Sutton Nursing Homes Limited

Orchard House Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 30 January and 2 February 2017 and was unannounced. At our last comprehensive inspection in January 2016 we found one breach of regulations in relation to good governance. When we carried out a follow-up inspection in June 2016 we found the provider had made the necessary improvements and the service was meeting legal requirements.

Orchard House provides accommodation with nursing and personal care for up to 44 people. This includes palliative and end-of-life care. At the time of our inspection there were 35 people using the service.

The service was required to have a registered manager in post but did not have one at the time we carried out this inspection. However, the home did have a manager who had recently been the registered manager at another service operated by the same provider and was in the process of applying to become the registered manager at Orchard House. 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.

At this inspection we found three breaches of regulations in relation to safe care and treatment, safeguarding service users from abuse and improper treatment and good governance. Some taps in handwashing sinks produced water that was hotter than the maximum safe temperature. Chemicals were not always stored securely and in appropriately labelled containers. Some risks around people's use of the garden and the storage of large pieces of equipment in bathrooms were not assessed and managed appropriately. There was not a robust system in place to monitor and check stock levels of some medicines, meaning errors or unauthorised removal of medicines could go unnoticed. Additionally, we found that some people may have been deprived of their liberty without the correct legal safeguards in place because the provider had not always followed legal requirements in relation to this. The provider had quality checks but they were not robust enough because they had not identified these problems.

You can see what action we told the provider to take at the back of the full version of the report.

The provider had systems in place to protect people from the risks of infection and poor hygiene, including food hygiene. People had individual risk assessments and management plans to help protect them from risks specific to them and the care they received. Staff received appropriate training around safeguarding people from abuse and there were procedures in place to enable staff to identify and report possible abuse promptly.

There were enough staff to keep people safe, although some people and staff felt there were not enough to spend meaningful amounts of social time with people. There were systems to review staffing levels and ensure they remained safe. The provider had robust recruitment systems to help protect people from the risk of being cared for by unsuitable staff.

Staff obtained people's consent before carrying out care tasks. Where people did not have the capacity to consent, the provider confirmed this by carrying out capacity assessments and involved families and other professionals involved in people's care to help ensure decisions made on their behalf were in their best interests.

The provider gathered information from a variety of sources to help staff keep up to date with current research and best practice. Staff had access to the training, supervision and support they needed to carry out their roles effectively.

People were able to choose from a variety of suitable, nutritious food and drink that met their needs. Staff monitored people's weight and other health indicators when needed, using the data to inform them when they needed to support people to access health services. People had regular access to healthcare professionals for check-ups and appointments. Staff shared information when needed to help them monitor people's health and wellbeing.

Staff spoke to people in a kind and respectful way, although sometimes they talked about people's private matters within earshot of others. People's personal records were not always stored securely to maintain confidentiality. However, staff knew how to promote people's privacy, dignity and independence while providing personal care.

Staff used appropriate communication styles, knew people well and had built friendly caring relationships with them. They knew about people's likes and dislikes and supported people to make choices about their care.

Staff assessed people's needs and produced personalised care plans that took into account people's wishes, preferences, religious and cultural needs, healthcare needs, what they could do for themselves and what they needed more support with. The service worked to ensure smooth transitions when people moved between services, particularly with hospital admissions. The service worked well with other providers to ensure people's needs were met and that staff had access to any expert advice they required to meet people's needs effectively.

Although activities were provided, some people who remained in their bedrooms during the day did not have access to these and some people did not feel they had a choice of activities corresponding with their interests and needs. We recommend that the provider seek appropriate guidance on providing person-centred activities for the people who use the service.

The service had an accessible complaints policy and there was evidence that managers responded appropriately to people's concerns. The provider carried out an annual survey to gather people's feedback and this was used to improve the service. The feedback we received about the manager was positive and the service had an open culture where people, relatives and staff had opportunities to express their opinions about the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. Some risks presented by the environment were not managed appropriately and there were not robust systems to ensure safe medicines management. People's individual risks were assessed and managed.

There were systems in place to safeguard people from abuse.

There were enough staff to keep people safe and systems were in place to help ensure suitable staff were recruited.

Is the service effective?

Requires Improvement

The service was not always effective. The provider did not always adhere to legal requirements around depriving people of their liberty as part of their care.

Staff obtained people's consent before providing care or, if they were not able to consent, followed appropriate procedures to help ensure decisions about care were made in people's best interests.

People were able to choose from a variety of nutritious food and had access to the healthcare services they needed.

