Seymour House Residential Care Homes Limited

Seymour House-Northwood

Inspection report

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Northwood
Middlesex
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21 November 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?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This comprehensive inspection of the service took place on 16 and 21 November 2017. The visit on 16 November was unannounced and we arranged with the registered manager to return on 21 November to complete the inspection.

Seymour House Northwood is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The care home does not provide nursing care and accommodates up to 36 older people in one purpose-built property. Most of the people using the service are living with the experience of dementia. When we inspected, 33 people were using the service and three people were in hospital.

The service has a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider had systems in place to keep people safe but some care staff did not fully understand these. This was because some care staff had difficulty reading and writing English. The provider and registered manager had taken action to identify English language classes for care staff and made arrangements for staff to support each other with the recording of the care they provided to people.

There were enough staff to meet people's care and support needs and the provider carried out checks on new staff to make sure they were suitable to work with people using the service. However, they did not assess applicants' ability to communicate orally and in writing in English as part of their recruitment processes.

People received the medicines they needed safely and as prescribed. The provider assessed people's healthcare needs and gave staff guidance on how to meet these. The service had good links with health care professionals and referred people to specialist services when needed.

The provider carried out checks on health and safety in the home and took action when they identified areas they needed to address.

Staff had the training and support they needed to care for people using the service.

The registered manager had a good understanding of their responsibilities under the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. The provider did not deprive people of their liberty unlawfully.

People told us they enjoyed the food provided in the service. There was a varied choice of nutritious food and drinks.

People using the service and their relatives told us the care staff who looked after them were kind and caring. We saw staff were kind, caring and gentle with the people they supported. We saw they allowed people time to make decisions and offered them choices. People using the service told us that staff respected their privacy.

The provider assessed people's care and support needs and developed person-centred care plans to meet these.

People told us they had access to and enjoyed the activities provided in the service.

People using the service and their relatives knew how to raise concerns and they told us they were confident the provider would take these seriously.

The provider had appointed a qualified and experienced manager who was registered with the Care Quality Commission. Staff told us they found the manager accessible and supportive.

The provider carried out regular monitoring visits to the service and developed an action plan to address issues they identified. The registered manager and staff carried out regular checks on quality in the service and identified improvements they needed to make.

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

Not all aspects of the service were safe.

The provider had systems in place to keep people safe but some care staff did not fully understand these.

There were enough staff to meet people's care and support needs and the provider carried out checks on new staff to make sure they were suitable to work with people. However, they did not assess applicants' ability to communicate orally and in writing in English as part of their recruitment processes.

People received the medicines they needed safely and as prescribed.

The provider carried out checks on health and safety in the home and took action when they identified areas they needed to address.

Is the service effective?

Good

The service was effective.

The provider assessed people's care needs before they used the service.

Staff had the training and support they needed to care for and support people using the service.

The registered manager had a good understanding of their responsibilities under the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. The provider did not deprive people of their liberty unlawfully.

People told us they enjoyed the food provided in the service.

The provider assessed people's healthcare needs and gave staff guidance on how to meet these.

Is the service caring?

Good

The service was caring.

People using the service and their relatives told us the care staff who looked after them were kind and caring.

We saw staff were kind, caring and gentle with the people they supported. We saw they allowed people time to make decisions and offered them choices.

People using the service told us that staff respected their privacy.

Is the service responsive?

Good

The service was responsive.

The provider assessed people's care and support needs and developed person-centred care plans to meet these.

People told us they had access to and enjoyed the activities provided in the service.

People using the service and their relatives knew how to raise concerns and they told us they were confident the provider would take these seriously.

Is the service well-led?

Requires Improvement

Not all aspects of the service were well led.

The provider did not carry out checks on new staff member's ability to communicate in English before they appointed them to work in the service.

The provider had appointed a qualified and experienced manager who was registered with the Care Quality Commission. Staff told us they found the manager accessible and supportive.

