The Cedars (Weston) Limited

Cedars (The)

Inspection report

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Date of inspection visit:
26 October 2016
27 October 2016
28 October 2016

Date of publication:
02 February 2017

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**

Summary of findings

Overall summary

This inspection was unannounced and took place on 26, 27 and 28 October 2016.

The Cedars provides accommodation and personal care for up to 28 older people including those with dementia. Some people at the home needed support to communicate verbally. During the inspection there were 25 people living at the home. The accommodation is arranged over two floors with bedrooms on both floors.. On the ground floor there are a number of communal spaces including a lounge, conservatory and dining room.

The registered manager had been registered for five months. A registered manager is a person who has been registered with the Care Quality Commission to manage the service. They are a 'registered person'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was supported by a deputy manager and two seniors.

People told us they felt safe and we saw evidence. Some improvements were required with the way medicines were managed and equipment was checked. Medicines taken 'as required' rather than regularly did not have written protocols for staff to follow and the provider's procedures for crushed medicines had not been followed.

When people lacked capacity to make their own decisions the principals of the Mental Capacity Act 2005 were not always followed. This meant some people were at risk of having their human rights breached.

The registered manager was developing quality assurance systems to help ensure people received good and safe care. Some concerns identified on the inspection had not been identified by the provider or registered manager.

There were enough staff to support people. There was a recruitment process in place but members of staff sometimes forgot to document all the checks completed. Staff told us they had an induction and had received a lot of training. The support staff received was through an informal process. People received care and support from staff who knew how to meet their needs.

Staff knew how to protect people from avoidable harm or abuse and had received training in safeguarding. They told us they would be confident reporting any concerns to the management and staff knew who to contact externally. The provider understood when they were responsible for informing the local authority and CQC about safeguarding.

People who required Deprivation of Liberty Safeguards to protect their human rights were in place and staff knew what process to follow.

People were able to see a wide range of health and social care professionals to meet their health and care needs. People's choices were respected by staff. People with different religious beliefs and cultural backgrounds had these respected by staff because they attended services or spoke in their first language.

People enjoyed eating food they were given and told us they had a choice of meals, snacks and drinks. When people expressed they wanted something different it was provided.

People and their relatives thought staff were kind and caring and we observed positive interactions. The privacy and dignity of people was respected and people were encouraged to make choices throughout their day.

There were care plans for all individuals which included their likes and dislikes. These plans made people central to their care and any decisions made. The needs of people were reflected within their plans. Staff had excellent knowledge about people's care needs.

People and relatives knew how to complain or had the information available if required. There had been formal complaints since the last inspection which had been managed in a timely manner.

The registered manager had a clear vision for the home and had systems in place to communicate this. People and staff were aware of these visions.

We have made a recommendation about staff supervision.
We have made a recommendation about quality assurance systems.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People could not always expect to receive their medicines as they had been prescribed because systems in place to manage medicines were not always safe. People were not always protected from deterioration in health because special equipment was not always checked.

People were protected from the risks associated with poor staff recruitment because a full recruitment procedure was followed for new staff. Sometimes these checks had not been correctly documented. There were enough staff to meet people's needs.

People had risk assessments which were required to help keep themselves and others safe.

People were being protected from abuse because staff understood the correct processes to be followed if abuse were suspected.

Is the service effective?

Requires Improvement

The service was not always effective.

People's rights were not always respected, because the home was not following the principles of the Mental Capacity Act. People's choices were supported.

People were supported by staff who had received training and informal supervision. The home's management were working towards formalising staff support.

People who were at risk of having their liberty deprived had the correct procedures followed.

People's nutritional needs were assessed to make sure they received a diet that met their needs and wishes. Some people were not happy with the quality of some of the food and the home's management were working to improve this.

People benefitted from good medical and community healthcare

support.

Is the service caring?

Good

The service was caring.

People's needs were met by staff who addressed and related to them in a friendly and positive manner. Staff respected people's individuality and spoke to them with respect.

