Leyton Healthcare (No 15) Limited

Ashlea Grange

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires improvement

Overall summary

This inspection took place on 6 October 2015 and was unannounced. This meant the provider did not know we would be visiting. A second day of inspection took place on 7 October 2015 and was announced. The service was last inspected on 30 October 2013. At that time it met all of the standards that we inspected against.

Ashlea Grange is a care home providing personal care for up to 40 older people. It is a purpose built care home spread over two floors, though only the ground floor was used for accommodation. At the time of the inspection 10 people were using the service, 9 of whom were living with dementia.

There was a registered manager in place. 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.

Summary of findings

Medicine records were not always filled in accurately, which meant it was not always possible to tell if medicines had been administered. Staff did not receive regular supervisions or appraisals, but felt confident to raise issues with the manager. Training the provider deemed as essential for staff to complete was not up to date.

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

People's relatives thought the service was safe. Detailed risk assessments were carried out, which were used to plan and deliver support in a safe way. The service operated a robust recruitment process, and during induction new staff were equipped with training to allow them to safely support people.

Staffing levels were sufficient to allow staff to spend meaningful time with people, and to deliver support in a patient and unhurried way. Emergency plans for people and the service minimised the risk of harm to people in emergency situations.

The service protected people's rights by ensuring they were not restricted unnecessarily unless it was in their best interests. The service worked collaboratively with the people's families to determine people's best interests, but had not always submitted Deprivation of Liberty Safeguards (DoLS) applications where it was thought people could be deprived of their liberty.

People were supported to maintain a healthy diet, and to access external healthcare when necessary. The service was involved in a number of collaborative projects with external healthcare professionals for the benefit of people.

Staff supported people kindly and with compassion. Relatives were positive about the care people received, and felt involved in it.

People had their own keyworker which helped to provide a continuity of care. Care plans were detailed and personalised, which meant people received the care and support they wanted. Plans were regularly reviewed to ensure they reflected people's current needs, and relatives felt involved in this process. The service was pro-active in obtaining the views of people living with dementia.

People had access to a wide range of activities that were tailored to their abilities, and which promoted a homely atmosphere. Relatives felt confident that they could make a complaint if they needed to.

The registered manager regularly assessed all aspects of the service to ensure that quality was maintained. Staff felt supported by the registered manager. The provider also undertook quality checks. Staff did not always feel supported by the provider.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not always safe.

Medicine records were not always filled in accurately, which meant it was not always possible to tell if medicines had been administered.

Risks to people were assessed and minimised, and plans were in place to provide a continuity of care in emergency situations.

People were supported by staff who had been appropriately recruited and inducted.

Requires improvement

Is the service effective?
The service was not always effective.

Staff training was not always up to date and staff did not always receive supervisions and appraisals to support them in their work.

The service did not always submit timely applications for Deprivation of Liberty Safeguards authorisation.

People were supported to maintain a healthy diet.

The service worked collaboratively with external professionals to support and maintain people's health.

Requires improvement

Is the service caring?
The service was caring.

People were treated with dignity and respect, and the service had a kind and caring atmosphere. Relatives felt involved in people's care.

The service did not advertise or promote advocacy services.

Good

Is the service responsive?
The service was responsive.

Care records were detailed, personalised and focused on individual care needs. People's preferences and needs were reflected in the support they received.

People had access to a wide range of activities, with an emphasis on involving people living with dementia.

Good

Is the service well-led?
The service was not always well-led. Staff feedback was encouraged but this was not done in a formalised way through staff meetings.

Staff did not always feel supported by the provider.

Requires improvement

Summary of findings

The registered manager carried out a number of checks and audits to maintain the quality of the service.	

Ashlea Grange

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 6 October 2015 and was unannounced. This meant the provider did not know we would be visiting. A second day of inspection took place on 7 October 2015 and was announced.

The inspection team consisted of an adult social care inspector, an expert-by-experience and a specialist advisor. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Before the inspection, we reviewed the information included in the PIR along with other information about any incidents we held about the home.