The provider carried out regular monitoring visits to the service and developed an action plan to address issues they identified.

The registered manager and staff carried out regular checks on quality in the service and identified improvements they needed to make.

The provider worked with other agencies, including the local authority to monitor standards in the service.

Seymour House-Northwood

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.

This comprehensive inspection of the service took place on 16 and 21 November 2017. The visit on 16 November was unannounced and we arranged with the registered manager to return on 21 November to complete the inspection.

The inspection team consisted of 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. The expert by experience for this inspection was a family carer of an older person.

Before the inspection we reviewed the information we held about the provider and the service. This included statutory notifications the provider sent us about significant events or incidents that affected people using the service.

During the inspection visit on 16 November 2017 we spoke with 12 people using the service, two visitors, the registered manager and seven members of staff. We reviewed the care records for four people, including their care plans, risk assessments and daily care notes. We also looked at six staff records, including records of staff recruitment, training, supervision and appraisal. We also reviewed the medicines record for 10 people and other records kept in the home, including accident and incident reports and complaints. On 20 November 2017 we reviewed other records of checks and audits the provider and registered manager completed to monitor quality in the service and make improvements.

Following the inspection we spoke with three relatives of people using the service to get their views on the care provided at Seymour House - Northwood.

Requires Improvement

Is the service safe?

Our findings

The provider carried out checks to make sure staff were suitable to work with people using the service but these were not always effective. Staff personnel records we checked were very well documented and consistently ordered with a recruitment check list at the front of each. Each file contained an application form with clear employment history, two references, including at least one professional reference, Disclosure and Barring Service (DBS) checks, evidence of the person's identity and right to remain and work in the UK and a health declaration. The provider had not assessed that the applicants had the necessary knowledge, competence and skills so they could adequately understand or communicate in English before offering them employment at the service. This may have placed people at risk of unsafe or inappropriate care.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives told us they felt safe and well cared for in the service. People's comments included, "I love it here, staff are nice and treat me well. I feel safe and when I became unwell the GP visited me and gave me medication" and "It's OK living here. It gives you some security and you are cared for. I like the food. I don't go out but I do get involved with any activities when they happen, but I do find some are childish for me. I find that staff are good but I do get the feeling that they are trying to put you off asking for things, they are listening but not listening." Relatives told us, "We've never worried about [family member's] safety, we are confident they are safe at Seymour House", "My [family member] is much safer in the home. They were not able to live on their own and I never have to worry about them now" and "My [family member] is perfectly safe, I have no concerns in that respect".

The provider had systems in place to safeguard people from abuse. We saw they had reviewed and updated their safeguarding adults policy and procedures in March 2017 and these referred to the local authority's procedures and the role of the Care Quality Commission (CQC). We also saw that, when required, the registered manager shared information with the local authority and raised safeguarding concerns appropriately.

Training records showed that all staff had completed safeguarding adults training and the care staff we spoke with confirmed this. However the staff had not fully understood the training that they received because they did not have a good command of English. When we asked, four care staff did not have a clear understanding of the term and were not able to provide a definition of different forms of abuse. Two care staff described safeguarding as, "Looking after the person and making sure they eat and drink" and "protecting dignity". Those that understood the term were able to describe the procedure to follow and said they would report any concerns to the team leader or manager. Three care staff were aware of a whistleblowing policy but only two were able to describe clearly what this meant. Three care staff told us that the provider's safeguarding policies and procedures could be accessed easily as they were kept in the lounge.

We also noted that in a recent meeting for people using the service, some people had said they did not like care staff speaking their own language rather than English. The registered manager had agreed that they would speak with staff to remind them to only speak English in front of people. We discussed this with the registered manager who told us she had discussed the issue with staff and asked them only to speak English. During the inspection we saw that care staff made sure they did this and we heard no examples of care staff speaking their own language in front of people using the service.

