JC Kunning

The Beeches

Inspection report

The Beeches
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on the 15 and the 23 June 2016. The inspection was unannounced. The previous inspection was completed in August 2015 and was a focused inspection to look at compliance against a previous breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was compliant with the outcomes assessed.

The Beeches is a care home for people with a learning difficulty or mental health condition and is located in the village of Brandesburton, close to the town of Driffield, in the East Riding of Yorkshire. It can accommodate up to 11 people under the age of 65. The home is located on the outskirts of the village in spacious grounds with parking and is close to local amenities and transport routes.

The Beeches has two registered managers who work as a job share. 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.

People we spoke with were positive about the care and support they received and it was evident from our inspection that care was person centred. People told us they felt safe and we found that staff knew how to protect people from avoidable harm. Staff knew how to recognise different signs of abuse and they were clear about what action to take if they suspected abuse was taking place. The registered provider had a safeguarding policy in place that had been updated to align with local authority guidelines.

We looked at staff rotas. Staff and people living at the home told us there was enough staff on duty and staffing levels were regularly reviewed to ensure that there were sufficient numbers to meet people's changing needs. However, we saw the registered provider did not have a robust system or process in place to support and record that staff had the required up to date qualifications, skills and experience necessary to ensure they were competent in undertaking their role and that this was regularly reviewed. This was a breach of regulation 17(2) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the registered provider to take at the back of the full version of this report.

People were encouraged to live as independently as possible and we saw detailed risk assessments and risk management plans were in place to enable people to live independently and undertake a variety of daily activities in a safe way.

We saw risk assessments for the home and the environment. However, these did not include personal emergency evacuation plans (PEEPs) for each individual person. PEEPs are documents that advise of the support people need in the event of an emergency evacuation taking place.

We looked at monthly checks on portable appliances, fire extinguishers, water temperatures and saw that these were all up to date and helped to ensure the safety of the premises for people.

The registered provider had a policy and procedure in place for the safe management of medication. However we saw where medication was required to be refrigerated it was stored in the food refrigerator in the kitchen. The registered provider told us a recent medication audit had failed to identify this as a breach of regulations and they told us they would obtain a separate refrigerator from their provider to store medication. We made a recommendation for the registered provider to followed guidance in this respect from The Royal Pharmaceutical Society.

Management and staff had received training in and understood the requirements of the Mental Capacity Act 2005 (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. Where people may have lacked capacity the registered provider ensured that the MCA was followed and we saw that prompt application for deprivation of liberty safeguards (DoLS) had been completed. DoLS were regularly reviewed and evaluated. Where an individual had capacity to make decisions in other areas of their lives we saw that they were encouraged by staff to provide their consent.

We saw there was a choice of menu and staff were aware of people's dietary needs that were recorded in their care plans. The registered service had an environmental health officer food hygiene rating (FHRS) award of five, which was the highest award.

People told us that they were well cared for and had access to a range of health professionals. People told us they could see a GP when they wanted to and they were trialling an electronic software system to self-manage their health and appointments. We saw records of professional contacts with healthcare services documented in people's care plans. These included the GP, district nurse, community psychiatric nurse, and mental health practitioner.

We saw a variety of activities and seasonal events were organised in line with people's requests and feedback. These were both individual and group activities and trips.

People and their relatives were involved in the assessment and planning of their care and support. Peoples care plans showed how they were involved in making decisions about their care, treatment and support. Care plans were detailed and included information about peoples likes and dislikes.

Staff told us of a supportive culture by management with a service that focused on the needs of the people living in 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?

Good

The service was safe

People we spoke with told us they felt safe.

Management and staff understood how to recognise different signs of abuse and were clear about what action to take if they suspected abuse was taking place. However recording of staff training in safeguarding was not up to date.

Comprehensive risk assessments were in place ensuring people could safely undertake daily activities. These were regularly reviewed and updated with involvement of people, families and professionals. However, we saw peoples care plans did not always include a personal evacuation plan to assist them in an emergency evacuation of the premises.