Staff received the training and support they needed to carry out their roles.

Is the service caring?

Requires Improvement

The service was not always caring. Staff sometimes discussed people's private information in front of others and personal records were not stored securely.

People benefited from positive caring relationships from staff who knew them well and communicated effectively. They received the information they needed to make choices about their care.

Staff worked to promote people's dignity and independence when providing personal care.

Is the service responsive?

Requires Improvement

The service was not always responsive. Although the service provided a variety of activities, some people did not have access to suitable activities and we have made a recommendation about this.

People had personalised care plans that met their care needs and took into account their preferences, likes and dislikes and their cultural and religious backgrounds.

There were procedures in place to deal with people's concerns and complaints.

The service worked to facilitate smooth transitions when people moved between the home and hospital.

Is the service well-led?

Requires Improvement

The service was not always well-led. There was a range of audits and checks to monitor the quality and safety of the service but these did not identify the problems we found in relation to safety.

People knew who the manager and senior staff were and there was an open culture where people, staff and relatives were comfortable expressing their opinions about the service. The provider regularly sought people's feedback and used it to improve the service.

The service worked effectively with other providers to facilitate joined-up care.

Orchard House Nursing 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 on 30 January and 2 February 2017 and was unannounced. It was carried out by two inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. This expert-by-experience had experience as a family carer of older people, including those living with dementia.

Before the inspection we reviewed information we held about the service. This included reports from previous inspections, feedback we received from people and their relatives via our online feedback form and notifications the provider is required by law to send to us about significant events that take place within the service.

During the inspection we observed how staff interacted with the people who used the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also undertook more informal observations of people's experiences of using the service. We looked at five people's care plans, five staff files and other records relevant to the management of the service such as staff rotas and maintenance records.

We spoke with nine members of staff plus the manager, three relatives or friends of people who used the service and six people who used the service. We also contacted two external healthcare professionals involved in the care of people using the service to ask for their views about the service.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe using the service. One person said, "I absolutely trust the staff. It's them that make me feel safe." Another person told us, "My call bell is always in reach so I know that I can get hold of someone." Relatives told us they felt "confident" that their family members were safe at the home.

However, despite the positive feedback we received, we identified some risks to people's safety. We checked the temperature of hot water from several outlets around the home. Hot water taps on the hand basins in two toilets to which people who used the service had access were running at above the maximum 50°C reading on the thermometer we used. This is above the temperature recommended by the Health and Safety Executive in their guidance, "Managing the risks from hot water and surfaces in health and social care". If people are exposed to hot water above 44°C for either washing, showering or bathing, they are at increased risk of serious injury or fatality.

Most cleaning chemicals and other hazardous substances were locked away securely to prevent people coming into contact with these. However, we found three utility rooms with open pots containing an unidentified, unlabelled blue liquid that smelled like bleach. The rooms were either unlocked or secured only with bolts and therefore potentially able to be accessed by people. The rooms also contained unsecured bottles of disinfectant, air freshener and in one case a basket containing a number of cleaning products including a toilet cleaner. Although there were risk assessments covering each individual chemical used in the home, these did not cover substances being stored in this way. People were therefore at risk of harm through coming into contact with hazardous chemicals as this risk was not appropriately managed.

There was enough suitable equipment to meet people's needs, such as hoists, adapted baths and wheelchairs. Equipment was checked and serviced regularly in line with manufacturers' instructions. However, we noticed that bathrooms were cluttered and sometimes difficult to move around in because they were used to store hoists, wheelchairs and other large pieces of equipment. There was no risk assessment in place and people may have been at risk of injury if they were to trip or fall on the equipment because the risk was not being managed appropriately.

The home had a large garden that people could access freely. However, there were a number of hazards to people's safety. Paving stones were uneven, which increased the risk of people tripping and falling. There was a raised walkway approximately one metre high, which had no railing and so there was a risk that people could fall off and become injured. We also found an unguarded barbed wire fence in a secluded area of the garden and some electric wiring that was loosely attached to a wall alongside some steps and so it could be removed or damaged if people pulled on it. The manager told us they did not currently have a risk assessment for use of the garden and this meant risks to people's safety through use of this facility may not have been managed adequately. However, the manager sent us evidence that a new fence was erected after the inspection to prevent people from coming into contact with the barbed wire.

Most people received their medicines in blister packs that corresponded with a four-week medicines cycle. This meant it was easier for staff to check stock levels and prevent administration errors. However, there

were no central stock records to cover other medicines that the home received in their original packaging and this meant for some medicines we were unable to verify whether the amount currently in the home was correct and whether people were receiving their medicines as prescribed. There was therefore a risk of these medicines being misplaced or misused, or of staff making administration errors, without staff noticing.