The registered manager also told us they had identified local English classes. A number of staff had signed up for the classes and were due to have pre-course assessments. When we asked about staff recording the care and support they gave people, the manager said that where a staff member's written English wasn't good enough, they would sit with another member of staff and tell them what they had done so it was recorded. The daily care notes we saw were well completed and clearly described the care and support people received.

In most cases, the provider assessed possible risks to people using the service and took action to mitigate those they identified. We saw assessments on people's care records of the risk of falls, nutrition, pressure care and wandering. Where care staff had identified that one person had lost weight, the registered manager reviewed their risk assessment and care plan and made sure they referred the person to the dietitian. We also saw that care staff referred people to mental health services when their care needs changed. However, during the inspection we did note that the provider had not updated one person's risk assessment following a fall. The registered manager confirmed they had referred the person to the district nursing service and on the second day of our inspection we saw the person had been provided with a nursing bed and bed rails and care staff had updated their risk assessment.

The registered manager told us they used a dependency level assessment to determine the number of staff needed to care for and support people on each shift. We saw they had reviewed their assessment in September 2017 and this showed the need for seven care staff from 8am – 8pm, plus the registered manager, an administrator, catering and domestic staff and one activities coordinator during the day. At night, there was a minimum of one senior carer and three care staff on duty. Staff rotas showed the service maintained these levels of staff and we saw these were sufficient to meet people's care and support needs. People did not wait for support or attention and there were enough staff at meal times to help those who needed it.

People received the medicines they needed safely and as prescribed. Training records showed 10 care staff were trained to give people their medicines safely. We saw they took time to administer medicines to people in a caring manner and without rushing. The provider stored people's medicines securely and kept up-to-date and fully completed records of medicines received, administered and disposed of, as well as a clear record of any allergies to medicines. All of the medicines records we reviewed included a photograph of the person so that nurses could make sure they gave medicines to the correct person. There were protocols in place for PRN ('as required') medicines and the covert administration of medicines that the provider had agreed with people's GPs and relatives. These records provided evidence that people consistently received their medicines as prescribed.

Service records for equipment used in the home were up to date. This included hoists, assisted baths and mobility equipment. The provider had a quarterly maintenance schedule that covered plumbing, heating, electrics and the general environment. They also carried out weekly checks of hot water temperatures and the aid call system and monthly checks of wheelchairs, slings and hoists used in the service. There were current gas and electricity safety certificates and the stair-lift was serviced in March 2017. The registered manager confirmed that care staff checked restrictors fitted to people's bedroom windows when they

checked their rooms each day, but these checks were not recorded. The registered manager told us she would ask the service's handyperson to start recording these checks.

We saw domestic staff used colour coded cleaning equipment and those we spoke with were able to explain their roles and responsibilities. Bathrooms and toilets were adequately equipped and care staff wore personal protective equipment when they supported people with their personal care and at mealtimes. This included gloves and aprons and we saw care staff used these when needed. The provider employed domestic staff to clean the service and we saw that all parts of the premises were clean, tidy and odour-free during our inspection.

The registered manager told us the service was part of the local authority's 'falls project' aimed at reducing falls in care services. The registered manager kept a record of all falls and sent a report each quarter to the local authority with details of the number of falls and actions taken. We did note that, in one case, there had been a delay in seeking medical advice following a fall. We discussed this with the registered manager who agreed that staff should have responded more promptly. They told us they would make sure all care staff were aware of the procedures to follow in the event of an accident.

Good

Is the service effective?

Our findings

The provider assessed people's care and support needs before they began to use the service. People's care records included an assessment of their care needs and risk assessments. The registered manager told us they used the assessments to develop a care plan when people moved into the service.

Care staff had the training and support they needed to meet people's needs. Care staff told us they had regular training and most were able to cite examples of recent mandatory training they had completed. Newer care staff said they had completed their planned induction training and a period of shadowing more experienced staff.