Medication was managed effectively with appropriate checks, policies and procedures. However, despite a recent audit, we saw that medication requiring refrigeration was incorrectly stored.

The home was clean, smelt pleasant and was well maintained.

Is the service effective?

Requires Improvement

The service was not always effective.

The registered provider did not have a robust system to ensure and evidence that care workers had appropriate training to meet the needs of the people they were supporting.

The service worked in line with the Mental Capacity Act 2005 (MCA) and followed guidance where people had a lack of capacity to make informed choices. However, the MCA policy and procedure in place did not contain information regarding the Deprivation of Liberty Safeguards (DoLS).

People were supported to eat and drink and individual dietary requirements were reviewed and documented in people's care plans.

Is the service caring?

Good

The service was caring.

We saw and people we spoke with told us that they received person centred care.

People and staff told us they felt valued and said that being at the home was like being part of a 'big family'.

People were encouraged to be independent and to make their own choices wherever possible. Where this was not possible, staff maintained dignity and privacy, when caring and supporting people.

Is the service responsive?

Good

The service was responsive.

People and their families were involved in planning and reviewing their care ensuring that their needs were met in a person centred way.

There was a variety of activities, trips and events provided which were inclusive of people's likes and interests.

People and staff told us they knew how to raise concerns and that they would be appropriately acted on.

Is the service well-led?

Requires Improvement

The service was not always well led.

Records within the home were kept securely however systems and process to ensure staff records were accurate or complete were ineffective.

Care workers present told us that they found management to be approachable and supportive of their needs.

There was a clear management structure in place and staff understood their roles and responsibilities.

The registered provider had a programme of quality assurance checks in place and we saw these were effective in improving practice at the home.

The Beeches

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 15 and the 23 June 2016 and was unannounced. The inspection was undertaken by one adult social care inspector. Prior to this inspection, we reviewed information we held about the service, such as notifications we had received from the registered provider and information from our previous inspection in August 2015.

During the inspection, we spoke with four people receiving a service, two care workers and a senior care worker. We looked at records which related to people's individual care, such as the care planning documentation for four people and other records associated with running a residential care service. This included four care workers files, recruitment and training records, the care workers rota, records of audits, policies and procedures and records of meetings. We observed daily activities in the home. This included a mealtime observation and people receiving medication.

We contacted the local authority for their feedback and they provided us with the outcome from their previous quality-monitoring visit with no major concerns highlighted.

Good

Is the service safe?

Our findings

People we spoke with at the service told us they felt safe. One person said, "I feel safe living here and we always have staff around to keep us safe." Staff told us they completed safeguarding as part of their in-house induction and received annual refresher training. However, we saw from records that training in safeguarding was not always recorded as up to date and it was unclear who had completed refresher training and who was scheduled to receive this training. We spoke with the senior care worker about this and they told us, "We do complete the required training and I will speak with the registered manager about updating the records when they return." Staff we spoke with were able to describe the types of abuse they would look out for in the home and were able to discuss how they would escalate any concerns.

The registered provider had an 'Adult Protection and Prevention of Abuse' policy and we saw a recorded log that included details of incidents, organisations contacted and an action plan. The registered person told us on the Provider Information Return (PIR), 'Threshold guidance produced by East Riding Safeguarding Adults Board is used.' We saw evidence in the safeguarding file this was used to determine when an alert to the local authority was required. We were told care plans were updated because of the investigations and our checks confirmed this was the case. This showed us that there was a system in place to identify and respond to signs of abuse to keep people safe.

Staff we spoke with told us they had not received training in whistleblowing. However, they told us they understood the process and would not hesitate to raise any concerns. A care worker told us, "If I had any concerns I would speak with management who I know would be supportive or I would inform the Care Quality Commission." They told us they had previously raised a concern and that it was dealt with swiftly and effectively in a confidential and professional manner. Another care worker said, "I would not hesitate in whistleblowing bad practice or concerns," they continued, "If in doubt; speak out."

