Elmwood Residential Home Limited

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Inspection report

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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?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on the second and third August 2016 and was unannounced. We previously inspected the service in April 2015 and found three breaches of regulations in relation to person centred care, consent and safe care and treatment. Some improvements had been made but new concerns were also identified which need to be addressed.

The service is registered to provide accommodation with personal care for up to 38 people. The home is mainly for people over 65 years of age, who may have physical disabilities, long term medical conditions or memory loss. There were 37 people at the service when we visited, one of whom was staying temporarily for a period of respite.

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.

At this inspection we identified several environmental risks for people who lived at Elmwood. These included scald risks due to excessively hot water, broken/missing window restrictors in some upstairs bedrooms, and balcony areas that appeared in a poor state of repair. We asked the registered manager to seek further advice to help them risk assess and prioritise what urgent actions were needed to improve people's safety and reduce environmental risks for them. They updated us within a few days of the inspection, of actions underway to reduce risks and further work was planned.

Although some aspects of care records had improved, we found the standard of record keeping was inconsistent. Some people's care records were up to date, there were gaps in other records and some were overdue for updating. This increased the risk people would not receive all the care they needed. People were not fully protected because the quality monitoring systems in place were not fully effective. This was because they did not identify the environmental risks or issues with records found during the inspection.

Staff had undertaken additional training and understood their responsibilities in relation to the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS).

People had access to healthcare services for ongoing healthcare support. Staff recognised when a person's health deteriorated and sought medical advice promptly when they were feeling unwell. Staff worked closely with local healthcare professionals such as the GP and district nursing team, who confirmed staff sought advice appropriately about people's health needs and followed their advice. People received their prescribed medicines on time and in a safe way. People were supported to improve their health through good nutrition and staff encouraged people to eat a well-balanced diet, and make healthy eating choices.

Staff were knowledgeable about people's care needs and received regular relevant training and updating.

Staff knew people well, understood their needs and care was personalised to their individual needs. Staff treated people with sensitivity, dignity and respect and in a caring and compassionate way. People were supported to keep in touch with family and friends and spend time with them.

Staff demonstrated a good understanding of what might constitute abuse and knew how to report any concerns they might have. The provider had a written complaints policy and procedure, and knew how to raise concerns or complaints, which were investigated and responded to.

The culture at the service was open, and promoted person centred values. Staff worked proactively with other professionals for the benefit of the people they supported. There was evidence of making improvements in response to people's feedback, and of learning lessons following accidents and incidents.

We identified two breaches of regulations during the inspection. You can see what action we told the provider to take at the back of the full version of the report.

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

Some aspects of the service were not safe.

People were at increased risk because environmental and safety risks had not been adequately assessed and managed.

Risks assessments for individuals were detailed and identified measures to reduce risks as much as possible.

People were supported by enough staff so they could receive safe care at a time and pace convenient for them.

Staff received training on recognising potential signs of abuse and knew how to report suspected abuse. Any concerns reported were investigated and dealt with.

People received their medicines on time and in a safe way.

Is the service effective?

Good

The service was effective.

Staff understood their responsibilities in relation to the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS).

People experienced a level of care and support that promoted their health and wellbeing. Staff recognised any deterioration in people's health. They sought professional advice appropriately and followed that advice.

People were cared for by knowledgeable and experienced staff. Staff received regular training and support with practice through supervision.

People were supported to eat and drink and maintain a balanced diet.

Is the service caring?

Good

The service was caring.

People received care from staff who developed positive and caring relationships with them.

Staff were kind and affectionate towards people and knew what mattered to them.

Staff treated people with dignity and respect and were caring and compassionate towards them.

Staff supported and involved people to express their views and to make their own decisions, which they acted on.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

Although improvement in care records had been made, the standard of record keeping was inconsistent. Some people's care records were up to date, but there gaps in other people's records and some were overdue for updating.

People received personalised care from staff who knew each person, about their life and what mattered to them.

People and their relatives felt confident to raise concerns with staff. There was a complaints process, and any complaints were investigated and actions taken to make improvements.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well led.

People were not protected because the quality monitoring systems in place were not fully effective.

There was a registered manager and the culture was open, friendly and focused on each person as an individual.

People, relatives and staff expressed confidence in the leadership and said the home was well run.