The provider supported care staff to complete their Care Certificate training. The Care Certificate is a nationally recognised set of standards that gives staff an introduction to their roles and responsibilities within a care setting. Training records showed that all care staff completed induction training and training the provider considered mandatory that also met the requirements of the Care Certificate. This included medicines management, fire safety, safeguarding, health and safety, first aid, moving and handling, dementia care, infection control and food hygiene. In addition, the provider arranged additional training where they identified people had specific care needs. This included end of life care and bereavement, the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards, equality and diversity, person centred care, communication, nutrition, challenging behaviours and continence.

Care staff said they had regular supervision and consistently reported that this occurred every 1-3 months, although one care assistant said she hadn't had supervision since joining earlier this year. Two care staff told us that supervisions were sometimes conducted in groups rather than 1:1. Care staff who had worked in the service for more than a year said that they had had annual appraisals in the past although not recently. We checked supervision records for four care staff and these were very well maintained with clear, typed records of the content of discussion with any required action points and evidence of input from both the staff member and supervisor. Records confirmed that supervision was conducted every two months for most staff. There were no records of recent annual appraisals although the registered manager said that this was being actioned at the moment to bring the service up to date.

People told us they enjoyed the food provided in the service. Their comments included, "The meals here are very good, the cook knows what I can and can't eat and I am catered for. I can't praise the cook enough" and "I like the food. The meals here are tasty". A relative told us, "The food is great. The cook will cater for the individual's need".

The chef us they kept records of those people who had specific dietary requirements such as allergies, pureed or fortified food and they were able to show us examples of this. The chef also told us they did not attend resident meetings but confirmed they received feedback from the registered manager. Training records showed the chef had received training in nutrition and food hygiene.

All rooms had jugs of water available for people with hot and cold drinks available throughout the day. Fluid

charts were maintained for those at risk of dehydration and people were weighed monthly or on a weekly basis if losing weight. We discussed the recording of food and fluids with the registered manager as it was not always clear from records what action care staff had taken. For example, where a person needed a fluid chart, this included a target for the amount of fluid the person needed to drink each day. We checked the fluid charts for six people for November 2017 and saw that none of the six people had reached the target amount they needed on any day during the month. We discussed this with the registered manager who was able to show us they had liaised with the speech and language therapy service and the dietitian to discuss individual strategies to encourage people to drink more fluids and maintain hydration. The registered manager told us they would make sure this information was highlighted in people's care pans.

People using the service and their relatives told us people's health care needs were met in the service. Their comments included, "Staff responded well when I was ill, they would monitor me for a few days before calling the GP", "I can always see the doctor if I need to, I just ask the [care staff]" and "I've seen the doctor and the chiropodist since I've been here, there's never any problem getting appointments". A relative also told us, "I think the health care is very good. They always tell us when [family member] has seen the doctor or if there are appointments we need to know about".

Care staff told us they were well supported by other health care professionals and mentioned the district nurses, GPs and the palliative care team. Records of visits from health professionals were recorded in a separate file, as well as people's individual care plans.

People's needs were met by the design and decoration of the premises and people and their relatives told us they were happy with the accommodation provided. Their comments included, "I have a lovely room with a view of the garden. Our outdoor activities include visiting Prescott Park which has a petting Zoo, we have lunch there" and "I'm very happy with my room, I spend a lot of time there". A relative commented, "We looked at other homes and this was easily the nicest. It's bright, clean and the standard of accommodation is first class".

During the inspection we saw that all areas of the home were clean and furniture was fairly new and of a good standard. Most people's bedrooms were personalised with items of individual furniture or pictures but others were fairly uniform. All rooms had the person's name on the door with a memory box on the wall which contained items relating to the person's past life or personal mementos. This enabled people to orientate themselves and identify their bedrooms. There were two lounges and two dining areas which were bright and cheerful and a separate small quiet lounge with items of memorabilia to support reminiscence activities.