The registered provider had undertaken risk assessments with people to help them live independently and with enough support to help keep them safe. Assessments identified the activity at risk, triggers associated with the activity and measures to reduce the risk. We saw these were recorded in people's care files and included information on risks associated with finance, mobility, medication, slips, trips and falls and discrimination, neglect. We saw assessments had been undertaken for activities such as horse riding, gardening, and accessing the community. We observed one person had bed rails fitted to their bed. A care worker told us the bed was purchased to keep the person safe from falling out at night but they told us the person had declined to have the rails in the upright position. We looked at the persons care plan and did not see a risk assessment in place for the bed rails. We were told the bed rails would be secured in the down position and we saw a risk assessment had been completed and was included in the persons file during our inspection. These measures helped provide care and support to people in a safe way and mitigated any risks associated with a given activity.

The home and its environment was checked to ensure the home and equipment was safe for everybody. The registered provider showed us a 'Health and Safety' file. This included details of portable Appliance Testing (PAT), Control of Substance Hazardous to Health (COSHH) that included a log of chemicals and an

assessment form, food hygiene inspection (with the highest rating of 5) and an environmental risk assessment review in line with guidance from the Health and Safety Executive (HSE). We saw checklists included any corrective action required with timescales and that this was signed when completed. The home had a 'Fire Safety' file. We saw this contained information on weekly fire alarm tests, premises detail, exits and hazards.

We looked at peoples care files and saw they did not contain a Personal Emergency Evacuation Plan (PEEP). PEEP's should be completed for any person living at the home who required assistance with any aspect of emergency evacuation. We spoke with the senior care worker about this and they told us they were in the process of inputting these as part of reviews of peoples care plans.

Accidents and incidents were recorded and we saw the majority of these related to falls. We saw the registered provider had reviewed these incidents and corrective action had been taken to mitigate future occurrences. This included the provision of walking aids, safety equipment, intervention from other health professionals and reviews of medication. Because of these interventions, the number and frequency of falls recorded had reduced. This meant the registered provider had procedures in place to investigate and learn from accidents and incidents to help keep people safe whilst maintaining their independence.

We checked the recruitment records for four members of staff. We saw that an application form had been completed and that a minimum of two references were obtained. Other background checks had been made with the Disclosure and Barring Service [DBS]. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and helps to prevent unsuitable people from working with children and vulnerable adults. It was evident from people's files that these checks had been undertaken and that this information had been received by the registered provider prior to the new employees starting work at the home. The registered manager advised us that staff shadowed experienced workers and had to have checks in place before being allowed to work independently. Checks that were undertaken by the provider meant that only people considered suitable to work with vulnerable people had been employed.

We looked at the management of medication for people at the home. Staff had received training in medication and we saw this was documented in their training records and that it was up to date. There was a medication policy in place. This provided staff with comprehensive guidance on the management of medications that included safe receipt, storage, administration and handling. We were informed about the system for ordering medication via the GP and pharmacy and how medicines were checked upon entering the home. The senior care worker told us there were no controlled drugs (CD's) in the home. Some prescription medicines are controlled under the 'Misuse of Drugs' legislation (and subsequent amendments). These medicines are called controlled medicines or controlled drugs (CD's). Medication was stored in a locked cupboard and individual records were kept. We saw individual medication administration records (MAR) which held details of the person and their current medication. Records we saw were complete and up to date. However, we observed a medication balance had been under recorded by 28 tablets and the signature sheet for people administering medication required updating. We told the senior care worker about this during our inspection. They said this would be identified and addressed as part of the monthly medication audit.