We contacted the commissioners of the relevant local authorities as well as health and social care professionals to gain their views of the service provided at this home. We contacted the local Healthwatch group to obtain their views. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During the inspection we spoke with five people who lived at the service and four relatives. We looked at seven people's care plans, medicine administration records (MARs) and daily care records. We spoke with 11 members of staff, including the registered manager, three senior care workers, three care assistants, the activities co-ordinator and members of the domestic and kitchen staff. We looked at three staff files, which included recruitment records.

We used a Short Observation Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk to us.

Requires improvement

Is the service safe?

Our findings

Medicine records were not always filled in accurately, which meant it was not always possible to tell if medicines had been administered.

We looked at people's medicine administration records (MARs). A MAR is a document showing the medicines a person has been prescribed and recording when they have been administered through staff signing the record. There were signatures missing from four people's MARs, which meant that it was not possible to see from the record whether they had received their medication. We asked the registered manager about this who identified the member of staff responsible and opened an investigation.

We looked at records for people who were prescribed paracetamol for pain relief. Two of the three boxes looked at had more tablets in than were recorded on people's medicine records. This meant staff had signed to say that medicine had been taken but it was still in the box. We asked the registered manager about this and they opened an investigation.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were audited every month by senior care workers, with the registered manager monitoring the results. The audits were up to date. Medicines were securely stored in locked cupboards and rooms and the only key holder was the senior care assistant on duty. Prescribed creams for topical application were dated on opening and all were discarded every month. A topical cream chart was available for care staff and contained within personal hygiene charts. Controlled drugs were stored in a suitable locked cupboard, and the stocks held by the service had been appropriately ordered for a person assessed for end of life care.

Staff we spoke with who administered medicines had knowledge of safeguarding regarding correct administration, discarding spoiled medicines, covert medicines and self-administration. One person had a letter from their GP authorising the use of covert medicines but this was not in the proper form. We asked staff about this and they told us that they were aware of this and were working with the GP to obtain it.

Relatives told us people were safe at the service. One relative said, "My [relative] is very safe in here and what is more she is happy and well cared for." Another said, "My [relative] is very safe with the staff in here. If I had any doubts at all then I would have him moved, but I have none."

There were safeguarding policies in place covering areas such as, 'Safeguarding Service Users from Abuse' and 'Safeguarding Service Users from the harmful actions and behaviour of other Service Users'. These were displayed in the reception area and throughout the service, and were easily accessible. Staff received mandatory training in safeguarding, though two members of staff had training overdue. There were no safeguarding incidents under investigation at the time of the inspection, but staff had a working knowledge of how they should be carried out. One member of staff said, "I have done safeguarding training. Safeguarding abuses could involve acting without consent, neglect of care and treatment and things like that". Another said, "I would know what to look out for." The registered manager said, "I sent one to safeguarding but they said it wasn't a safeguarding. I would basically send anything I was concerned about. Would rather be overcautious."

The staff handbook contained a whistleblowing policy which set out the procedure for raising an issue, the lines of responsibility and a 'statement of commitment to support staff'. One member of staff said, "There is a whistleblowing policy. I have never had to use it but I would if I needed to". Another said, "We have a policy but I would go straight to the manager if I had a concern".

Care records contained risk assessments for falls, skin integrity, hoist, mobility, challenging behaviour and the input of tissue viability nurse. The assessments were reviewed on a monthly basis and the reviews were up to date. Care notes also contained a general risk assessment. This contained detailed information about the person's abilities and meant staff had the information they needed to safely support people. People had an individual personal emergency evacuation plan (PEEPs) which assessed their mobility, overall level of dependency and the level of assistance each person would need to evacuate the building in an emergency. People also had an Emergency Health Care Plan, which contained details of their medicines and the support they needed in case of an emergency hospital admission.

Requires improvement

Is the service safe?