The home was suitable for people living with the experience of dementia. There was a colourful scheme of decoration with friezes on the walls, and there was good signage throughout the home. A board showing the day, date and weather was displayed in the hall and there were clocks in communal areas. The activities schedule for the week and the daily menu were shown clearly in pictorial form.

There was a large, pleasant garden with large decking areas easily accessible from the lounge and dining rooms which could be used for seating throughout the year. All bedrooms had ensuite facilities with shower, toilet and hand basin and liquid soap was available in each toilet and bathroom. There were additional communal bathrooms and shower rooms.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to

take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care services and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

Most care staff told us they had received training in the MCA and this was confirmed by certificates in staff files and the provider's training matrix. However, some care staff had a limited understanding of the Mental Capacity Act. Only four of the seven care staff we interviewed were able to define mental capacity as the ability to take decisions, understand and retain information relating to decisions.

Some care staff lacked clarity over the approach to assessing mental capacity and the documentation used. However, the registered manager reported that each person using the service had a mental capacity assessment relating to decisions over their care and we saw these on people's care records. Some care staff were also unclear if they had a role in assessing people's capacity to make day to day decisions but we did see they offered people choices and explained the support they gave people before providing care.

Consent forms were kept in the care file for each person and we saw these were included in the care plans we reviewed. Care staff also said they always checked for the consent of each person before offering support such as personal care, using facial expressions or body language to gauge the person's reaction if they were unable to verbalise their consent. During the inspection we saw that care staff took time to explain to people the support they provided and ensured people had time to agree and understand the care they received.

Staff comments included, "We know if they have mental capacity as we see them every day. The GP does mental capacity assessments and memory tests", "Most of them have dementia so they don't have capacity" and "If they lack mental capacity it means they have a lack of memory and can't take their own decisions".

The registered manager had a clear understanding of their responsibilities under the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). Where people using the service were deprived of their liberty the registered manager made sure they applied to the local authority for authorisation and notified the Care Quality Commission of the outcome. For example, where people needed constant supervision and were unable to leave the service without support from staff, the registered manager applied for authorisation from the local authority in order to keep people safe. During the inspection we saw no examples of people being deprived of their liberty unlawfully.

Good

Is the service caring?

Our findings

People using the service and their relatives told us the care staff who worked in the service were kind and caring. Their comments included, "Nice people. I feel safe and staff are always good to me. If I had any problems or concerns I would be happy to speak to staff. If I wanted to spend time in my room during the day I am free to do so. This place is very clean, my sheets are changed once or twice a week", "It's very pleasant here. The staff are gorgeous. The girls (staff) are lovely" and "Staff are friendly and helpful".

Family members we spoke with were happy with their relatives' care. They described Seymour House as a home away from home and also said that the registered manager was visible and approachable. Their comments included, "Fantastic staff, my [family member] is treated with respect and staff are kind and friendly. I have never heard staff be unkind to anyone and they are all very welcoming. I am very happy for my [family member] to be here. Whenever my [family member] returns he is greeted with a "welcome home" from staff. The manager is very visible during the day and is very personal with people", "It's so clean, Seymour House is a family environment, home away from home for my [family member]. I am given updates on my [family member's] care regularly", "The staff are very good, very caring and they work very hard" and "The staff treat my [family member] as if they were one of their own family, they are excellent".

During the inspection we saw that care staff treated people with respect. They were able to tell us about the people using the service and knew about their life histories, family members and significant events. We saw that care staff took the time to sit with people, chatting or reading the newspaper and made sure that they asked people how they were feeling when they supported them. Care staff were gentle, empathetic and patient with people, assisting then to move about the home and go to the toilet when required.

Where people lacked mental capacity to make decisions about their care we saw the provider worked with their relatives and social and health professionals to agree decisions in their best interests. Care staff told us the level of family involvement varied in the home with some families and next of kin in regular contact with their relative and staff. We saw during the inspection that care staff welcomed family members when they visited and also spoke with people using the service about their families. Relatives told us they could visit at any time and care staff made them welcome. One relative said, "We visit any time we want and we've never found any problems. My [family member] is very well cared for".