People's, relatives' and staff views were sought and taken into account in how the service was run and examples of suggested improvements were implemented.

Elmwood Residential Home Limited

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 second and third of August 2016 and was unannounced. Two inspectors completed the inspection.

The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information included in the PIR along with information we held about the home. This included previous inspection reports and notifications sent to us. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing any potential areas of concern.

We spoke with 16 people using the service, five relatives or friends and looked in detail at five people's care records. We spoke with ten staff, which included the registered manager, deputy manager, the provider, care, catering, housekeeping and administration staff. We looked at four staff records, at training and at quality monitoring records such as health and safety checks, medicine audits and at accident/incident monitoring. We sought feedback from health and social care professionals who regularly visited the home including GP's, community nurses, therapists and commissioners and received a response from four of them.

Requires Improvement

Is the service safe?

Our findings

People said they felt safe living at the home. One person said, "Of course I feel safe. They go out of their way, they really do." Another said, "I can go where I like. Everything is done, I don't have to worry." A relative said, "I feel she is safe here, I can sleep at night." However, during the inspection we identified several environmental risks for people.

Since we last visited the home, the Care Quality Commission (CQC) received a concern from a relative about a person, saying they were bathed in water that was too hot. We asked the registered manager to investigate. The investigation identified, that, although staff tested the temperature of bath water, they were not recorded, so staff could not confirm the person's bath temperature and although upset, the person wasn't harmed. In order to improve safety, the registered manager arranged for staff to document all bath water temperatures. We found this practice was being maintained and demonstrated people were bathed in safe bath water temperatures.

When we checked the hot water temperatures coming from taps in two bathrooms and six bedrooms, we found the hot water was too hot to hold your hand under. This suggested the hot water temperatures exceeded the 44 degrees limit recommended by the health and safety executive (HSE), to prevent people's risk of scalding by immersion in hot water. The registered manager said the maintenance man checked the bath water temperatures each week, which they confirmed were documented as part of their monthly health and safety audit. However, in one bathroom, these checks failed to identify the bath tap temperature was too high. Also, no checks of hot water temperatures in hand wash basins were undertaken. The registered manager said they were falsely reassured, because they thought all baths and basins were fitted with temperature controlled valves, to ensure the water was no hotter than the recommended limit.

Some environmental risk assessments had been risk assessed (such as fire hazards related to portable oxygen) but others had not been (such as hot water). There was no risk management system in place to control the risk of exposure to legionella bacteria. (This is a bacteria that can be found in water systems and cause a form of pneumonia, known as Legionnaires' disease). We also identified some rooms on the first floor that had no window restrictors fitted. The HSE recommend window restrictors, which limit the size of window opening, should be fitted in all upstairs rooms, to reduce the risk of people falling from upstairs windows. We also identified some balcony areas that appeared in a poor state of repair. These findings meant people were at increased risk of avoidable harm because some health and safety risks were not being adequately managed.

This is a breach of regulation 12 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

We asked the registered manager to check the rest of the building and to take further urgent action to reduce these environmental risks and improve people's safety. On 5 August 2016, the registered manager contacted CQC to outline immediate actions being taken to address and manage these risks. On 13 August 2016 CQC received a further update which confirmed work to fit thermostatic valves to all remaining rooms

had started, window restrictors were fitted and the balcony repair had been completed. They also confirmed a system of weekly checks had been instigated to manage Legionella risks.

Staff received regular fire, health and safety, and infection control training. Each person had a personal emergency evacuation plan which showed the support they needed to evacuate the building in the event of a fire. Fire drills were carried out regularly in accordance with fire regulations. Regular checks of the fire alarm system, fire extinguishers, smoke alarms, and fire exits were undertaken. A maintenance book was used for staff to request any maintenance issues and to confirm when they were completed. Gas and electrical appliances and equipment was regularly serviced and tested. Regular checks of equipment such as beds, mattresses and hoist slings were undertaken.

People were protected from potential abuse and avoidable harm. Staff received safeguarding adults training and knew about the various types of abuse and how to report them. No safeguarding concerns had been reported by staff at the home, and any concerns identified externally were investigated and followed up. The provider had safeguarding and whistle blowing policies which provided staff with details of who to contact and what to do if they suspected or witnessed abuse or poor practice.