Medicines required to be kept at a low temperature were held in a food fridge in the kitchen. Access to the kitchen was via a keypad and we were informed people were unable to access the kitchen without a member of staff. The registered provider showed us a copy of the risk assessment about this following our inspection. The Royal Pharmaceutical Society guidance states, 'In residential care there should be a separate secure fridge that is only used for medicines." It states, 'A separate fridge may not be necessary in a

small home unless there is a constant need to refrigerate medicines that a resident takes regularly'. We observed medication in the fridge included some prescriptions that people take regularly and so the home would be required to have a dedicated fridge. We spoke with the senior care worker about this. They told us, "We have reviewed our medication policy and procedure and were not aware of any concerns highlighted as a result of those checks." After the inspection, the registered provider informed us that they would obtain a dedicated fridge from their pharmacy provider to store medication that required refrigeration. This meant the registered provider had taken appropriate steps to ensure the proper and safe management of medications.

The CQC made a recommendation that the registered provider takes action to ensure that medication is stored in a separate refrigerator in line with the recommended guidance from, The Royal Pharmaceutical Society. This is because medication stored in the shared food fridge at the home included prescriptions that a resident takes regularly.

Requires Improvement

Is the service effective?

Our findings

The last inspection of the service on 5 August 2015 was undertaken as the home had previously installed a CCTV camera in the home's office. At that time there was no evidence that people who lived at the home had been consulted about the use of CCTV cameras or that their consent had been sought. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection on 14 June 2016 we saw that although a CCTV sign remained in the office, we were advised additional signage had been taken down and we saw the camera was no longer in use and had been removed. Despite removal of the camera, the provider had met the requirements of and was no longer in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection, we reviewed the induction and training process for four care workers. We saw from the files we looked at that care workers attended an induction. The first day included an oversight of the home, the fire safety system, dealing with aggressive situations and assisting of a care worker to observe and help with an activity. Day two to four involved working with people and exposure to the working role of a care worker. Each day was evaluated and signed off by the registered manager. A care worker told us, "The induction process works well and allows you to gain an understanding of the role with full support from management and other established staff."

Staff told us their training was well managed and up to date and they said they had appropriate skills for the role. The registered provider told us on the PIR, 'Completed training is annotated on to individual training records and a team matrix to easily identify areas of improvement.' A staff training record was available in staff files. This had provision to record service user related training and additional training, however, the information we inspected was not always up to date. We saw gaps where recording of training, for example, in Safeguarding, Mental Capacity Act, Infection Control, Deprivation of Liberty and Safeguards and Positive Behaviour Support had not been recorded. It was not always clear when refresher training was scheduled or when it had been completed; some recordings did not show dates but recorded a signature. We spoke with the senior care worker about this and they showed us a training matrix in the main office. They told us the registered manager had undertaken training on challenging behaviour and that they were in the process of cascading this to all staff. We saw some training was highlighted on the matrix but it was not clear what training had been completed, what was due to expire, and what was planned.

Staff we spoke with told us they were encouraged to undertake National Vocational Training (NVQ) in Health and Social Care alongside the Care Certificate. We were unable to check and evidence which staff had completed this training or who had commenced the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working. This showed us that this system was not always effective in ensuring that care workers had completed appropriate training for the care and support they were providing and that this was updated in line with best practice and recorded. We concluded due to the above concerns that the registered provider required a more robust process to ensure that training and monitoring records were created and updated to record that staff had the required qualifications, competence, skills and experience required to undertake the role. This was a breach of regulation 17(2) (d) Good Governance, of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

Staff we spoke with told us they received a review at the end of their probationary period. We saw this was recorded in their personal files. A care worker told us, "I feel I get a lot of support whenever I need it; the office door is always open and we have monthly staff meetings where we can raise any concerns and discuss things about the home." We saw some documented supervision logs in staff files but these, along with annual appraisals, were inconsistent. This meant the registered provider did not have effective documentation in place to record that staff remained competent in undertaking their role and that this was regularly reviewed.