The provider arranged monthly meetings for people using the service to discuss care issues, food, activities and domestic tasks. We saw the registered manager maintained a file that documented these meetings throughout 2017 with agendas, attendees and typed minutes with evidence of input from people and their relatives and action points. For example, we saw people discussed menu options and arrangements for Christmas and Remembrance Sunday. People also commented on good cleanliness in the home, good activities and a good level of care.

Good

Is the service responsive?

Our findings

People using the service and their relatives told us they received care and support that met their needs. Their comments included, "I am well looked after here, it's very good" and "They [the care staff] are very good, they know how to look after people".

Each person had a care plan that detailed their care and support needs and how care staff would meet these in the service. The plans included a 'This Is Me' form that care staff used to record people's preferred name, a brief life history, likes, dislikes and routines, as well as an outline of their care and support needs. Plans included people's physical and mental health, medicines, nutrition, mobility, communication and night care. The plans were written in a person-centred way that used the person's name to describe the care they needed and gave care staff clear guidance on how to provide this. For example, "[Person's name] enjoys watching old movies", "Offer [person's name] reassurance when anxious and always explain any planned interventions" and "Encourage [person's name] with their breathing exercises to reduce the risk of infection".

Staff had up to date information about people's care and support needs. The registered manager and care staff reviewed people's care plans regularly and acted when people's needs changed. For example, they referred people to healthcare services when they identified loss of appetite, weight loss or changes in a person's behaviour.

The provider maintained people's care records on an electronic system and this included daily care records for each person. Input to the electronic care planning system was limited to certain members of staff who had received relevant training. The registered manager told us that where staff were not able to enter information on records as they needed to improve their written English, they would sit with another member of staff and describe the care and support they gave people so this was recorded.

Care plans were printed out so that staff had access to them if required. Staff were familiar with the needs and personalities of different people and knew how to support them. New staff explained that they had learnt about people's care needs by talking to colleagues or observing and talking to people. Some also said that they read people's care plans. In addition, changes to people's needs were communicated at daily handover sessions.

When people approached the end of their life, the provider and registered manager made sure they had support from specialist palliative care services. They discussed people's end of life care wishes with the person and their family and recorded this in a sensitive and caring way. Some people's care pans included a Do Not Attempt Resuscitation (DNAR) form. We saw the registered manager had discussed this with the person or their representatives if the person lacked mental capacity. All the DNAR forms we saw had been signed by the person's GP and the registered manager ensured they were regularly reviewed to make sure they reflected people's wishes.

People told us they enjoyed the activities arranged in the service. Their comments included, "I do like to join

in with the activities", "I like the area because its local for trains and it makes it convenient for travel. I feel safe and happy. It's not often that they have activities, but when there are I would normally join them" and "I feel comfortable and safe and like the building. I do feel listened to and cared for but sometimes staff don't have enough time for me".

The provider employed two activities coordinators who also had administrative or domestic responsibilities so only one coordinator was organising activities at any time. We saw there were schedules of weekly activities on noticeboards on each floor and these included ball games, quizzes, puzzles, exercises, reminiscence sessions and listening to the radio. The activities coordinators also carried out one to one sessions if a person was unwilling to join in group activities.

During the inspection activities staff told us a range of activities were available throughout the week. We saw that one of the activities coordinators organised a 'Name That Tune' activity with appropriate music and 15 people obviously enjoyed taking part. The coordinator ran the session with enthusiasm and encouraged all those present to participate. In the afternoon, the coordinator organised a card game that people taking part also enjoyed. Activities staff said they recorded participation in activities in each person's care plan each week and the records we saw confirmed this. In addition there was a monthly activities report for each person outlining what they had enjoyed and their level of engagement in life at the home.