People benefitted because they were able to exercise their religious beliefs and live amongst 'like-minded people'. Visitors were welcome at any time, and family members were being encouraged to take part in providing more person centred activities.

People's privacy and dignity were respected and supported.

Is the service responsive?

Good

The service was responsive.

People's needs and wishes regarding their care were understood by staff who ensured they were followed and respected.

People benefitted because staff were aware of the risks of social isolation and made efforts to engage with people throughout the day. New activities were being developed in accordance with people's interests.

People could be confident concerns and complaints would be investigated and responded to.

Is the service well-led?

Requires Improvement

The service was well-led.

People had their care needs and were kept safe because the provider and registered manager had some quality assurance systems and an action plan. Not all concerns found on the inspection had been identified by these processes and the registered manager was working on improving them.

People benefitted from living in a home where the provider and registered manager had a clear vision which was communicated to staff and relatives.

People received support from staff who understood the clear lines of accountability.

Cedars (The)

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 26, 27 and 28 October 2016 and was unannounced. It was carried out by one adult social care inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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. We looked at the information in the PIR and also looked at other information we held about the home before the inspection visit.

During our inspection we spoke with 15 people and two visitors about their views on the quality of the care and support being provided. We also had informal conversations and completed observations with groups of people throughout the day. We spoke with six members of staff including the registered manager, the deputy manager and care workers. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at six people's care records. We observed care and support in communal areas. We looked at four staff files, previous inspection reports, staff rotas, quality assurance audits, the compliments and complaints systems, staff and resident meeting minutes, medication files, environmental files, handover forms, the communication book and a selection of the provider's policies.

Following the inspection we asked the registered manager to send us further information including the training records, the provider's quality assurance audits and observations. We asked for information in relation to concerns found on the inspection. All these were sent within the time frame requested.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe and we saw some safe care and treatment. However, medicines were not always managed safely and staff were not always aware how to use some equipment. Some people were prescribed 'as required' medicines used to alleviate pain or reduce anxiety. On occasions people would be unable to tell staff when they required them. Some staff knew when these medicines should be used to prevent pain or anxiety. There were no guidelines in place to help new staff. The registered manager told us they would make sure guidelines were written for 'as required' medicines.

People received their 'as required' medicine as prescribed. However, because records were not complete staff were not able to carry out a fall audit of medicines held in stock. For example, one person had five new boxes of a specific medicine and one open box with 11 tablets left. The stock records only accounted for the unopened boxes. We spoke with the registered manager who was going to introduce a new system for stock control.

Some people had begun to have difficulty swallowing their medicines. Members of staff had been crushing the medicines and mixing with food or drink. They had not considered whether this could damage or reduce the effectiveness of the medicine. There was a letter from a GP stating they could. Staff had not taken advice from a pharmacist or other health professionals in relation to this practice. We spoke with the registered manager who told us they would make contact with relevant health professionals.

The registered manager told us no one had developed pressure sores in the home. Staff always sought advice from a health professional if people had any concerning marks on their body. To reduce the likelihood of pressure sores people had pressure relieving air mattresses. Staff were unaware they should be checking mattresses were on the correct settings. We spoke with the registered manager who said a health professional had requested the mattress. They told us they would find out the correct settings and the frequency of checks. Other medical equipment was being used by members of staff to monitor people's health. Again, they were unaware how to maintain the equipment and people's safe ranges because they had not been informed by a health professional. We spoke with the registered manager who organised for a health professional to show staff how to complete calibration tests and what each person safe range was.

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

There was a recruitment procedure for new staff which was designed to minimise risks of abuse to people. This included carrying out checks to make sure they were safe to work with vulnerable adults. A member of staff talked us through the recruitment process including completing an application form, attending an interview and checks with previous employers. They told us they had not started work until all their checks were completed. During the inspection there was some information which had not been documented correctly. The registered manager resolved these issues by contacting a previous employer and speaking with the members of staff. They explained a member of staff had forgotten to correctly document checks which had been completed.