People we spoke with told us there was enough suitably trained staff on duty in the home. A care worker said, "There is enough staff on duty, we have time to spend with people on an individual basis and we are not rushed." A person living at the home said, "Staff always seem to have time for me, they're not rushed." The senior care worker told us there was no specific staffing tool used to decide on the number of staff or staff deployment. They showed us a staffing rota that included two activities co-ordinators that were allocated to two people living at the home. A care worker told us this freed up time for staff to spend with other people in the home. During our inspection, there was one senior care worker and two additional care workers on duty. During the night, the home had one person working and one 'sleep in' member of staff. Night staff carried a pendant they could use to call for further assistance if required.

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 procedure for this in care homes and hospitals is called the Deprivation of Liberty Safeguards (DoLS).

The senior care worker showed us a policy and procedure for the Mental Capacity Act 2005 (MCA). We saw this did not include information on DoLS. The registered provider told us they were in the process of updating the policy to include information on DoLS. Care workers had received training and from our discussions, demonstrated they had an understanding of the requirements of the MCA.

The registered provider told us in the PIR that one person living in the home was supported by an Independent Mental Capacity Advocate (IMCA). IMCAs provide a legal safeguard for people who lack the capacity to make specific important decisions on their own. We saw that one person had their liberty, rights and choices restricted by their care plans and that they were subject to authorisation under the DoLS. One care worker told us they had a limited understanding of the processes for DoLS but told us "We have some people who we have to make decisions for. They have a DoLS in place." They told us and we saw that where there was a documented capacity assessment in care plans, care workers supported people, following care plans and risk assessments, to help them make their own decisions wherever possible. This showed that the provider always sought consent to care or treatment where the person had capacity and where they did not, relevant legislation and guidance was followed.

We saw people were supported to eat and drink enough and to maintain a balanced diet. The menu for the home was changed monthly and there was a choice of healthy eating for people. We saw a wipe board documented the meals for that day. The home had two dining room areas. We observed people choose where they preferred to eat their lunch. We observed people were provided with a choice of sandwich for lunch and they had access to drinks around the home and throughout the day. The home had a kitchen for

people to prepare their own food if they chose to do so.

We saw in people's care files a nutritional screening tool that recorded any specific support they required with their nutritional intake. Monthly records were also kept of people's weight to help monitor peoples dietary intake. A care worker said, "We monitor people's weight using BMI [Body Mass Index] monthly, if we have concerns we monitor weekly and will involve a GP who will refer to a dietician."

Care plans we looked at included information about the support people received with their health. This included support from other professionals, for example, a psychologist and a specialist learning disability nurse. Records were also kept of any professional visits including the persons GP. The senior care worker told us people in the home were involved in trialling a software application called 'My Health Guide'. We saw this was an electronic way for adults with a learning disability to manage their healthcare, and to communicate their needs and wishes independently.

Care plans included a health passport. These recorded a summary of the person's medication and health needs on a template provided by the Humber Mental Health NHS. The health passport was shared with other health professionals when the person was away from the home, for example, if the person was admitted to hospital. This meant that hospital staff had relevant information about the person's specific support needs.

Good

Is the service caring?

Our findings

Our observations during the inspection confirmed that staff knew the people in the home and people knew the staff. The senior care worker told us, "We always ask people if they want to be involved in the recruitment process for new staff to help us make sure they are the right match." One person confirmed, "I am involved with the recruitment process, I can ask questions and this helps to make sure we have the right people." Once recruited, staff underwent a period of induction where they were introduced to people who lived at the home alongside an experienced worker to help people adjust. Staff told us care plans contained good information about people and that they were required to read and sign to demonstrate they understood people's individual needs. A care worker said, "We get to know about people's needs from their care files but we find out more by spending time talking with them and their families." People told us they were happy living in the home and confirmed they liked the staff. One person said, "I like [care worker] best but everybody is nice."