The provider had a policy and procedures for investigating and responding to complaints from people using the service and others. They had reviewed these in March 2017. People's relatives we spoke with told us they knew about the provider's complaints procedure but said they had never needed to make a complaint. We saw the provider responded to complaints they had received from people using the service in line with their procedures and notified relevant people of the outcomes of any complaint.

Requires Improvement

Is the service well-led?

Our findings

The provider carried out checks and audits to monitor quality in the service and make improvements and they made monthly monitoring visits to the service. They gave the registered manager a written report after each visit and we saw they took action to address any issues the reports identified. We saw records of visits the provider completed in June, July, August and September 2017 and the manager confirmed that agreed actions had been addressed. For example some environmental improvements had been completed. However, the provider had not identified difficulties caused by the appointment of care staff who were not able to fully communicate in English. Their recruitment processes did not include an assessment of applicant's spoken or written English and this meant that some staff they appointed did not have the necessary knowledge, competence and skills so they could adequately understand or communicate in English. This may have placed people at risk of unsafe or inappropriate care.

People using the service, their relatives and staff told us the service was well managed. Their comments included, "[Registered manager's name] is the manager. She is very good and always asks how we are", "The place is well managed, they know what they are doing", "[The registered manager] is always available and will do anything to sort things out" and "I think the management is good, it is a well-run home".

The provider's stated purpose in their business development plan was to "Promote the dignity and self worth of all our residents and strive to give them an excellent quality of life as defined by the residents, individually and as a group".

The provider had appointed a qualified and experienced manager to run the service. They told us they had completed their Care Quality Commission (CQC) registration in August 2012. The registered manager held qualifications in health and social care and the management of social care services. They had worked as a care worker, deputy manager and manager of residential and home care services. They told us they were a member of the Chartered Management Institute (CMI) and that they kept up to date with developments in social care by attending the local authority's provider forum. They also said they had online access to resources from the CMI, the National Institute for Health and Care Excellence (NICE) and CQC. Following a recent increase in the number of people using the service, the registered manager told us the provider was looking to recruit a deputy manager to provide management support but they had not yet appointed to the post.

Care staff were very positive about working in the service and felt that there was an open and transparent culture. They said that the manager was extremely supportive and that she was visible throughout the home at all times with a clear open door policy for staff, residents and their relatives. Their comments included, "[The registered manager] is around all the time so she knows what's going on", "The manager is around all the time, she explains everything, she supports us very well" and "If I have any problems I can talk to the manager".

Staff were confident that they could approach the manager at any time with queries or concerns and considered the service to be responsive to the requirements of both staff and residents. All felt that there

was a positive atmosphere in the home with a strong sense of teamwork. They told us, "I've never met such a nice team as this, we all help each other out", "We are a good team and we are trying to do our best for them" and "We are the best team but I need to improve my English".

Staff told us that there were regular staff meetings to discuss the running of the home which gave them the opportunity to express their views and raise any issues of concern. The staff meeting file was well maintained with a clear record of dates of meetings, agendas, attendees and typed minutes. Meetings covered a variety of topics for example holidays, CQC changes, privacy and dignity, staff training and the kitchen environment. We saw minutes for meetings held in February, July and September 2017. These were evidence that the provider shared information with care staff and gave them the opportunity to comment on the way they ran the service.

The provider and registered manager worked with other agencies to monitor quality in the service and make improvements. The local authority carried out their annual monitoring visit in June 2017 and agreed an action plan with the provider and registered manager to address issues they identified. These included involving night staff in fire drills, introducing personal evacuation plans for people in the event of a fire and improving the recording of people's life histories and pre-admission assessments. We saw the local authority's monitoring officer had returned to the service in October 2017 and they confirmed the provider and registered manager had addressed all of the issues they identified.

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	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not assessed that applicants had the necessary knowledge, competence and skills so they could adequately understand or communicate in English before offering them employment at the service .