The above paragraphs demonstrate that the service was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home environment was visually clean and was fresh-smelling. Bathrooms were equipped with handwashing materials. Staff used colour coded bags to identify clinical and hazardous waste and this was kept securely, separate from other types of waste. We also noted that staff completed infection control training. This helped to protect people from the risks of acquiring infections from hazardous materials or poor hand hygiene. However, we also noticed some baths had fibre board side panelling that was difficult to clean thoroughly and we also saw some cracked grouting and chipped paint in bathrooms, which could harbour micro-organisms. The manager said they would consider this when planning refurbishments. We also noticed that some equipment stored in bathrooms was dusty despite staff completing a monthly cleaning check of all equipment.

We found evidence that staff took appropriate food hygiene precautions when storing, preparing and serving food. This included checking that the kitchen area was clean and that food was stored and served at safe temperatures.

Several people and some staff felt staffing levels were sometimes too low to allow for meaningful interaction with people. One person said, "You can wait ages for a bell to be answered. It may be something trivial but they don't know that it's not really important. Nobody has time to stop for a chat anymore, they are just here to 'do'. I am on my own most of the time." However, this person also told us they were comfortable with the situation and people did not feel staffing levels were unsafe. The manager reviewed staffing levels on a daily basis based on people's current needs and whether there were any new admissions. The manager told us they also sent a three monthly report with various data about the home to the local healthcare commissioner, who analysed the data to check the home was meeting their guidelines for staffing for people receiving nursing care. The service used a staffing agency to provide cover where needed, although the manager told us this was rare.

Staff said they were kept up to date with training around safeguarding people from abuse and were able to describe the signs of abuse and action they would take. We saw evidence that, where people made allegations of abuse, the provider acted appropriately and reported the allegation to the relevant authorities in line with their safeguarding procedures. Where necessary, they took appropriate action to prevent the incident happening again.

Medicines records were up to date and showed people received their medicines as prescribed. Controlled drugs were managed and stored safely. There were appropriate stock records for these medicines showing the amount of each that should be present, which corresponded with what we found.

Other risks were appropriately managed. One person told us, "They keep us safe by having regular fire tests and they change the day so that staff aren't expecting the alarm to go off." Upper floor windows were fitted with suitable restrictors to prevent people from falling through windows. People had individual risk assessments and management plans for the risks that were specific to them. These were updated at an appropriate frequency or sooner if needed in response to changes in people's needs. The risks that were assessed included those associated with moving and handling, falls, use of bed rails, pressure ulcers,

malnutrition and choking. We saw evidence that appropriate measures were in place to help prevent people from coming to harm through these and staff we spoke with knew how to follow them. Where people did develop pressure ulcers, staff followed wound management plans and consulted appropriate professionals. When one person had multiple falls within a year, staff updated their risk management plan and care plan to reflect newly identified risks.

The provider carried out appropriate checks on new staff as part of the recruitment process. This including obtaining evidence of their qualifications, identity and right to work in the UK, criminal record checks and evidence of fitness to work. This helped protect people from the risks of having unsuitable staff providing care and support to them.

Requires Improvement

Is the service effective?

Our findings

As part of this inspection, we checked whether the provider was meeting the requirements of the Mental Capacity Act (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). 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.

We saw that the provider had applied for and obtained DoLS authorisations for several people. Where relevant, the provider was meeting the conditions of the authorisations. One person, who had previously been able to consent to receiving care at the home, no longer had capacity and the provider promptly applied for a DoLS authorisation as the person was unable to consent to staying at the home. However, some people were already living at the home when the applications were made. The DoLS Code of Practice states that if it is not possible to obtain a DoLS authorisation before the person is deprived of their liberty, the provider must put in place an urgent DoLS authorisation while they wait for the authorising body to carry out their assessments. Because this was not done, people may have been deprived of their liberty without the correct legal safeguards in place.

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed that when staff carried out care tasks they always asked for people's consent first. Staff understood they should not provide any care people did not consent to first unless it was established that they did not have capacity and the care was agreed to be in their best interests.