People were appropriately dressed and employees were mindful that any personal care should be offered in a way that respectfully promoted the individuals dignity. We saw people were addressed how they wanted to be. We spoke with care workers and they confirmed to us that they had a good appreciation of what was meant by treating people with dignity and respect. We saw staff knocked on people's doors and awaited confirmation before entering. A care worker said, "I always treat people how I would expect to be treated in my own home; I ask people what they can do and what they would like me to do and I always respect their wishes and preferences." The registered provider told us in the PIR, 'Everyone has the opportunity to lock their bedroom door if they wish to do so.' A care worker told us, "[Person] likes to remain in their room and has a key but chooses to turn around a 'Do Not Disturb' sign," they continued, "We keep up regular checks to make sure they are safe." This meant the registered provider respected people's privacy and their wishes.

People told us they were included in discussions around their care and that these were recorded. We saw care plans included; 'Life story; historical facts about me.' During our inspection, we looked through a care plan and the person living at the home joined us. They discussed the content with us and it was clear from our discussions they had been involved with and agreed to the content. Other people we spoke with confirmed they had been involved with the planning and reviewing of their care and support. Care plans we inspected included detailed information about people's needs and the support they required and we saw they were signed by the person to agree to the content. The registered provider documented a daily diary for each person that provided a record of how the person's daily care and support needs had been met and any activity they had undertaken.

We saw that people receiving a service had any disability needs documented in respect of the seven protected characteristics of the Equality Act 2010: age, disability, gender, marital status, race, religion and sexual orientation. We saw these needs were adequately provided for within the service and by peoples own family and spiritual circles. We saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this.

Staff told us they understood the term confidentiality. They told us "I would not discuss peoples care in front

of others or with anybody who does not have a need to know," they continued, "If I received information that was a safeguarding concern and the person was at risk, I would discuss this with the person and would share that information with the relevant individual."

Good

Is the service responsive?

Our findings

People received person centred care, which was responsive to their needs. Each person had an initial assessment that, along with support plans, identified people's interests, goals and aspirations before they started to receive the service. Care plans we looked at were individualised and person centred. It was clear from talking to people and staff that support and care provided at the home was centred on the person. One page profiles in care plans included 'What people appreciate about me', 'What's important to me' and 'Good to know'. One person showed us where 'Good to know' included information that the person suffered from Hay fever. They told us they enjoyed going out to visit educational farms and it was important others were aware of their allergies so they could enjoy the day. There was clear information about people's physical and emotional needs, their likes and their routines, as well as how best to communicate with people who received a service. We also saw a weekly diary sheet highlighting any routine activities that people had undertaken. These were all reviewed with the person, their family and health and social care professionals and signed by people who used the service.

The registered provider told us in the PIR, 'The Beeches aim is to help people live as independently as possible, development of independent living skills: travel training, money management and cooking are a few.' A member of staff told us, "This is the person's home and as such we have to respect their wishes and everything about them." They said, "We encourage people to be independent and to do as many things as they are able to." We saw one person had a weekly list of tasks around the home." We asked the person about this and they told us, "I asked to be involved with the running of the home and staff came up with this plan," they added, "I can do as much or as little as I want to depending on how I feel on the day." Other people we spoke with told us "There is a lot to do living here, there are trips, celebration parties and I can visit my sister too," and "I am happy living here, there are lots of activities."

We saw the registered provider held a residents meeting once a month. Minutes of the previous meeting included discussion by people on their care, maintenance, food, social activities, complaints, suggestions and general business. The minutes included actions taken following the previous meeting. This meant the registered provider encouraged people to be independent and to take control over their lives and their homes, and that their concerns were actioned.

We saw care plans were reviewed at least monthly and amendments were made as people's needs and preferences changed. We saw that these reviews took into account the needs and views of the person receiving a service. All of the care workers we spoke with said they had time to read the support plans and they told us they were an important tool in getting to know people and their individual needs. This meant the service was responsive to people's individual requirements and staff had access to up to date information to provide effective personalised care and support.

A member of staff told us they really cared about the people they supported, they told us, "I enjoy working here; it's like a close family." Comments from staff included "We give people choices about drinks, food, time to get up and go to bed" and "People are able to make their own decisions, for example, if they want a bath or a drink there are no set times." Care workers we spoke with told us there were no restrictions on what

people could do as long as people were safe. We saw people watched TV, took part in other activities and one person baked a cake in preparation of a birthday party.

