do if readings were too low or too high. There was information to guide staff about how people communicated in each care plan. For example one person used Makaton signs and there were photos of the signs used within the care plan.

When new care plans were written a copy was placed in the care plan folder and a copy was also placed in a folder in the staff room. Staff were asked to read and sign the new care plan and this was not removed until all staff had signed. We were told this ensured staff who had been on leave had an opportunity to catch up quickly on all changes since they had worked last. Staff told us they found this system very useful for keeping up to date.

There was a building onsite dedicated for day services use. People had the choice to attend activities on a

daily basis if they chose to Monday to Friday. On a daily basis three to five additional people came from other settings to join the activities on offer. A programme of activities was drawn up each week. There were a number of structured activities including swimming, a transport group and a yoga group. Staff from the local college ran some groups from Tinkers Hatch. The drama group was working on a Christmas production and we heard a number of people talking excitedly about this as one of the highlights of the year.

The home had five cars/two seven-seater cars, one of which had been adapted to take wheelchairs. Some people were involved in an arts group in Lewes and there was a visit to a monthly event at the De La Warr Pavilion in Bexhill. We were told key workers helped identify with people options to explore, for example cinema or photography groups. Annual health reviews had identified a number of people where it was desirable to involve them in monitoring their own weights. Day services responded by setting up an exercise-based healthy living group. They also had a ball skills trainer who came in to do exercises with people.

A number of people from the main house had opted out of day service activities as they felt the day services were too lively. As a result, some groups had been set up in the main house. These included groups to discuss current affairs, reminiscence, literacy, which was also offered 1-1 for support with letter writing. Bingo was popular as a weekly fixture in both the day care centre and main house. Staff were available in the lounge and hall area at all times and supported people with their choice of films and TV programmes.

One person told us they knitted blankets for the local pet rescue centre. They said when they were finished they were taken to the centre to hand them over and were always offered a chance to stay for a drink and meet the animals, which they enjoyed. Another person told us they were supported to go to church regularly. There was a daily outing to cafes, shopping or places of interest.

We looked at activities that were carried out with one person who had dementia. There was a sensory muff with lots of different sensory objects sewed into to twiddle with. There was a memory box that contained objects that were important to them and a life story book that staff supported them to look at. We were told the person enjoyed listening to music regularly. We were told advice from the in Reach team had been to alter the room to enable the person to see the garden and to bring flowers in from the garden in the summer months. This had been done.

People told us they knew who to talk to if they had any worries or concerns. There was an easy read/pictorial version of the complaints procedure on display. The document would assist people who were unable to use the full complaint procedure to raise any concerns or worries they might have. Records demonstrated complaints raised with the home had been dealt with appropriately. Staff told us they would feel comfortable raising concerns if they had any. A relative told is, "I've not had any complaints but if I did I would feel comfortable raising them and I know they would be dealt with."

Requires Improvement

Is the service well-led?

Our findings

The culture at the home was open, relaxed and inclusive. The provider's mission was, 'To ensure the clients at Tinkers Hatch Ltd receive the best possible standard of care and support whilst promoting choice & independence through person centred support and advocacy.' We found people were happy and there was a warm atmosphere. There was a registered manager in post. People and staff gave very positive feedback about the registered manager. A staff member told us, "We are supported well and there are opportunities for us to develop as carers."

Despite positive work in this area we identified some shortfalls in record keeping. Most were addressed during the inspection process but additional time is needed to ensure they are embedded into everyday practise.

The last fire drill had been carried out in April 2017. The registered manager told us people had become complacent about regular fire drills. As a result a decision had been taken that the training company used would do role play with staff as part of their training instead. However, there was no assessment of how long it took to evacuate the building and as there was no evaluation of fire drills it was not possible to determine if staff knew what to do in the event of a fire.

Records were kept of all accidents and incidents that had occurred in the home. A record was kept of the likely causes and this was colour coded to assist with ongoing analysis of accidents and incidents. We were told actions were taken where appropriate, but these had not been documented.

One person's fluid intake was monitored daily. We noted the fluid intake was low. However, there was advice about various types of food that could be offered that had a high water content. Records did not always show fluids had been offered and declined. They also did not show if anyone had analysed the information to ensure the person had received enough fluids on any given day. By the second day of inspection the form had been adapted to show drinks offered and declined. Advice within the care plans stated this person should be turned regularly. Whilst it was evident during our inspection this was done there were no records to demonstrate this happened. On the second day of our inspection this had been put in place.

We asked what involvement people had in staff interviews. We were told all potential new staff were asked to work trial shifts. As part of this, an assessment was made of the new staff members interactions with people. We were told people were asked their opinions but these were not always documented and there was no method of recording people's views. We were also told there were some people, who with appropriate planning, could form part of the interview panel and ask questions. During the inspection a new format was designed to capture people's views both during and at the end of the staff interview.

People were not always protected, by a safe recruitment system. Personnel files included application forms, interview records, identification, references and employment history. Each member of staff had a disclosure and barring check (DBS). These checks identify if prospective staff had a criminal record or were barred from working with children or people at risk.

However, two staff had only one reference and we were told second references were being chased. One staff member's interview notes were blank and there was only one form of identification on file. This meant the provider had not carried out effective checks to ensure staff were of suitable character to work at the home. However, the registered manager was confident the systems for supporting new staff would mean a high level of supervision until references were received.

We recommend the registered provider seeks guidance on improving and strengthening record keeping demonstrating the running of the service.

There were ongoing plans for redecoration and refurbishment. At the time of inspection a bathroom was being converted to a shower room. There were plans to redecorate the lounge/hall in the main house. Quotes had also been obtained for the refurbishment and possible alterations to the cottage. Decisions on the preferred options had yet to be reached. We discussed the lack of kitchen/lounge area for three people. People told us they were happy with this arrangement and having their meals either in the main house or cottage. The registered manager confirmed this would be part of their ongoing development of the service but as yet no timescale had been set.

We recommend the provider consults with CQC, 'Registering the right support' document to ensure any planned or future alterations are in line with current guidance.

Detailed handover sheets were kept to ensure clear communication between shifts. This included information staff would need to know. For example, if someone had a seizure, or had been given required PRN medicines. There was also advice to staff to read through incident or accident records. Staff meetings were held regularly. A staff member told us, "Staff meetings are an open forum. We can all say what we want and make suggestions if we think things need to change."

People's views were sought through a variety of means. There were regular 'Ideas group meetings' where people got together to look at options for activities and meals. We also saw through this process people were kept up to date on matters such as current affairs and matters related to the running of the home. Recently the service had started working with a local advocacy group who had started joining the 'Ideas group.' The purpose of the involvement was to enable people to have an independent avenue to have their voices heard and to have a say about the service they received and the environment they lived in. The registered manager told us the advocacy group would also carry out an independent survey seeking people's and relatives' views of the service.

The owners had contracted with an external consultant to carry out a care safety and compliance audit. This had been carried out in July 2017. A small number of recommendations had been made. The actions had not been signed off as completed but the registered manager was able to tell us about the actions taken.

Audits were carried out in relation to medicines and in relation to the kitchen. The home's champion on infection control had recently completed an infection prevention and control practitioner's course. We were told five hours had been delegated every two weeks to ensuring audits would be carried out in relation to infection control. This was due to be started.

The home sent notifications to the CQC when appropriate. A notification is information about important events which the provider is required to tell us about.