There was an overall business continuity plan in case of emergency which listed relevant contact details. The registered manager told us that arrangements were in place with nearby services operated by the same provider to provide a continuity of care in case of emergency. There were regular inspections of food hygiene, PAT testing, gas safety, lifting equipment such as hoists and the passenger lift. Fire records showed monthly checks of internal and external escape routes, fire doors and fire extinguishers. Monthly fire alarm drills took place. We saw that the last fire risk assessment of the building took place in 2010, but the registered manager told us that Tyne and Wear Fire Service visited annually and had last inspected the service in February 2015. We were shown an email from the fire service which read, 'I am pleased to inform you that in February this year the home was inspected and received a more than satisfactory outcome. Well done and keep up the good work'.

The service had an accident book, and the registered manager audited incidents on a monthly basis for trends. They said, "I look at what's happened and any action that needs taking, for example referrals." We saw that accidents had been recorded in the accident book, and that where remedial action was recommended it had been taken. For example, following a person falling the investigation recommended referral to the falls team. The person's care records showed that this had been done.

Staff files contained a photograph of the member of staff. Recruitment involved an interview which assessed staff knowledge and motivation, ability and experience, communication and personal qualities. Two references were sought and a Disclosure and Barring Service (DBS) check was completed prior to people starting work. One member of staff started a month before their DBS check was complete and an issue was raised by one their referees. This had been disclosed by the member of staff in interview; a risk assessment was undertaken on their suitability to work with vulnerable people and they were offered the job with conditions of regular supervisions. There was evidence of investigations where staff had been through the disciplinary process, and outcomes were recorded. This meant the provider ensured that people were protected by its robust recruitment and disciplinary processes.

Staffing levels were based upon people's dependency. This was reviewed on a monthly basis, and staffing levels matched that assessed as required. Staff felt that staffing levels were sufficient to support people. One said, "There are only nine residents at the moment. We do all we can for them because we love them. Nothing is a burden; I love my job and everyone in here." Another said, "We have enough staff. We always cover. It's only ever night shifts where we struggle if a senior is off as this isn't always easy to cover."

The building was clean and well-kept, and corridors were free of obstructions and clutter. Staff displayed an understanding of infection control as they worked, washing their hands and using aprons during medicine administration and whilst giving personal support. A domestic staff member said, "We keep the place tidy and clean. Bedrooms are checked and bins emptied every day. I do monthly checks of bedrooms where we check general housekeeping and wear and tear, and also the call alarms. Things get dealt with straight away when I report it."

Requires improvement

Is the service effective?

Our findings

Training the provider deemed as essential for staff to complete was not up to date. There was an overall training matrix to allow the service to monitor staff completion of training. All staff received mandatory training in food hygiene, fire safety, medicines, emergency first aid, health and safety, moving and handling, infection control, challenging behaviour, dementia, safeguarding, mental capacity/DOLS, End of Life Care, COSSH and falls prevention. The policy was to refresh this training annually. Staff also undertook additional distance training in safeguarding, medicines, dementia, healthy eating and food hygiene, health and safety, infection control and end of life care. Staff were encouraged to train for higher level NVQ Health and Social Care qualifications. Nine were working towards level 3 and three towards levels 4 and 5.

The training matrix showed that some refresher training was overdue. All staff were overdue refresher fire training, five staff were overdue refresher first aid training, 18 staff were overdue refresher health and safety training, seven staff were overdue refresher moving and handling training, 17 staff were overdue refresher health and safety training, 18 staff were overdue refresher dementia training, 10 staff were overdue refresher dementia training and 11 staff were overdue Mental Capacity Act/DoLS training. The registered manager said, “There is some training overdue. The overdue on the matrix have forthcoming sessions. If we don’t have a forthcoming session we have four sister homes and we can use their training. I don’t update the matrix until I have the certificates. We take part in the Tyne and Wear Care Alliance…they always email when there’s training available”.

We asked about supervisions and appraisals. These are a means for management to assess staff competency and knowledge in the delivery of their role. The registered manager said, “Supervisions are every three months and appraisals yearly. I am a bit behind. I keep supervisions in my diary. I used to have a wall chart but they moved it when decorating.” We saw that a pro-forma supervision sheets was used, and we looked at completed forms. These covered areas including staff time management, communication, awareness of training, policies and their duty of care and any comments made by staff. ‘Action points’ were recorded at the end of the form. There was no supervision and appraisal matrix or plan that allowed management to see who was overdue a supervision or appraisal.