We saw that when people started using the service, staff assessed their capacity to consent to the proposed plan of care. They repeated these assessments at regular intervals or if there was any reason to believe people's capacity had changed. Where people did not have capacity, the provider followed the appropriate procedures, such as holding meetings with others involved in people's care to determine whether any proposed care and treatment was in their best interests. We saw evidence that GPs and other medical professionals were involved in healthcare decisions people did not have the capacity to make for themselves. Where people had others who were legally authorised to make decisions on their behalf, there was documentary evidence that this was the case.

The service has been implementing some of the learning that has arisen from the Vanguard initiative in the London Borough of Sutton. This was an approach to the provision of care for people in care homes designed to reduce hospital admissions, shorten hospital stays, facilitate joined-up healthcare, improve

health outcomes for people and ease transitions between services. The manager told us this had been helpful in keeping up to date with best practice in nursing care as it gave them regular opportunities to speak with healthcare providers and nursing home managers and to attend best practice meetings. Information about good practice in nursing care was displayed in staff areas. This included reading materials about pain management, end of life care and safeguarding people from abuse.

We saw evidence that staff received a variety of training relevant to their roles. New staff received an induction and a variety of training courses, after which they undertook a competency assessment and were required to retrain if they did not pass. Other training included specialist training from a local healthcare commissioner to help ensure staff were familiar with specific health related issues. A healthcare professional confirmed that staff had undertaken some specific training relevant to the healthcare needs of people using the service and told us the training was effective. The manager told us about a weekly training session they led, which all staff were able to attend when they needed refresher training.

The manager told us they had not yet carried out staff appraisals as they were still relatively new in post and wanted to get to know the staff team better as they believed this would make the process more effective. However, there was a clear plan for when these would take place and staff were receiving regular one-to-one supervision to help support them to carry out their roles.

People and their relatives and friends told us the food was of a good standard. One person said, "There's plenty of food, often the portions are too large, quite a variety. I choose to eat in my room and it's always a good temperature." Another person told us, 'I like the meals. I need help but they never rush me'. A relative said, "The food is very good. [Person] gets support with eating and it's wonderful." The day's menu options were displayed where people could see them and we observed staff offering people the two choices at the mealtime. Although one of the choices differed slightly from the displayed menu, people said they were happy with the options they were offered. Throughout the inspection we noticed that a variety of cold drinks was always available in communal areas. Staff monitored people's food and fluid intake when required, weighing people regularly to help ensure they were getting enough to eat and taking appropriate action if people showed signs of malnutrition or weight loss. We spoke with the chef, who was aware of people's diverse needs and preferences in relation to food and drink. They gave examples of new dishes they had offered to give people the opportunity to try something new or in response to people's requests. For example, we heard one person telling the chef on the first day of our visit that they would like a steak and on the second day the chef was able to show us some steak they had bought for that person and others.

We observed how staff handed information over between shifts. They talked about how people were, any signs or symptoms of ill-being or ill health and what they did in response. This helped staff consistently monitor people's health on a daily basis. People told us they had access to the healthcare services they needed to use, such as dentists, chiropodists and mental health services. Records confirmed this was the case. One relative said their family member had regular reviews for their long-term health condition and this helped staff meet their needs as they changed over time. Staff used screening tools to help them decide when people might have specific health conditions or require additional input from healthcare providers, such as for depression or urinary tract infections.

Requires Improvement

Is the service caring?

Our findings

People told us staff were thoughtful, caring and helpful. One person said, "When it was my birthday the staff brought a birthday cake in and joined the celebrations. I was so appreciative of their kindness." Another person told us a particular member of staff "is very special and listens to me." A third person told us how staff had reassured them when they were worried about a loved one not turning up for a planned visit and said, "That's real care. I was so grateful." Relatives told us, "The staff are very accommodating and accepting. They are all brilliant. 10 out of 10," "Nothing is too much trouble. They are like a family. They care for [our relative] like a member of their own family" and "The care and compassion staff showed helped us through a very difficult time."

Staff did not always demonstrate a full understanding of confidentiality. We observed that staff kept people informed about what they were doing, especially when carrying out care tasks. However, on occasions they did this in such a way that others could overhear personal information that might embarrass people. For example, twice we heard staff telling people within earshot of other people using the service that they were going to help them change their continence pads. One person told us a particular member of staff had a loud speaking voice and this meant that "everyone knows everyone's business." We also noticed that staff did not observe the principles of confidentiality in terms of written information because care plans and people's other personal information were kept in cupboards that did not have locks. The cupboards were in a part of the home that was accessible to all through communal areas and we observed that there were not always staff there. This meant there was a risk that people's privacy might be compromised in relation to their personal information. We discussed this with the manager, who told us they would speak with staff about this and would also review their policies in relation to the storage of confidential personal information.