Staff had a good understanding of their responsibilities for reporting accidents, incidents or concerns. Risk assessments were in place to protect people and support them to be as independent as possible. Where accidents and incidents were reported, these were reviewed to identify ways to further reduce risks. For example, for a person at risk of falling, the advice of the community falls team was sought. The person's risk assessment included making sure the person's room was kept free from clutter, that they were wearing good fitting shoes and for staff to remind them to use their mobility aid. Other measures to reduce falls risks included extra checks of people at risk, particularly at night and the use of call bell pendants for some people. This meant they could move around the home independently, and call for staff assistance, if needed, wherever they were in the home.

Staff knew people well and there were sufficient numbers of staff to keep people safe and meet their needs. Staff worked in an unhurried way, and supported people at a time and pace convenient for them. There was seven or eight care staff in the morning, five in the afternoon and two staff at night. There was also housekeeping, catering, maintenance and administrative staff. The registered manager used a dependency tool to assess the number of staff needed to provide people's care, which they adjusted as people's needs changed. For example, depending on people's moving and handling needs and when they needed end of life care. Two regular agency staff covered any gaps in staffing due to sickness and annual leave which provided continuity of care. Staffing rotas showed recommended staffing levels needed were maintained.

People were supported by staff with the appropriate experience and skills. No new staff were recruited since we last visited, although the home had two agency staff working there long term. Records showed the agency had undertaken the appropriate recruitment procedures to make sure those staff were of good character and suitable for their role. The deputy manager had worked alongside both staff during their first month to check they had the appropriate clinical skills to care safely for people.

People received their medicines safely and on time. Staff administered most people's medicines, although people could administer some or all of their own medicines, where it was assessed as safe for them to do so. Staff who administered medicines were trained and assessed to make sure they had the required skills and knowledge. Medicines administered were well documented in people's Medicine Administration Records (MAR), as were the application of prescribed creams. Medicines which needed extra security were audited monthly, to make sure their use was accounted for. The registered manager said they checked MAR sheets regularly and followed up any discrepancies or gaps in documentation with staff, although these checks

were not documented.
People were cared for in a clean, hygienic environment and there were no unpleasant odours in the home. Staff had hand washing facilities and used gloves and aprons appropriately to reduce cross infection risks. Housekeeping staff used suitable cleaning materials, colour coded mops and cloths were used in designated areas to prevent cross infection and staff followed cleaning schedules.

Good

Is the service effective?

Our findings

We followed up concerns raised at the last inspection about the lack of up to date mental capacity assessments and records of 'best interest' decisions and found improvements had been made. The registered manager sent us an action plan which showed staff had undertaken additional staff training on the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS).

Staff sought people's consent for day to day support and decision making, for example, about personal care, food and drink choices and some people had signed to confirm their consent for their care and treatment plans. People's legal rights were protected because staff demonstrated a better understanding of the MCA and DoLS and how these applied to their practice. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision was made involving people who know the person well and other professionals, where relevant. For example, where a person's mental capacity assessment showed they lacked capacity, their care record said, 'Give me a choice' and 'needs plenty of reassurance, I will call out to ask if I'm staying.'

Relatives and professionals confirmed staff consulted them about 'best interest' decisions regarding people's care and treatment. We saw evidence of this in end of life care plans and in decisions made about resuscitation. However, we had difficulty identifying other 'best interest' decisions from people's records. For example, about the use of a pressure mat to monitor a person's movements or about the decision that a person should remain in their room, as they became too distressed when they were in communal areas of the home. We followed this up with the registered manager, who said these decisions would have had been documented in their daily records, at the time those decisions were made. The registered manager was going to seek some further advice from the local authority in order to better capture all 'best interest' decisions.

DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. The safeguards exist to provide a proper legal process and suitable protection in those circumstances where deprivation of liberty appears to be unavoidable and, in a person's own best interests. Following the last inspection, staff had sought the advice of the local authority deprivation of liberty team and submitted DoLS applications for three people, and was awaiting their assessment. This was because they felt those people had restrictions on their freedom due to their physical and mental health needs. This demonstrated that staff were acting in accordance with national guidance.