The registered manager said, “They are pretty much all behind. The ones on the clipboard have been done but everyone else is behind”. The clipboard contained supervisions for three members of staff. The most recent appraisal record in one staff file was dated March 2014 and the supervision record September 2014. In another staff file the most recent appraisal record was dated April 2014 and the supervision record June 2014. One member of staff said, “I have never had a supervision or appraisal. I just go and raise issues when I have them.” Another said, “I can’t remember my last supervision or appraisal…if I had an issue to raise I would go and see [the registered manager].”

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff felt that they received enough training to support people, and encouraged to progress their careers. A domestic member of staff said, “I can do any training that I want to do. I am actually doing medicines training at the moment. I’ve done my NVQ levels 2 and 3 and eventually want to move into a carer role. The organisation is brilliant. Anything I want to do I can do straight away.” Another said, “If we ask for any training that helps us do our job then we can have it. Our manager is good at supporting us and knows us well enough to know what courses will help us most. Safety is one of them.” Another said, “I have identified some training I needed and [the registered manager] organised it for me. The organisation is good, they pay you while we do our training”. A fourth said, “I am going to do level 3 NVQ. I have finished level 2 and I have been on a number of courses which have included moving and handling, first aid, dietary needs, etc. I am doing medication and fluids now. I have done all the mandatory training to keep our people safe”.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. MCA is a law that protects and supports people who do not have the ability to make their own decisions and to ensure decisions are made in their ‘best interests.

Requires improvement

Is the service effective?

Care records contained a 'mental capacity' care plan which was reviewed every month. People were free to move around the building, and no-one received support in a way that restricted their liberty. There was a keypad lock on the front door which prevented people from leaving the service. We asked the registered manager about this restriction and the lack of DoLS authorisations. They said, "At the moment two people have DoLS and one application went in yesterday. I am busy putting the rest in...we were advised to hold off as the forms were changing. The new forms came through in September and I have most of them filled in now and ready to send. I think probably everyone needs one here. It will probably take me about a week to do them." We asked what would happen if a person who did not have a DoLS authorisation in place asked to leave. The registered manager said, "People don't make attempts to leave but doors are locked so they are restricted. If we let them out on their own I think they would be at risk of self-neglect. For the seven people without authorisations we try not to restrict them. If someone was adamant they wanted to leave I wouldn't stop them as we can't, but we have a duty of care so would go with them, let the family know and encourage them to come back." Staff had a working knowledge of capacity and the Mental Capacity Act 2005. One said, "We observe capacity and have outside support. Just because a person can't make a decision one day doesn't mean they can't the next, or make different decisions". When staff supported people they asked them questions and explained what they were doing even where the person did not respond. We concluded that staff understood and applied the principles of the Mental Capacity Act 2005.

Relatives said that they were involved in making decisions in the best interests of people. One said, "I have been involved from the beginning in making decisions for my dad. I can honestly say they do listen to me and they act on what I say. My dad is treated with great kindness and respect. I am listened to, too, and play a big part in any decisions made for him." Another said, "My husband can't make decisions for himself. He is a wonderful husband and I want the best for him. I am involved in any decisions that are made." A third said, "Mam can't make any decisions for herself now, although there are times when she is better than others. I am involved with any decisions and I come to reviews."

People were supported with their food and nutrition. Throughout the day staff ensured people had enough to eat and drink by offering snacks and drinks. Staff were aware of people's specific dietary needs and who required specialist diets such as soft diets or fork mashable food. Most people chose to eat in the dining room, though one person was supported to eat in their room. Picture menus were used and the menu was updated daily. Staff promoted people's independence by encouraging them to eat without support where appropriate, and we saw that people appreciated this. One person said, "I think I can manage but I will let you know, thank you." Staff supported people with patience and kindness, and people were allowed to enjoy their meal in a relaxed atmosphere. During lunch a person started singing and other people and staff joined in.