We noticed that several people were in bed, apparently asleep, with their doors open. Staff told us people had a choice about whether their doors were left open or closed. However, people we spoke with said they were not offered this choice although they did not mind the doors being open. We discussed this with the manager who told us they would revisit this with people to ensure they were aware of their choices.

Staff told us how they got to know people when they moved into the home. They spoke with people as much as possible to find out about their likes and dislikes, hobbies and interests, what was important to them and what made them happy. We saw staff chatting with people throughout the inspection, asking them about their family members and talking about their likes and dislikes. For example, one member of staff asked a person what their favourite biscuit was and made a note to offer them that type in future.

Staff also gave examples of different ways of communicating with different people, such as using visual prompts for a person who was deaf. We observed staff adjusting their communication styles when speaking to different people. This helped ensure that everyone understood key information and felt valued by staff. One example was a person who staff told us had problems with short-term memory. We observed that staff reintroduced themselves each time they spoke with the person as the person may not have been able to retain the information. They also helped orient the person to time, for example by telling them what time it

was and then saying they had brought their supper and that it was their third meal of the day. We also noticed that staff used humour to make interactions more pleasant for people. They regularly checked that people were comfortable, asking if they needed the toilet or anything to drink and if people showed signs of discomfort staff asked if they were in pain.

We observed staff giving people information to help them make decisions about their care, such as what to have for lunch. They took time to list all of the options of main and side dishes and waited for people to make their decisions. We also saw evidence that people were offered choices during the care planning and review processes, such as whether they preferred male or female staff to support them with personal care, and their choices were noted in the care plans.

A healthcare professional gave us an example of how staff had planned a person's care around their choices, wishes and preferences. The home had a service user guide that contained a variety of information to help people make choices about their care. This included information about safeguarding procedures, complaints, staffing, activities, laundry and other facilities. Each person had a copy of the guide and some were also available in communal areas.

People told us staff promoted their privacy, dignity and independence while supporting them with personal care. Staff gave examples of how they did this, for example by checking doors and curtains were closed and covering parts of people's bodies that were not being washed. Staff told us they encouraged people to retain as much of their independence and daily living skills as possible and always allowed people to do things for themselves if they could. We saw that care plans were designed to facilitate this with information about what people could do for themselves and instructions for staff to encourage people to do these things.

Requires Improvement

Is the service responsive?

Our findings

An activities timetable was displayed in a communal part of the home. During the inspection, we observed various activities taking place such as singing, quizzes and individual manicure sessions. Activities equipment such as board games and craft materials were available in a large cupboard. Where people declined to take part in activities or preferred to spend time in their rooms, they had care plans instructing staff what support to give them so they did not become bored or isolated. However, we did not see evidence that people received this support and some people and staff felt the amount and variety of activities could be improved. One person said, "Nobody brings any activities to my room or asks what I might like to do." Another person told us, "There used to be someone who came in to do things with me and that was lovely, but that doesn't happen any more. It can be very boring." Other people said they were happy to take part in the activities that were offered but they did not always have opportunities to pursue activities relevant to their own interests or personal tastes.

We recommend that the provider seek appropriate guidance on providing person-centred activities for the people who use the service.

A relative told us, "We didn't look anywhere else after we saw Orchard House because we were very impressed." Staff carried out a pre-admission assessment for each person before they moved into the home. This involved collecting information about their or their representatives' views, life history, preferences and care needs. Relatives confirmed they were involved in this process and we saw documentary evidence of this. One relative told us, "The manager asked us what we hoped for them to achieve with our [family member]." This information was used to create personalised care plans, including areas such as nail care, continence, cultural and religious support, communication and personal care. These covered details such as what equipment staff should use and how, so staff had all the information they needed to provide the care required. Staff also carried out detailed pain assessments to help them meet people's needs in this area. Care plans were regularly reviewed to ensure they remained up to date with people's changing needs.

Three people moved into the home during the week of our inspection. We observed the manager speaking with staff about those people's main care needs and asking staff to read their care documentation so they were able to respond appropriately to people's needs.

We saw that care plans took into account people's preferred routines, favourite foods and drinks, favourite ways to spend their time, any emotional support they needed and their day-to-day support and healthcare needs. One person required support to meet their psychological and emotional needs and their care plan instructed staff to allow the person time to talk about their emotions, encourage them to take part in activities and socialise and to encourage their family to visit them when needed. People with long-term health conditions such as diabetes had detailed care plans to instruct staff how to support them to manage their conditions. Staff also created care plans for specific short-term needs, for example for one person who was anxious about moving into the home and needed support to manage this.