People were supported by sufficient numbers of staff to meet their needs. One person said, "There are staff around when I need them". A relative said, "Staff check on [person's name] all the time". We saw staff responded quickly to call bells so people were not waiting long. The registered manager explained some people had fluctuating needs in the afternoon; they were constantly reviewing staff levels to ensure the right number were working. Most staff thought there were enough staff. One member of staff explained they sometimes felt rushed in the afternoon because there were less staff. The registered manager told us they would be doing further work reviewing the levels of staff required to keep people safe and meet their care needs.

People told us they felt safe at the home and with the staff who supported them. People said, "I feel safe and comfortable", "I feel safe, I can go and ask somebody if I need something" and "This is a safe environment for me". A visitor said, "My loved one is safe here".

Staff and the PIR told us, and records seen confirmed, all staff received training in how to recognise and report abuse. Staff spoken with had a clear understanding of what may constitute abuse and how to report it. One member of staff told us they would contact CQC if the management did nothing. All staff were confident that any concerns reported would be fully investigated and action would be taken to make sure people were safe. Where allegations or concerns had been bought to the registered manager's attention they had worked in partnership with relevant authorities to make sure issues were fully investigated and people were protected.

People told us they were happy with the way their medicine was given. They confirmed staff waited until they were sure the medicine had been swallowed before moving on. We saw one person was struggling to independently take their own medicine from the pot to their mouth. A member of staff spent time finding out how the person wanted help. There were suitable secure storage facilities for medicines which included secure storage for medicines which required refrigeration. We saw medication administration records and noted that medicines entering the home from the pharmacy were recorded when received. We also looked at records relating to medicines that required additional security and recording. These medicines were appropriately stored and clear records were in place. Staff told us and records confirmed there were observations to ensure people administering medicine were competent.

People had risk assessments in line with their care needs such as behaviours which could challenge and mobility. These provided staff with details about the type of risk and how to mitigate them. Care plans contained other risks assessments which outlined measures in place to enable people to take part in activities with minimal risk to themselves and others. The PIR told us other health and care professionals were consulted and we saw this had happened. For example, one person regularly accessed the community alone. The risks to the person and others had been clearly identified including sometimes they forgot where they lived. As a result, the use of a special device had been agreed by the person and other professionals to alert staff if they got lost. Another person had a behaviour which put them at risk of being hurt. Risk assessments and guidelines were in place to inform staff how to mitigate these risks. All staff were aware of the risk assessment and guidelines. This meant staff were familiar with people's risk assessments and they provided enough information to keep people safe.

People's nutritional needs were assessed to make sure they received a diet in line with their needs and wishes. There were mixed views about the food. Some people said, "The food is pretty good" and "The food is alright". Whilst others said, the "Food is not very good, I do not enjoy it" and "Food is so-so, but I will eat it". We spoke with the registered manager who explained they would look into people's individual experiences. They told us if changes were required these would be made.

Requires Improvement

Is the service effective?

Our findings

Some people whilst living at the service did not have the capacity to make decisions because of their medical conditions. Those that lacked capacity were not always having decisions made following the principles 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. 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. Best interest means a decision is made by others for a person considering what will be the best option for them. We checked whether the provider and staff were working within the principles of the MCA. During the inspection we found when people lacked capacity the principles of the MCA were not always being followed.

One person's care plan said, "After a capacity assessment it was decided that [person's name] does not have the capacity to make decisions regarding their care needs". By making this statement staff were not making an assessment for each specific decision. This was not in line with the principles of the MCA. They were at risk of falls so had a piece of equipment which alerted staff when they got up. We saw this being used in their wheelchair during the inspection. There was no MCA or best interest decision in place for the use of this monitoring equipment to demonstrate it was in their best interest.