Where people were supported this was done discreetly. Staff took time to speak to people while they were eating, and we saw them exchanging jokes and stories. Relatives were encouraged to eat with people, and the 'Residents and Family Christmas Dinner' was promoted in communal areas. One relative said, "I visit my dad almost every day, only very occasionally I miss a day but I know how well cared for he is. Staff are very welcoming. I have a meal with dad and see the care he receives. Wonderful caring staff. I couldn't praise or thank them more." People were weighed on a monthly basis, and care records showed that where weight loss was identified they were increased to weekly. A new care plan was then put in place to identify this and a nutrition chart put in place to monitor food intake. If needed the GP was contacted and referrals were made to the dietician. Where people had been prescribed fortified drinks this was fully documented fully documented in care plans about people's nutritional well-being

Care records contained evidence of appropriate referrals to health professionals, including the speech and language therapy team (SALT), respiratory and tissue viability nurses, social workers, opticians, dentists and chiropodists. Referrals were clearly documented in the 'professional visits section' of care plans. The service worked collaboratively with a nearby GP practice. This involved a GP visiting the home on a weekly basis to talk to people and their relatives, make necessary referrals and reviewing do not resuscitate records and Emergency Health Care Plans. The service participated in the 'Coalfields Project', a local healthcare initiative resulting in weekly visits from an assigned community nurse and an assigned SALT member to whom the service can make self-referrals. The service had also signed up to a pilot scheme called, 'Care Home

Requires improvement

Is the service effective?

Tablet'. The registered manager said, "I signed up in July 2015. It's run by the CCG. We will upload information about people on the tablet. We're getting a Bluetooth blood pressure cuff, temperature probe and pulse oximeter. We'll upload readings to the tablet and that analyses the baseline readings and advises. GPs, nurses and dieticians can access the readings. We're not sure exactly when it's coming in but I'm at a meeting next week."

Good

Is the service caring?

Our findings

Staff supported people in a kind and caring manner. Staff knew people well and were able to talk to them about their lives and relatives. Support was given in a discreet way which helped to maintain people's dignity. For example, we saw one person signalling to a member of staff for assistance with moving from the lounge. The member of staff knelt down and whispered closely to the person to ask how they could assist. Staff closed doors when they were delivering personal care which helped to promote people's dignity. Staff responded to incidents quickly, and we did not hear call bells ringing for lengthy periods of time.

Relatives told us that people were treated with compassion, respect and kindness. One said, "From the day my [relative] came in here he was treated so very kindly with care, respect and with compassion. I love him so much I wish I could have given him the care he needs at home, but I couldn't. I go home after visiting him every day knowing he is well cared for." Another said, "This is a wonderful home. The care, and kindness even us as a family get, is tremendous. I know [relative] is happy. I know he is well cared for. They get in touch with me if they have any concerns. You can't beat the care and support he gets in here." A third said, "I could not praise them too highly. They are there in a minute when he needs help. These staff care about people and it shows."

Visits by relatives were encouraged, which helped to create a homely atmosphere. One said, "I visit my [relative] every day… I know he is in very good caring hands. I can sleep at night." Another said, "I visit [relative] often and I have always been welcomed and with a smile. The staff look after her well and are so kind, nothing to worry about in here, I am sure of that. They are great." Relatives were also encouraged to take part in planning people's care. One said, "I came to discuss my [relative's] care plan a couple of months ago. We were all quite satisfied about his medical care. A doctor calls in every week so I get told if there is a concern. Everything apart from his known problems is OK." Another said, "I am fully involved in my [relative's] care plan. He is a very poorly man at the moment and I care about him so much. The staff are excellent. I am fully informed about everything." A third said, "We do get involved in my [relative's] care plan. She is doing quite well at the moment."

Relatives told us that staff met people's needs. One said, "Without doubt, I do feel they do their very best for my [relative]. He is bathed often, his clothes are kept clean, his bed gets changed almost daily, and he is warm and comfortable and gets good food. I can't fault them." Another said, "If my [relative's] needs were not being met then he would not be in here. No. I must say you could not find better care than he gets in here. Any problems with his health they are straight onto the doctor and call me too." A third said, "I think they are wonderful staff who give wonderful care to my [relative]. She gets better care than I could provide."

