Accommodating Care (Southport) Limited

Sandley Court Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
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

This inspection took place on 27 and 28 July 2016 and was unannounced. A previous inspection, undertaken in July 2014, found there were no breaches of legal requirements.

Sandley Court is registered to accommodate 23 older people. It is a converted house with an enclosed rear garden situated in a residential area of Southport. There is ramped access to the main entrance to assist people with limited mobility. Accommodation is provided over four floors, including the basement area. There is a central lift and a number of stair lifts to support people's movement around the building.

The home had a registered manager in place, who was also the registered provider, and our records showed she had been formally registered with the Care Quality Commission (CQC) since December 2012. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People said they felt safe living at the home and said the staff treated them well. Staff had received training regarding safeguarding and the protection of vulnerable adults. They said they would report any concerns to the registered manager. There were processes in place to monitor and review the safety and maintenance of the premises. However, we found a number of issues with the premises and equipment at the home. Some windows did not have restrictors, to limit their opening that met with current Health and Safety Executive guidance. Checks on other safety systems were in place.

Some areas of the home were not clean. Shower rooms and toilets required cleaning and some rooms had unpleasant odours. Commodes used at the home were rusted and could not be cleaned effectively. A sluice area had been left unlocked, meaning there was public access and a risk of infection. Clean clothes were stored in the staff area where they could become soiled.

Suitable recruitment procedures and checks were undertaken, to ensure staff had the skills and backgrounds to support people. People said they did not have to wait long for support. However, the registered manager did not carry out an assessment of people's dependency meaning we could not be sure appropriate levels of staff were always available.

Medicines were not always dealt with safely and appropriately. Staff signed for medicines they had not observed being taken, a cupboard containing medicines had been left unlocked and administration records were unclear or had been altered.

People were happy with the standard and range of food and drink provided at the home and could request alternative dishes, if they wished. Food for people who required soft or pureed diets was presented in a manner that supported their dignity.

People told us staff had the right skills to look after them. Staff confirmed they had access to a range of training and updating. Regular supervision took place and staff received annual appraisals.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS are part of the Mental Capacity Act 2005 (MCA). These safeguards aim to make sure people are looked after in a way that does not inappropriately restrict their freedom. The manager told us one person was subject to a DoLS and further applications had been made. Assessments had taken place to check whether people met the criteria for a DoLS application. There was some evidence that care decisions had been taken in line with best interests guidance.

People's health and wellbeing was monitored, with regular access to general practitioners and other specialist health or social care staff.

People told us they were happy with the care provided. We observed staff treated people appropriately, supportively and with an understanding of people's needs. People said they were treated with respect and their dignity maintained during the provision of personal care.

Care plans reflected people's individual needs and were reviewed to reflect changes in people's care. Details in people's care plans were not always specific enough to ensure staff could provide care safely and consistently. Some activities were offered for people to participate in, although no dedicated staff time was available. There had been two recent formal complaints, which had been dealt with appropriately.

The registered manager carried out checks on people's care and the environment of the home. These audits had not identified the short falls highlighted at the inspection. Staff felt positive about the manager and the homely nature of the service. They told us management were approachable and supportive. There were no regular meetings for people who used the service, although they said they could speak to the manager at any time. Records were not always well maintained and were not always stored securely.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to Safe care and treatment, Person-centred care and Good governance. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Some windows in the home did not have restrictors in place that met current guidance from the Health and Safety Executive and a risk assessment was not in place. People told us they felt safe living at the home and staff had undertaken training on safeguarding issues.

Some areas of the home were not always clean and some commodes used in the service were rusted. There were odours in some areas of the home. The sluice area was unlocked giving potential access to soiled items and cleaning products. Medicines were not handled safely and effectively. Records relating to the administration were unclear and appropriate practices had not been followed.

Suitable recruitment processes were in place to ensure appropriately skilled and experienced staff worked at the home. People said they did not have to wait for care, but there was no formal system to ensure staffing levels were always sufficient to meet people's needs.

Is the service effective?

Good

The service was effective.