The PIR told us MCA assessments were completed as soon as possible for some decisions. We found some people who lacked capacity there were MCA assessments completed. Although these were completed for people who lacked capacity they were not always for one decision. There was no record of the professionals and relatives who had been involved in the best interest decisions. For example, one person's MCA assessment said it was for "Personal care and treatment from health professionals". Another person's said, "This assessment was carried out to find out if [person's name] has the capacity to make informal decisions regarding washing and dressing and treatment from health professionals". This meant people who lacked capacity had not had their human rights protected in line with the principles of the MCA.

This is a breach in Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met and they were. Applications had been made for most people living at the home because they were unable to leave the building unaccompanied and they required constant supervision. One person's DoLS had been authorised and there were no conditions to follow.

The registered manager was aware supervisions for staff were behind but had prioritised people's care plans and care when they started. Supervisions were an opportunity for staff to discuss their practice and training

needs. It was an opportunity to address any concerns with members of staff. They had an action plan, which originally had the completion in September 2016. This had moved to December 2016 when they identified how much work had been required in other areas. The registered manager explained they were regularly informally supporting staff. Two members of staff told us they had a recent supervision. Whilst another said, "I have not had a supervision". Most staff who had worked at the home for over a year had not received annual appraisals.

We recommend that the provider finds out more about supervision for staff, based on current best practice, take action to update their practice accordingly.

People received effective care and support from staff who had the skills and knowledge to meet their needs. Some people said, "Staff know what they are doing" and "Staff are good, they know better than me". Staff told us they had completed training including manual handling, first aid, fire warden, dementia and medicine administration. Some staff were completing additional training in health and social care such as level two and three diplomas. One member of staff said, "I have had lots of training". By checking staff the provider was making sure people were kept safe.

People were supported by staff who had undergone an induction programme. This gave staff basic skills to care for people safely and meet their needs. One member of staff told us they were currently completing the Care Certificate. The Care Certificate is a set of standards social care and health workers follow and is the new minimum standards which should be covered as part of induction training. By having new staff complete the Care Certificate the provider was making sure all staff had a basic knowledge for working in care.

People chose their food for the next day during the inspection. If they had forgotten or wanted something different this was accommodated on the day. For breakfast there were menus on the table and people could place an order. Some of the options included hot breakfast choices, sandwiches, toast and cereals. There was a selection of drinks which could be chosen. The registered manager told us when people asked for; "The usual" staff always checked they had seen other options on the menu. This was to make sure people were aware of all the options.

At lunch time we saw people were able to choose where they ate their meal. Most people were encouraged to eat in the dining room to make it a social experience. Members of staff prompted people if they identified they were struggling to eat. If people chose to stay in their bedrooms this was respected and their food was brought on a tray. During the lunch people had three courses and afterwards the option of tea or coffee in pots. The registered manager told us they tried to recreate people's experiences of going out for a meal. We saw a person requiring care in bed was supported with their meal in a sensitive and unrushed way.

The staff arranged for people to see health care professionals according to their individual needs. Care plans showed us people had appointments with dentists, opticians, GPs and occupational therapists. One person told us the staff had supported them to hospital. They explained they had access to their GP if required. During the inspection staff reported a new superficial skin tear to the registered manager. As a result, the registered manager made a referral to another health professional to get it dressed. A health professional said, "[Staff] are pretty good at letting us know" if they are required. They told us staff communicated well with them. By communicating with other health professionals the provider was making sure people's health needs were met.

Good

Is the service caring?

Our findings

We saw people were supported by kind and caring staff. People and their relatives confirmed this. People told us, "Staff are absolutely wonderful, the Queen could not be treated better than we are treated here", "Staff are respectful" and "Staff are excellent, very respectful and caring". A visitor said, "Staff are kind and polite and know what my loved one needs". During the inspection staff would check people were alright even if they were just walking past them. When people came to the office to ask a question staff would always stop what they were doing to engage with them.