Advocacy services were not advertised or promoted. The registered manager said, "No-one uses an advocate. We did arrange one for [a person] once before. The social worker said they had capacity but we didn't think they did so we arranged for an advocate. We arranged for an advocate then. If someone wanted to use an advocate now they would just ask."

Good

Is the service responsive?

Our findings

People had a designated keyworker, and care plans were personalised and focused on individual care needs. The care plans were in place for consent, environment, nutrition/diabetes, communication, personal hygiene, sleeping, pain, social needs, medication, mental capacity, skin assessment and continence. These were reviewed on a monthly basis and were rewritten every six months or more frequently if people's needs changed. In addition to an Emergency Health Care Plan, each person also had a 'hospital admission pack' with information on which documents should accompany them during any hospital admissions.

Care plans were clear and easy to follow. At the front of each plan was a photograph of the person, their room number, a list of abbreviations used in the plan and a list of staff signatures so that it was easy to see who had delivered care. The front of the file also contained details of any allergies and whether the person had a do not resuscitate decision. One person stayed in bed most of the time and had developed soreness. The care plan contained information on the treatment that was being provided by the district nurse and evidence of two hourly turns to assist the healing. Another person's care plan identified that they had behaviour that challenges. A 'behaviour support' care plan was put in place, which contained detailed guidance on triggers that the person might respond to and how staff could comfort, reassure and support them in a wide range of scenarios. Care plans contained personalised life histories and people's likes and dislikes. In one person's care records they had mentioned they previously enjoyed playing the piano. The service arranged for the piano to be transferred to the home so that they could continue to play it.

Each person had their own reminiscence box, which were individually decorated by them. These contained items that were of importance to that person or which reminded them of happy memories. They also contained a booklet called, 'The Ongoing Life Story of…' that listed people's relatives, their hobbies and interests and their memories of significant moments in their lives such as weddings or births. We saw staff using these to talk to people. Communal areas were decorated with reminiscence items and posters from the local area to assist people living with dementia.

Activities were promoted throughout the building, and the service had an activities co-ordinator. These included physical exercises, arts and crafts, reminiscence sessions, sing alongs, parties (for birthdays and festivals such as Halloween) and trips to parks and shopping in the local area. Throughout the inspection we saw that the activities co-ordinator was fully engaged with people, and that they were enjoying themselves in exercise sessions and in making birthday cards for a person's upcoming birthday. One person was confined to bed during the inspection, and we saw that the activities co-ordinator spent some social time with them.

There was a schedule of activities but the activities co-ordinator was responsive to people's views and abilities. They said, "We go with the flow as every day is different. It's hard to get feedback but I do try to involve everyone in planning. It feels awful if people just have to fit in so I try to keep them involved as much as possible. We have some really supportive families who get involved." Staff we spoke to said that activities were one of the things the service did best. One said, "[The activities co-ordinator] is amazing. I have seen two or three people in my time here and residents didn't always do a great deal. [The activities co-ordinator] does exercises, raffles, is always involving families and making arrangements. She's amazing." Another said, "[The activities co-ordinator] is the best thing that we've done as the residents do much more."

The provider had a complaints policy. This detailed the procedure to be followed if a complaint was made but it was not on display anywhere in the building. There were no records of any complaints having been made. The registered manager said, "There have been no written complaints and no major complaints from people since I started. Any issues have always been resolved pretty quickly. If I got recurrent complaints I would fill in a log to keep track but I haven't had any." We asked how people and their relatives would be aware of the complaints procedure, and the registered manager said they would be given a copy if an issue arose.

People's relatives said they would feel confident to make a complaint if they needed to. One said, "I have never had the need to make a complaint about the care my [relative] gets. I would certainly complain if I needed to, of that you could be certain, but no, he is well cared for and I am happy with the care he gets." Another said, "I have not had any concerns. I would certainly see the manager if I was not

Good

Is the service responsive?

pleased with the care my [relative] needs and gets. There has not been one single thing I could complain about. I am more than delighted with the care he gets. Wonderful care." A third said, "I would not hesitate to make a complaint if it was necessary. I can't see it happening with this staff – they are so kind, caring and helpful."