People and their relatives spoke positively about staff and told us they were skilled to meet their needs. Comments included: "Staff are very good, they look after her well;", and "I feel he is well looked after" and "Staff are very competent." A professional said, "I'm impressed, the atmosphere is one of care, there is an attitude of an attentive approach to each person."

When staff first came to work at the service, they undertook a period of induction. This included working alongside more experienced staff to get to know the person and how to support them. The deputy manager

had worked alongside two agency staff when they first started working at the service to assess they had the right skills and attitudes to ensure good standards of practice.

The provider had a training programme to ensure staff had the right knowledge and skills and they supported them to gain qualifications in care. A training matrix showed staff undertook regular update training such as safeguarding adults, health and safety, medicines management and moving handling. They also undertook training relevant to the needs of the people they supported. For example, staff had recently undertaken training on the mental capacity act, dementia and end of life care. The registered manager said this had helped staff to better understand and meet people's communication needs. Staff were supported in their practice through regular supervision (one to one meetings). They confirmed they regularly received feedback on their performance and had opportunities to discuss their future training and development needs.

People had access to health and social care professionals such as their GP, dentist, chiropodist and district nurse. Staff supported people to attend specialist appointments when required. Staff had undertaken further training on the use of assessment tools for assessing nutritional, pressure area and falls risks and demonstrated a good understanding about how to use those tools to improve care. Where assessments had identified individual health needs, more detailed care plans were in place about how staff should meet those needs. For example, in relation to pressure area care, nutrition and hydration and catheter care.

Staff monitored people's health care needs and reported any changes in their health or well-being to their GP or district nurse. For example, we followed up the care of a person with nutrition and hydration risks we had been concerned about previously. The person's nutritional risk assessment tool was accurately completed; staff had sought the advice of a dietician and had compiled a detailed care plan about their nutrition and hydration needs. They kept detailed daily records of all meals, drinks, snacks and nutritional supplements given. They monitored the person's weight regularly and updated their nutritional risk assessment, which showed their nutrition and hydration had improved.

People gave us very positive feedback about the quality of the food at the home. Comments included; "The food is excellent;" "Food is really good. I don't think they could do much better;" and "They really do go out of their way to make sure you have proper food. One person said, "We always have a choice … if you really don't like something you only have to say, they will get you something else." People's care records included details of their food likes and dislikes and any specific requests. For example, one person liked scrambled eggs, ham and cheese but disliked cucumbers and spicy foods, and another person preferred soft food as they found it difficult to chew. Staff had all the information they needed about people's dietary preferences and relevant health needs.

People were supported and encouraged to eat a well-balanced diet. All meals were cooked from scratch each day using fresh fruit and vegetables and local ingredients. The chef had a four week menu, and people had a choice of two main courses for lunch each day. At monthly residents meetings, people were regularly asked for feedback about the food and were consulted about changes to the menu. Staff promoted healthy eating choices, for example, people with diabetes were offered sugar free alternatives and some people had chosen to have smaller portions as they were trying to reduce their weight. Where people needed to gain weight, extra butter and cream was used to increase the calorie content of their food.

Good

Is the service caring?

Our findings

People described Elmwood as "homely" and "friendly" and said they were happy with the care they received. People and relatives feedback showed staff developed positive caring relationships with them. Comments included "Staff are extremely helpful, so friendly" and, "Staff are kind, I complement them all. They do the best for us, I appreciate that." A relative said, "Lovely staff, friendly place." Other written feedback from cards and letters from relatives included; 'Thank you for providing such a caring and supportive home;' 'Thank you for the support and friendship you have shown which she valued and enjoyed.' A professional said, "It's homely and people are treated in a respectful way."

People appeared happy and contented. Staff treated each person as an individual and there was lots of joking and laughter and gestures of care and affection. Staff knew people well, and spoke about them with respect and affection. A staff member noticed when a person was looking at the home's pet bird in his cage. They joined them and taught them how to whistle to get a response from the bird. When a person became anxious about their failing eyesight and their forthcoming appointment with a specialist. The registered manager spent time chatting with them and reassuring them that it was all arranged.