People had visits from religious leaders, if they wanted it. Where people's religion was a significant part of

their lives they had care plans covering the support they required to meet their religious needs.

During our inspection, the home had a visitor from an organisation that trains care staff to use music as a means of communicating with people who are living with dementia, have had strokes or have other conditions that affect communication. Staff told us the visit was very good and they believed the work would help them better understand how to respond to the needs of people living with dementia.

People said managers and senior staff were responsive to their concerns. We saw examples of concerns people and their relatives had raised and records of the action the provider took to resolve them. The service had not received any formal complaints since our last inspection. However, the complaints policy was on display where people and their visitors could see it and people had accessible information in their rooms about how to complain.

Relatives told us staff facilitated smooth transitions between the home and hospital. One relative said the manager had worked hard to resolve a problem that had come up with their family member's transfer. Staff were aware of what information they needed when a person returned from hospital. They used the 'red bag,' which was a local initiative designed to ensure that people had all the paperwork and information, personal possessions, toiletries, medicines and other things they would need in hospital. This helped to make hospital transfers easier as it used standardised documentation so hospital staff could easily find the information they needed about the person before and during their stay.

Requires Improvement

Is the service well-led?

Our findings

The manager assessed and monitored the safety and quality of the service through a variety of methods. There was a system to identify trends in accidents and incidents, for example if the same person had several falls. They checked hoists and lifting equipment regularly and ensured these were serviced in line with manufacturers' instructions. There were also monthly fire drills and the provider noted any issues and action they took to resolve these. The provider carried out clinical audits, which included checking care plans every three months and medicines management every six months.

However, the provider's safety checks were not sufficiently effective to identify the issues we found during our inspection. Medicines audits had not identified the lack of a reliable system to keep track of medicines stocks. Although there were risk assessments for hazardous chemicals kept at the service, these had not identified that they were not always stored securely or appropriately labelled in their original containers. Daily temperature checks of hot water tanks did not include temperatures of water from outlets and so had not identified that two taps were producing dangerously hot water. The provider's checks had also not identified our concerns in relation to DoLS applications, confidentiality and person-centred activities. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with knew who the manager and senior staff were and told us they were comfortable speaking to them with any feedback they had. One person told us, "I would be very happy to speak to [the manager and senior member of staff] and would be sure that they would sort any problems." Another person said, "I have great confidence in [the manager]." Relatives told us the manager was "very good," "wonderful" and "keeps us informed at all times." They said the culture of the home was inclusive and they felt they were part of their family members' care. One relative said, "You can talk to [management] about anything." Staff said there was a fair and open culture and they were able to express their views. They said the provider's values were clear and teamwork was good.

Although the service had recently changed managers, staff and external healthcare professionals felt the change was positive and spoke highly of the new manager, who was previously the registered manager at the provider's other service. When speaking to the manager and observing their interactions with people, we found they were familiar with people who used the service and aware of their needs, communication styles and preferences.

The manager told us they had not held a residents' meeting as they had only been in post three months and wished to get to know people better first. However, the provider had used other methods of seeking people's views and feedback, including a survey that took place in October 2016. We reviewed the results of the survey and found they were positive with most people describing the service as excellent or very good overall.

We observed the manager asking the opinions of staff about an issue to do with one of the people using the service. They listened to what staff said and welcomed suggestions. The manager later told us they involved

staff as much as possible in problem solving and care planning to help ensure that staff understood the reasons behind planning care in particular ways and to help ensure all staff responded to people in a consistent way. They also told us it helped staff to understand complex processes such as making decisions on behalf of people who did not have capacity, which they felt was important for staff to know about.

Relatives told us the manager was a "strong link" between the home and other services such as tissue viability nurses, diabetes nurses and GPs and that the standard of information sharing was high. A healthcare professional told us the home made regular contact with them to discuss people's needs and that the service worked well with the healthcare provider to get people out of hospital more quickly. Another healthcare professional told us the service had been working well with a GP to agree protocols for administering certain medicines. We saw evidence of contact between the home and local authorities who placed people there, to discuss how their placements were going and whether the home was suitable for them.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not provide care and treatment in a safe way for service users. They did not ensure the premises were safe to use for their intended purpose or the proper and safe management of medicines. Regulation 12 (1) (2)(d)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not ensure service users were not deprived of their liberty for the purpose of receiving care or treatment without lawful authority. Regulation 13 (5)