Requires improvement

Is the service well-led?

Our findings

The registered manager oversaw a number of monthly audits. These included maintenance checks, kitchen cleanliness and repair, infection control, PPE, waste disposal, hand hygiene, uniforms, bathrooms and toilets, cleanliness, mattress, laundry and medicines. We saw the audits were up to date. The registered manager said, "We do a questionnaire to people every six months. An activities one, a Family and Friends one, a service user one and a meals one. We usually send them out in June and December."

The 'Questionnaire for Service Users' asked people questions covering areas such as their privacy, personal preferences, whether they knew how to make a complaint and whether they thought staff were trained. The 'Family & Friend Questionnaire' asked questions including, 'Does your relative feel safe?', 'Is your relative's privacy and dignity respected?' and 'If you have an issue regarding the care provided to your relative do you know who to speak to?'. We asked how the information gathered from the questionnaires was used. The registered manager said, "We have had a problem as the administrator filed the responses away and nobody knows where they are. The administrator has since left. The only records we have are for June 2014, and I did one in January or February 2015. If actions that needed dealing with were raised I would raise and action plan to deal with it." This meant that the service had no record of people's feedback before June 2014, and the only feedback it had was from February 2015.

Relatives confirmed that they were encouraged to give their feedback. One said, "I have filled in a few surveys, I have always been positive because I find the care given here is excellent." Another said, "Yes, through surveys. We are asked if we are happy with the service and you can always put in suggestions." A third said, "I have filled in the forms they give you asking if there is any improvements they can make and also if we are satisfied with the service. I think they do very well for all the people in here."

The registered manager understood their responsibilities to make relevant notifications to the Commission, and had knowledge of Commission guidance. Links had been forged with other services operated by the provider in the area. The service participated in collaborative work through the 'Coalfields Project' and through its forthcoming pilot of 'the Care Tablet'.

We asked how feedback from staff was sought. The registered manager said, "I do have staff meetings. I try to do monthly but we didn't have one in September. If something specific arose we might have more than one a month". There were no minutes or records of staff meetings. This meant staff who were unable to attend had no information about what was discussed including expected standards and practices. The registered manager said, "They aren't minuted as usually I just write things on the board. If an issue was raised by staff I would just bring them in and deal with it individually. Staff tend to come to speak with me separately."

Staff said that there had not been staff meetings but that they were confident to speak to the registered manager and other staff about any matters arising. One said, "We have never had a staff meeting since [the registered manager] took over. Staff are very good at communicating with each other and [the registered manager] is approachable." Another said, "We have never had a staff meeting since the old manager left but [the registered manager] is approachable." Another said, "I think she is a good manager. If I had any problems or concerns about the people we care for, then I would go and talk to her." A fourth said, "The manager is a person you can go and talk to. She cares about everybody residents and families too."

The provider undertook 'Monthly Monitoring Visits'. This evaluated areas such as, the care and treatment of service users, dignity and respect, consent, safeguarding and receiving and acting on complaints. The most recent visit took place on 14 September 2015, and where issues had been identified an action plan had been generated for the registered manager to follow. The registered manager was previously supported by an area manager based in Yorkshire, but area manager responsibilities had recently been changed to an operations manager based in Kent. Staff did not always feel supported by the provider. One said, "I don't think they have any interest in us and they are not approachable in any way". Another said, "I think the provider management needs improving". A third said, "[The provider] isn't approachable. They have very little to do with the home."

Staff spoke positively about the culture and values of the service. One said, "It is a nice place that has a great rapport with families and residents." Another said, "I like working here and like the residents. I think it's nice here and the residents are together a lot. It makes it nice and homely."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. 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 Medicine records were not always filled in accurately, which meant it was not always possible to tell if medicines had been administered. Regulation 12(2)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff did not receive such supervisions or appraisals as is necessary to enable them to carry out their duties. Training the provider deemed as essential for staff to complete was not up to date. Regulation 18(2)(a).