People received care and support from staff who had got to know them well. The registered manager had introduced a 'Life Story book' so staff had more information about each person's life before they came to live at the home. For example, that a person had worked in the Royal Air Force and was married and had a family. People were supported to dress how they wished, a hairdresser visited regularly and staff offered people nail care. Care plans included details about people's preferred personal appearance, such as, that it was important to a person that they always looked smart and tidy.

People were wearing their glasses or they were at hand, and staff ensured people's hearing aids were checked and maintained in good working order. Staff knew about people's individual communication skills, abilities and preferences. For example, that one person had a hearing loss in one ear, so referred staff to speak to them in the other ear. Another person sometimes said 'no', when they meant 'yes' due to a brain injury, all of which was captured in their care records.

People confirmed they were consulted and involved in decisions about their care and most people had signed their care plans to confirm they agreed with them. Staff involved relatives and kept them informed of any changes through personal contact, by telephone, email or by letter.

People were asked whether they had any preference about whether they received personal care from male or female staff, and this was recorded. People said staff always treated them with dignity and respect and provided them with privacy when they were receiving personal care. For example, by pulling the curtains and covering the person with a towel during personal care. A staff member offered a person a clothes protector, to protect their clothes from spills during their meal. Another staff member discreetly prompted and helped a person in the lounge to go to the bathroom. Where people expressed religious preferences, they kept in contact with their local church through regular communion services at the home and by attending church coffee mornings.

People were supported to remain as independent as possible. For example, a GP arrived to see a person who had contacted them directly to arrange their visit. Care records included information about which aspects of care people could manage themselves and which aspects they needed help with. For example, that a person needed a plate guard and occasional prompting to eat independently.

People's bedrooms were personalised and decorated to their taste with people able to bring treasured pieces of furniture or other mementoes when they moved to the home. Family photographs, favourite ornaments and pictures were on display in people's rooms.

Staff were proactive and made sure that people were helped to maintain relationships with those that mattered to them. Family and visitors dropped in regularly throughout the day, and were warmly welcomed with a hot drink and chatted easily to staff. On the second day we visited, it was a person's birthday, and staff arranged for family members to have a private lunch party for family to use to celebrate the person's birthday with them. One person said, "Staff are kind, friends pop in and are made welcome." A relative appreciated that staff kept in contact with them about the person, whilst they were abroad on holiday.

People and their relatives were given support when making decisions about their preferences for end of life care. Some people had made advance decisions to refuse active treatment or admission to hospital if their condition deteriorated. The provider information return (PIR) showed people's individual care plans included what where they would like to be cared for at the end of their life, as well as their preferred funeral arrangements. Hospice staff had worked with the home to improve end of life care by providing end of life care training for staff. For example, on managing pain relief and mouth care. Where people were identified as nearing the end of their life, staff had obtained 'Just in case bags' which provided anticipatory medicines their GP thought they might need for pain relief.

When we visited, two people were receiving end of life care. Staff were attentive to their needs, offered them regular pain relief and repositioned them regularly, using pressure relieving equipment to make sure they were kept comfortable. We observed a member of staff on their knees at a person's bedside, as they talked gently to and reassured the person. Professionals said they were very happy with the standard of end of life care provided and confirmed people were cared for with dignity and kept comfortable and pain free.

Requires Improvement

Is the service responsive?

Our findings

Following concerns found at the previous inspection, the registered manager sent an action plan detailing improvements made to make people's care plans more personalised about how each person wished to receive support. They also highlighted that they had added an index and dividers to each person's care records, so it was easier to identify and access each different section.

People and relatives confirmed they were involved in developing their care, support and treatment plans. Each person had a named member of staff referred to as a keyworker, who was responsible for ensuring people's care needs were met, supporting them with activities and spending time with them. They were also responsible for reviewing and updating people's care plans with them. However, the standard of record keeping was very variable. We found some people's care records were more difficult to navigate because they contained a lot of duplicate documents and out of date information.

For example, one person's care record still contained daily record entries going back to 2013, and another person's had three versions of a Treatment Escalation Plan (TEP), completed at different times. TEP's provide staff information about a person's wishes about resuscitation in the event of an unexpected collapse. This increased the risk to the person because out of date information could be used to make resuscitation decisions in an emergency. In one person's care record, a person's initial mental capacity assessment undertaken was crossed out and the assessment document reused to undertake a further mental capacity assessment at a later date, which made it unclear and confusing to read.