People's privacy was respected and all personal care was provided in private. Personal care is when staff provide support with intimate care such as washing and dressing. One person said, "Staff are very nice, I am never embarrassed". They continued to tell us they preferred someone supporting them of the same gender and this was respected. Staff knocked on people's bedroom doors and waited for a response before entering. Staff knew they should shut the door, close curtains and cover people with towels when supporting them with personal care. One staff said, "We close doors and curtains. Use two towels for women and one towel for men". This meant staff understood to protect people's dignity it was important to deliver personal care in private. The registered manager and PIR told us each day staff were allocated to groups of people. By doing this people knew who to contact should they require help. The registered manager explained by having named staff people's dignity could be protected when they required support of a personal nature.

Staff told us people were able to have visitors at any time. We saw relatives and visitors were welcome throughout the day. One visitor arrived and was greeted by the registered manager who updated them on their family member in detail. Each person who lived at the home had a single room where they were able to see personal or professional visitors in private. The registered manager told us they preferred if visitors booked to come at meal times. This meant the time was protected to ensure people receive support they need. All visitors had to ring a doorbell and be invited in by a member of staff. Every visitor was asked to sign the visitor's book when they arrived. This meant people were able to have visitors but were kept safe by staff.

The information in the PIR told us people's choices were respected. We saw people made choices about where they wished to spend their time. Some people preferred not to socialise in the lounge areas and spent time in their bedrooms. One person told us they liked to spend time in their bedroom dusting their belongings. If staff smoked they were encouraged to see if a person who smoked wanted to go in the garden for a chat with them. This meant smoking was made into a social occasion for people. There was a house cat which people told us they liked spending time with. One person said, "[The cat] can be good company". Other people chose to access the community independently to visit the shops.

There were ways for people to express their views about their care. One person told us the staff were "Always asking questions". Another person told us they made choices to maintain their bedroom in a certain way. Staff had respected these choices. Where there were concerns around cleanliness a compromise had been reached with the person. Staff gave people ample time to respond when they were asked for a preference. By allowing time it meant people who struggled to process information were respected.

Some people had their care needs reviewed on a regular basis which enabled them to make comments on the care they received and review their opinions. Members of staff told us this was often done informally and then care plans updated. Some people had medical conditions which meant their memory was not as good. Staff felt informally updating people's care needs and wishes made it more manageable for them. Two people were aware they had a care plan but were unaware if it had been reviewed. This meant although reviews were happening people were not always made aware.

Staff were aware of issues of confidentiality and did not speak about people in front of others. When they discussed people's care needs with us they did so in a respectful and compassionate way. People's documents were stored in the office or in a locked cupboard. The office was always occupied by members of staff, but if required could be locked. By doing this they were protecting private information from being seen by unauthorised parties.

People's religious and cultural needs were respected. A chaplain visited the home once a week and people were asked if they wanted to take communion. Another person had dual nationality and spoke a second language. Some of the staff were encouraged by the registered manager to speak with the person in their second language. The registered manager told us this was so they did not lose the ability. The person was excited to tell us about their culture. Staff from the same country told us they often brought in traditional food for this person from their home. Currently, no food to represent this culture was cooked at the home. The registered manager told us they were trying to see if some meals from this culture could be prepared. This meant people's religious and cultural needs were respected and staff were trying to meet them.

Some people in the home had end of life plans which are important to ensure people's wishes are respected. The PIR told us how people's end of life wishes were being respected. A health professional explained if the person had no family staff would "Rotate and sit with the person". They continued to tell us the provider was proactive rather than responding to a crisis. We saw people's care plans contained information about their wishes. For example, one person's care plan said, "I would like a visit from a member of church". The plan continued "[Name of person] has requested red roses to be put in [their] room" and they would like music playing. By having clear end of life plans staff would be able to meet people's wishes.

Good

Is the service responsive?