The registered manager was aware of the Mental Capacity Act 2005 (MCA) and applications under the Deprivation of Liberty Safeguards had been made. There were formal assessments of people's capacity to determine if they fell within the guidance relating to DoLS. There was some evidence that best interests decisions had been undertaken.

People told us food and drink at the home was plentiful and they enjoyed the meals. Meals for people requiring a softer diet were served in a manner that promoted dignity.

People said staff had the right skills to support them. A range of training had been provided and staff received regular supervision and annual appraisals. People had access to a range of health and social care professionals for assessments and checks.

Is the service caring?

Good

The service was caring.

People told us they were happy with the care they received and felt well supported by staff. We observed staff supported people fittingly and recognised their individual needs.

People told us they were involved in their care through systematic reviews. There were no regular meetings with people because the manager said these were not well attended. People said they could raise issues anytime.

Care was provided whilst maintaining people's dignity and respecting their right to privacy, although there were covers on furniture which needed to be removed.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People told us the home was responsive to their needs and care plans reflected people as individuals. Details in care plans, about how staff should support people, were not always clear or specific. Plans were reviewed and updated as people's needs changed.

Some activities were available for people to participate in, although there was no dedicated staff time given to supporting such events. Some people went out into the community. People told us they were able to make choices about their care.

People were aware of how to raise complaints or concerns but said they had not made any recent formal complaints. Two recent complaints had been handled appropriately.

Is the service well-led?

Requires Improvement

The service was not always well led.

The registered manager and provider regularly undertook checks to ensure people's care and the environment of the home were monitored. However, these checks had not identified the items noted at the inspection.

Staff and people talked positively about the support they received from the manager and described her as approachable and supportive. People and staff commented on the homely nature of the service.

Professionals told us the home was responsive to any issues they highlighted. Records were not always appropriately maintained and were stored in a cabinet that could not be locked to ensure security and confidentiality.

Sandley Court Care Home

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 27 and 28 July 2016 and was unannounced. This meant the provider was not aware we were intending to inspect the home.

The inspection team consisted of one inspector.

Before the inspection, the registered provider completed a provider information return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the information we held about the home, in particular notifications about incidents, accidents, safeguarding matters and any deaths.

We spoke with four people who used the service to obtain their views on the care and support they received. Additionally, we spoke with the registered manager, deputy manager, care manager, two care workers and a kitchen staff member. We also spoke with a health professional who was visiting the home during the inspection. Following the inspection we spoke on the telephone with a member of the local infection control team.

We observed care and support being delivered in communal areas and viewed people's individual accommodation. We reviewed a range of documents and records including; four care records for people who used the service, 14 medicine administration records (MARs), four records of staff employed at the home, complaints records, accidents and incident records and a range of other quality audits and management records.

Inadequate

Is the service safe?

Our findings

During out inspection we noted a number of safety issues at the home. On the first day of the inspection a number of windows did not have restrictors in place or had devices that did not meet current Health and Safety Executive (HSE) guidance. Risk assessments had not been undertaken to assess whether window restrictors were appropriate. One window in a person's room opened onto a significant drop. The manager told us the windows were relatively new and the person had requested that the windows could be opened. She said she was not aware of the current HSE guidance on the use of window restrictors in care homes and agreed there was a risk. Some roof light windows on the top floor, at a potentially accessible level could be fully opened. Other windows had restrictors that did not meet current guidance or had not been risk assessed. The manager said she would immediately look to source appropriate restrictors and undertake risk assessments. By the end of the second day of the inspection the five windows without any safety devices had restrictors fitted. This meant there was a potential risk of people falling from windows and sustaining serious injury because proper safety systems were not in place.

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

We found concerns related to the infection control and cleanliness of the home. Toilets were not always cleaned effectively and where devices had been fitted to raise the height of seats there was significant soiling under the raised seats. A shower room on the first floor had areas of mould on the doors and grouting. Working surfaces around some sinks in people's rooms were chipped and cracked, meaning they could not be cleaned properly. The manager agreed this was unacceptable and said she would ask the domestic staff to ensure these and other areas were fully cleaned. This meant there was a risk or cross infection because areas people used for personal care had not been cleaned effectively.