People told us they knew how to complain and to whom. One person told us "When I need to complain I speak to the manager or [Care worker]." Care workers told us they thought people knew how to complain and said this was encouraged. Care workers told us they would report concerns to management or if it concerned the service, they would speak to the CQC or the local authority. We saw the service had a 'Concerns and Complaints' policy in place. The registered provider kept a record of complaints and compliments received. Documented concerns included details of the concern, details of the investigation, outcomes and actions, and whether or not the complainant was satisfied with the outcome as well as any other additional action taken. We saw complaints were analysed for any trends and learning as a result was actioned to reduce re-occurrence.

Requires Improvement

Is the service well-led?

Our findings

The home had two registered managers in post on a job share basis. The registered managers were not available during our inspection and we were supported by a senior care worker. The registered provider told us on the PIR, "The senior has previous managerial experience and qualifications." There was positive feedback from everyone we spoke with about the leadership of the home and there was a high degree of confidence in how the service was run. There was a clear management structure in place and staff understood their roles and responsibilities.

We saw the registered provider had an organised filing system. People's files were maintained in a locked office and staff files were maintained in a separate locked manager's office. Despite this, we found that systems and process to manage and record information for people employed was ineffective. This was a breach of regulation 17(2) (d) Good Governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The senior care worker told us during our inspection, "The management team, including the proprietor of the home, is extremely supportive and they have a strong focus on the people who live in the home," they said, "We have a great team of staff and have recently recruited additional care workers to ensure people receive consistent care and support from people they know."

Care workers present told us that they found management to be approachable and supportive of their needs. They told us there was an open door policy and that they were confident that if they had to whistle blow the manager would retain confidentiality and deal with the information in a professional manner.

The senior care worker understood the requirements of the registered provider's registration with the Care Quality Commission (CQC) and they were able to discuss notifications that were required to be submitted as part of that registration.

Information, best practice and learning was shared during monthly staff meetings. Where care workers were unable to attend, they told us they received copies of the minutes and had to sign to agree they had read and understood the information provided. Minutes included updates to working practices, for example, food safety, medication and record keeping. Minutes from a staff meeting in March included an exercise in identifying service users from both old diary and recent diary notes. Staff guessed the person correctly from the old notes but struggled from the new notes. A care worker told us the exercise was to emphasise the importance of documenting person centred care notes and not just generic information.

The registered provider showed us a file containing policies and procedures in the general office that was available for staff to access. We saw from staff files that staff were required to sign their understanding of these documents and the contents were discussed during staff meetings.

There was a quality assurance system in the home. This included surveys sent out to close relatives and health workers involved in people's care. We saw 22 surveys had been sent out and nine completed forms

had been returned. Feedback was rated, for example, 100% of respondents agreed that staff were polite and helpful, 78% of respondents felt they were always consulted and 28% sometimes about the support given to the person who lived in the home.

Quality Assurance included monthly medication audits, care plan audits, night call alarm tests, and water temperature checks. We saw where problems were identified actions were apparent. For example, we saw not all hot water bath taps were fitted with a thermostat and the registered provider had requested quotes for the installation of thermostats for sources of all hot water. Staff we spoke with told us they thought quality assurance was used to improve the home for people. A care worker said, "We are included in discussions on outcomes and we are able to feedback, it all helps improve things."

The registered provider had a statement of purpose with ten aims and objectives that included, 'To provide an inclusive homely environment where service users develop a sense of belonging and are safe from all aspects of harm'.

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 17 HSCA RA Regulations 2014 Good governance The registered provider did not have a robust system and process in place to support and record that staff had the required up to date qualifications, skills and experience necessary to ensure they were competent in undertaking their role and that this was regularly reviewed. Breach of Regulation 17 (2) (d)