Our findings

People received care that was responsive to their needs and personalised to their wishes and preferences. One person told us the registered manager had arranged for a representative from their bank to visit and talk through some personal financial matters. People were able to make choices about all aspects of their day to day lives. Staff understood and knew the people they supported in depth. For example, one member of staff told us about a person who had specific preferences in their bedroom. Another member of staff told us about people who enjoyed spending time with the house cat. By knowing people well staff were able to provide the care and support they required. This reflected what we were told in the PIR.

One person had been given a specific role within the home so they felt valued. They had a name badge and uniform plus had been given the title "Shredding manager". They proudly showed us their badge and we saw them collect non-confidential paperwork which needed shredding from the office. The registered manager explained when the person had first moved in they felt lost and this helped them to settle. A risk assessment and special shredder had been purchased for them to safely undertake their role. As this had been so successful the registered manager and staff had plans to expand this to other people.

Care plans were personalised to each individual and contained information to assist staff to provide care in a manner that respected them. Each care plan had a detailed section for staff. These covered people's likes and dislikes, help they needed from staff and information about their life. For example, one person's care plan said, "They had a dog called Penny" and they were a post lady. In people's bedrooms there was further information to inform staff which was a summary of the care plan. For example, one person's bedroom had a poster which said, "I enjoy watching television, chair aerobics, mind and motion and baking". It continued to say "I need full support when walking with my trolley". The PIR had further plans to make a mini care plan for when new staff joined or agency staff were working. The registered manager said this was to help new or agency staff to remember key information about the person. They told us due to revising all care plans they had not had time to complete these yet. This meant people were being supported by staff who had access to detailed information to meet their needs and wishes.

The staff responded to changes in people's needs. For example, one person had mobility needs which changed throughout the day. A member of staff told us they were aware of this. Another person had recently declined in health. In response their care plan was being amended and additional input sought from health professionals. This meant the management were proactive in making sure people's care and support needs were met when changes occurred.

People were able to take part in a range of activities according to their interests. Some people had activity timetables in their bedroom and there was an activity board. We saw four people participated in an activity run by a member of staff. Other people had been asked but declined the opportunity. A person who was visually impaired told us until recently a volunteer had visited the home and done crossword puzzles with them. Whilst a new volunteer was being sourced a member of staff sat with them. Some people accessed the community, either supported by staff or independently. A member of staff showed us a photograph of a happy person receiving their ice cream whilst out during the inspection.

People were supported to maintain contact with family. We saw people had visitors during the inspection. When relatives were unable to visit they could phone people. The registered manager had a system where the phone call was transferred to a handset which was then taken to a person's bedroom. This meant people could speak with family members in private even if they were unable to visit.

The registered manager sought people's feedback and took action to address issues raised. There had been recent questionnaires sent to relatives and health care professionals. At the time of this inspection these had not been returned or analysed. We looked at the previous year's questionnaire. Most of the feedback was positive from residents and other professionals. There had been no suggestions for improvement from people and their relatives. The healthcare professionals had raised concerns about some people on respite not receiving regular washes. The management had tried to investigate this but due to lack of details were unable to reach a conclusion. By listening to feedback the registered manager told us they could make changes and follow-up suggestions which had been made.

Every three months there was a resident's meeting at the home. When suggestions had been made actions had been taken. For example, in February 2016 one person wanted less green beans for meals. In August 2016 the meeting minutes recorded "[Person's name] was pleased less green beans were on the menu". Other topics which were discussed at these meetings included the range of activities provided, including day trips. Another person said they wanted more singers to visit the home. The registered manager told us they had organised a singer who was accompanied by an accordion. This meant people's views were valued about the care and support they received.

The provider collected positive feedback from relatives and visitors to the home. Some people completed short stays at the home. They said, "I have been so grateful for all the excellent care and attention you have given me during my stay" and "I am happy to go home, but I am also upset because I will miss everyone". Relatives said, "Thank you for looking after [name of person] and your help in the last few days" and "this is a lovely home and you are doing a fantastic job".