Some risk assessments we looked at were not signed and dated, so it was unclear who wrote them or when they were written and some people's care plans were overdue for review. Where a person's health had changed it was evident staff had contacted other professionals for advice and guidance. For example, where a person had lost their confidence after numerous falls when they became unwell, staff had sought the advice of the mobility team and encouraged the person to use call bell when they needed help. However, their care plan had not been updated since September 2015 so didn't capture these changes, although staff were aware of them.

This is a breach of regulation 17 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives said care was personalised to meet people's needs. Comments included "Staff are very good, they look after me well;" "I have a pendant if I want to ring them, it is on my trolley;" and "They do the rounds at night. If I am still awake they ask me if I want something, either a tablet or a warm drink. They are very attentive….they seem to know if something is wrong." Staff responded to people's changing needs quickly. For example, when a person became anxious that their son hadn't arrived, staff reassured the person that their son visited each evening after work. When a person became upset and wanted to leave, a staff member took them outside in the garden whilst they waited for their son to arrive.

A verbal handover meeting was held between staff at the start of each shift which ensured that important

information was shared, and acted upon. A communication book was used to highlight changes in people health, care or medicines. Care records had more personalised information about how each person wished to receive their care and support and examples seen reflected people's needs and choices. For example, one person liked to get up slowly in the morning and enjoyed a chat with staff before receiving their personal care and another person needed help and encouragement to eat, which they received at lunchtime.

One person said they particularly liked having company at the home, and that there was something going on every day. "It's sheer luxury for me, I'm so lucky to be here." A relative said, although the person wasn't terribly sociable, they would like staff to be more proactive in trying to engage the person. They said, "She sits there on her own in the afternoon, I would like them to walk her around the garden in her wheelchair." Two other people also said they would like staff to help them access the garden more regularly.

Several people had a daily paper delivered and some people had joined the local library and enjoyed trips there to choose their reading books. Others enjoyed listening to the radio, music and watching TV. People had a range of activities they could be involved in. They could choose what activities they took part in and suggested other activities they would like at monthly residents meetings. For example, people had recently requested a weekly 'tuck shop' which staff had arranged.

Although Elmwood did not employ a dedicated activity co-ordinator, staff were encouraged to do individual and group activities with people. A weekly activity programme showed external entertainment and internal activities available such as quizzes and crosswords. On the first day we visited, ten people enjoyed a harp recital in the lounge in the morning and on the second day several people joined in a 'knit and natter' session run by a volunteer. Other activities included a 'Forget me not' reminiscence event using a box of interesting items as a reminder to people and a weekly 'film night,' which was popular. The August 2016 newsletter showed photographs of people enjoying an 'indoor garden party' in July 2016, attended by friends and family.

Where people chose to remain in their rooms, they said staff popped in regularly to chat and keep them company. However, a relative commented that they often saw staff sitting together in an office, when they could be chatting with people in their rooms and keeping them company. A social activities book highlighted people who were at risk of becoming isolated. Staff could record when they spent time with a person and when they had visitors. However, there were lots of gaps between entries. For example, one person's entry showed a staff member last spent one to one time with them on 24 April 2016, and another person's hadn't recorded that the person's friend visited them the previous day. This meant the activity book could not be relied on as an accurate record of each person's social activities.

People and relatives said they had no concerns or complaints about the home. They said if they had any concerns, they would feel happy to raise it with the manager or deputy manager and were confident it would be dealt with straightaway. One person said, "The girls are very nice and helpful, I've no complaints about anything" and another said, "I would tell [deputy manager] if I really had something bothering me, she is quite good." People were also asked if they had any concerns or worries at monthly residents meetings.

The provider had a written complaints policy and procedure. Written information about how to raise a complaint was given to people and was on display in the home. Complaints and concerns were taken seriously and used as an opportunity to improve the service. The PIR showed there had been 11 complaints in the past 12 months. We sampled some of these and found they had been thoroughly investigated, with staff interviewed and actions taken to follow up the concerns raised. Where concerns were raised about individual staff these were dealt with through on going monitoring and supervision. Response letters were sent to complainants with apologies offered and explanations given about actions being taken to improve.

Any wider lessons were discussed with staff at team meetings and in one to one meetings.