The majority of the rooms at the home were not en-suite and people were supported during the night through the use of commodes in their rooms. A number of the commodes were rusted, which meant they could not be cleaned effectively. The manager acknowledged this and arranged for replacements to be ordered. Several replacement commodes had been sourced by the second day of the inspection. We noted unpleasant odours in several rooms at the home. This may have been due to commodes or carpets in people's rooms not being cleaned effectively. The manager said she would ensure additional cleaning took place.

The home had a sluice area for the disposal of waste and cleaning of commodes which had been built since the last infection control audit of the home. This area was clean and tidy and allowed cleaning of sanitary items. There was no lock on this area, leaving it potentially open to the public. Cleaning products were stored in this area. This meant there was a risk people could enter the area and touch dirty items or inadvertently access cleaning chemicals. The manager arranged for a lock to be fitted on the second day of the inspection, although we had to reminder her to ask staff to keep the area locked.

The manager showed us the home's most recent infection control audit, conducted by the local infection

control team, dated October 2014. One of the areas for action was that clean clothing should not be stored in the staff area of the home. We saw clean linen was still being left in this area, 20 months after the original action point was raised. This meant clean clothes were being left in an area where staff gathered during the day, meaning there was a potential for cross infection.

The manager told us there was 30 hours a week of dedicated domestic time for the home, split into eight hours shifts on Monday, Wednesday and Friday and a further six hours to be worked on a Saturday or Sunday. This meant there were days at the home when there were no dedicated domestic hours to ensure the home was cleaned effectively. The manager told us she would reassess the domestic needs of the home.

We noted two fire doors at the top of stair wells had self-closing devices in place, but saw these doors did not always close fully into the door frame when people walked through them. We brought this to the manager's attention who said she would address this. We also noted a linen cupboard on the first floor, which was fitted with fire resistant doors, was not locked and was sometimes ajar. The manager told us a new lock had been fitted but an internal catch was still required. She said she would ask the maintenance worker to rectify this as soon as possible.

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

We looked at how medicines were managed at the home. During the lunch time period we noted one person's medicines had been left on the table whilst they were having their meal. Whilst the person subsequently took their tablets this was not observed by staff and not observed by the staff member who had signed the medicine administration record (MAR) to say the medicines had been given appropriately. We spoke with the member of staff about this. They told us the person always took their medicines, but agreed they had not observed the person do so. We also found a cupboard, located in the corridor outside the home's office, which stored cough medicines and other similar items, had been left unlocked. This meant people could inadvertently access this cupboard and potentially take medicines not prescribed for them. Regularly taken medicines were stored in a locked cupboard in the main office. Whilst these were stored securely we saw there was no regular check on the temperature in this area, to ensure medicines were stored in an appropriate condition.

We examined the MARs for several people living at the home. We found some items had not been signed for but still appeared to be prescribed and instances where correction fluid had been used on the MARs to block out signatures previously written. We spoke to the manager about this. The manager said several items not signed for were no longer required or were temporarily not being given, but these instructions had not been entered onto the MARs. She said she had used the correction fluid on the MARs because staff had signed at the wrong time. She said staff had also continued to sign for some medicines that had been discontinued. We checked these medicines and found the remaining numbers tallied, which confirmed no additional doses had been given after the items had been stopped. MARs are legal health and social care records and should not be amended with the use of correction fluid. National guidance states any errors in recording should be simply struck out and signed and dated.

We noted one person had been prescribed a cream by the district nurse, with the instructions "use as directed." We asked the manager how staff knew how to use the cream. She said this would be written in the care plan. However, the manager then confirmed no care plan had yet been written. This meant there was no care plan for staff to follow to ensure the medicine was given correctly.