People and visitors we spoke with knew how to complain. People said, "I can talk to staff, especially [name of manager], [they] will listen" and "I would talk to [name of manager] if I was not happy". A relative said, "I would certainly speak to the manager if I was not happy about their care and treatment". There had been six complaints recorded since the registered manager had started their new recording system. All had been resolved and managed in a timely manner in line with the provider's policy.

Requires Improvement

Is the service well-led?

Our findings

The registered manager was in the process of developing the quality assurance systems in the service. This was to monitor the care people were receiving and make sure they were safe. For example, the medication administration records (MAR) were regularly checked to ensure people had not missed their medicines. There was an action plan showing shortfalls identified by the management and when these would be resolved. Any unresolved issues had a planned completion date. In addition, some audits were being completed. Some health and safety checks were being completed; this led to the registered manager identifying an issue with staff walking with soiled laundry through the dining room. During the inspection we saw a new system which prevented this practice. This meant when concerns were identified action was taken to resolve them.

The provider had systems in place to monitor the safety and quality of care every three months. During these audits previous concerns identified were followed up. By doing this the provider was checking appropriate measures had been taken to resolve identified shortfalls. Between June 2016 and August 2016 the registered manager had attended recommended training. Care plan audits had been improved between the provider visits. This meant the registered manager used the provider's audits to improve people's care.

However, the provider and registered manager audits had not always identified shortfalls found during the inspection. For example, recruitment checks for two staff were undocumented and medicine management had some issues. Neither had recognised the safety issues when equipment was being used by members of staff without calibration. The registered manager told us they were still developing their quality assurance systems including liaising with other registered manager's.

We recommend that the service seek advice and guidance from a reputable source, about quality assurance systems in order to update their practice accordingly.

People, visitors and staff were positive about the management of the home. All people were complementary about the registered manager and knew them by name. They all felt they could go to them with any problem and would be listened to. One person said, "[The registered manager's name] is very good. All three managers are good". A visiting health professional said, "[The registered manager's name] is brilliant. This is the reason why the home has turned around". Staff said, "[The registered manager and deputy manager's names] are both great", "[The registered manager's name] is lovely and supportive" and "[The registered manager] is amazing".

The registered manager had a vision for the home to promote independence and make it a home from home. Their vision and values were communicated to staff through staff meetings and speaking with them. One member of staff said, "This home is like my home. These people are like my family". Another told us the registered manager's vision was "To have a lovely home which feels homely". The PIR told us there were regular staff meetings which the staff and records showed us. There was a system using text messages and emails to update staff with important information and we saw this in use. Staff told us the management do take notice of suggestions given. For example, one member of staff explained they suggested drawer

dividers to help organise people's laundry and it was implemented. Other staff members said, "They listen to everything we say. We needed more bedding and they got it" and "When we need something, everything happens".

There was a staffing structure in the home which provided clear lines of accountability and responsibility. The registered manager was supported by a deputy manager, two seniors and team leaders. This meant on each shift there was clear leadership for the rest of the staff. One member of staff said they have had "Great support from the management team". They told us they lacked confidence in some areas so things had been put in place. This included shadowing more experienced members of staff. The management team told us they led by example and were regularly completing shifts to demonstrate good practice. Another member of staff explained they had changed roles recently and this was supported by the management team.

Significant incidents were recorded and where appropriate were reported to the relevant statutory authorities. All incidents had been by recorded by staff and the manager explained that these were regularly reviewed so any trends or concerns could be identified. The provider had notified the Care Quality Commission of most significant events which had occurred in line with their legal responsibilities. We spoke with the registered manager who was not aware of one allegation which required reporting; during the inspection this notification was completed.

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 11 HSCA RA Regulations 2014 Need for consent Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to act in accordance with the law, make decisions based on the principles of best interest and obtain consent appropriately. This is a breach of Regulation 11 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 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure care and treatment was provided in a safe way for service users. This is a breach of Regulation 12(1)(2)(e)(g) of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014