Requires Improvement

Is the service well-led?

Our findings

The service had a range of quality monitoring systems through which people's experience of care and the quality of service was monitored. However, some of these were not fully effective because they did not identify the two breaches of regulations found at this inspection.

For example, the registered manager completed monthly health and safety checks of the premises, but these had failed to identify the environmental concerns we identified about hot water temperatures, a lack of legionella controls, absent/broken window restrictors and balcony repairs needed. They also did a monthly audit of people's social activities, although this had not highlighted gaps in people individual records. We asked the registered manager whether any audits of standards of record keeping were undertaken and found none were. This meant that opportunities to identify gaps and inadequate record keeping were being missed.

This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager looked at all accidents/incidents reported each month to identify any trends or themes. Improvements made in response to these audits included the introduction of pendant call bells for people at higher risk of falling and increased staffing levels early in the morning and in the evening when demand for staff was high. Regular cleaning audits were undertaken to check cleaning schedules were followed and made sure people's rooms were kept clean and tidy.

People, relatives and staff were positive about the home and described the culture of the home as open and friendly. Staff said they worked well together as a team and there was good communication. People, staff and health professionals expressed confidence in the leadership and management skills of the registered manager and deputy manager. Both shared an office in the centre of the home and operated an 'open door' policy. People, staff, relatives and professionals came into the office regularly to ask questions, share information and raise any concerns.

They registered manager and their deputy described their leadership style as 'hands on,' in that they both did shifts alongside staff and worked weekends. This meant they were able to role model the behaviours expected and monitor staff practice, attitudes and skills. The registered manager said they were committed to promoting people to have choices and to enhance their wellbeing by listening and supporting people to make their own decisions. Three senior care staff led the staff team in the absence of the registered manager or deputy manager and the registered manager said they were gradually giving them more responsibilities to develop them for the future.

The registered manager and deputy manager went to see everyone regularly to check on them. The provider also visited the home regularly and spoke with people, relatives and staff and sought their feedback about the service and ideas for further improvement. One person said, "I have seen him a couple of times, he seems quite a nice man, he asked if everything was ok and if there was anything they could do better."

Relatives were encouraged to contribute ideas to the running of the home, which were implemented. A relative with an interest in fossils had suggested to them that they did a talk for people about the Jurassic era which was very well received. Another person's relative recently set up the 'knit and natter' group with staff support. The registered manager met with the provider regularly and said they were supportive of any improvements suggested. There was an ongoing programme of work to improve the environment of the home such as painting and decorating. Since we last visited, the carpets in corridor areas had been replaced.

The service worked in close partnership with two local GP surgeries and the district nursing team to support people's health care needs. The registered manager said they had recently attended a meeting with their local GP practice to discuss medicines management and prescribing. The registered manager and deputy manager had recently undertaken training on 'verification of death,' as this service was no longer available from GP's out of hours.

Evidence based policies and procedures were provided to guide staff in their practice. These included policies on safeguarding, Mental Capacity Act, health and safety and infection control. People's care records were kept securely and confidentially, and in accordance with the legislative requirements. The registered manager had notified CQC about significant events. We used this information to monitor the service and ensure they responded appropriately to keep people safe.

Where areas for improvement were identified and discussed during the inspection, the registered manager was open to feedback. Since the inspection, they have e mailed us about further actions already underway to make improvements in relation to the breaches of regulations we identified. This showed they were committed to making further improvements. The registered manager said they kept up to date with current practices and changes in legislation and national guidance through a professional magazine, via the CQC website and by seeking professional advice and undertaking their own research on areas relevant to people's needs.

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 12 HSCA RA Regulations 2014 Safe care and treatment People's safety was at risk because of environmental risks at the premises. These included risks of scalding because hot water supplies exceeded maximum temperatures recommended by Health and Safety Executive for vulnerable people. Other health and safety risks included a lack of legionella controls and absent/ faulty window restrictors. This is a breach of regulation 12 (2) (a) (b) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People were not protected because the quality monitoring systems in place were not fully effective. This was because they had not highlighted environmental risks for people and inconsistent standards of record keeping. This increased the risk people would not receive all the care they needed. This is a breach of regulation 17 (2) (a), (b), (c), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.