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

12. Safe care and treatment.

Checks were undertaken on the fire systems, such as alarms and emergency lighting, and on the water systems. There was evidence regular fire drills had taken place. People also had personal emergency evacuation plans (PEEPs), which detailed how people should be helped in the event of an emergency, such as fire. Certificates showing checks were in place for the fixed electrical systems at the home, the lift and individual lifting equipment, small electrical items in use at the home and gas appliances were available. Regular legionella tests were undertaken and temperature checks made on water outlets throughout the home.

People also had individual risk assessments in relation to their care. For example, people had been assessed to ensure health related equipment they used in their rooms was managed safely. There was also information to remind staff about how to deal with equipment and contact details for support. The home had several open access stairs cases, including an open staircase in the main hall and a small narrow set of stairs leading to the basement area. There was no general or individual risk assessments related to the use of stairs in the home. The manager said people rarely used the stairs and if they did it was usually with staff support, although there were times when these areas were not observed and people could potentially mount the stairs without support. This meant there was no clear assessment to ensure people could use stairs safely. We recommend the manager undertakes risk assessments in relation to the use of open access stairs at the home.

People and their relatives told us they felt safe when being supported by staff. One person told us, "I feel safe. They are not rough with me or anything. If they were, I would say something." Staff told us, and records showed training in relation to safeguarding vulnerable adults had been undertaken. The provider had a safeguarding policy in place to ensure the correct action in the event of any concerns. The manager told us there had been no recent safeguarding matters that required reporting. This meant the provider had processes in place to deal with any concerns or potential abuse issues.

We looked at personnel files for staff currently employed at the home. We saw an appropriate recruitment process had been followed, with two references requested, identity checks and Disclosure and Barring Service (DBS) checks undertaken. DBS reviews ensure staff working at the home have not been subject to any actions that would bar them from working with elderly or vulnerable people. Records for more recently recruited staff showed they had been subject to a formal interview process. Staff confirmed they had been subject to a formal induction process prior to commencing work at the home. Where necessary, staff had been subject to an assessment to make any required adjustments to support their work, such as a review of work practices in the event of a pregnancy. The manager said she was using the apprentice scheme to help develop staff for the future. We saw apprentice staff had also be subject to appropriate checks before starting work at the home. This meant the provider had an appropriate system in place to recruit staff.

The manager told us the home currently employed 33 staff to support 23. She said a morning shift was covered by five care workers and the manager or deputy manager. This reduced to three care workers after 1.00pm with one covering kitchen duties after 5.00pm. Nights were covered by two waking care workers. She said there was one person who required two staff to support them with personal care. However, staff told us that at night there were three or four people who may require two staff for support. We asked if the manager undertook dependency assessments of people living at the home to determine what level of care people required each day. She said she did not do this formally. She said she was looking at employing additional staff and apprentices to help boost the available staff on duty during the evening. People we spoke with told us that in the main they did not have to wait excessive periods for staff to support them.

Accidents and incidents were recorded by the manager, although it was not always clear from records they had been reviewed to identify any trends or recurrent causes. The manager said she would look to do this.

Good

Is the service effective?

Our findings

People told us staff had the right skills and knowledge to support them. One person who was supported with special equipment told us, "Staff understand what to do. They know how to change things." Staff told us, and records confirmed staff had access to a range of training and development opportunities. One staff member told us, "We do a lot of training. I've done a lot since I've been here. I'm doing an NVQ (National Vocational Qualification). I've progressed a lot." Staff files contained copies of certificates indicating they had undertaken recent training. The manager showed us the home's training matrix, which detailed the range of training staff were required to complete. There was also a list of future training that had been booked for staff to access over the coming year. Copies of attendance lists were also available to show staff had undertaken the required training.

Staff told us, and records confirmed they had regular supervisions and annual appraisals. We saw recently employed staff had more frequent supervision sessions to ensure they were settling in and up to date with required training. Records showed the home was following the national care certificate as part of the induction process. The national care certificate is an agreed set of standards that care workers should adhere to in their daily work. This meant staff were supported to maintain appropriate knowledge and skills to support people.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care 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.

The manager told us she had made three applications for DoLS, one of which had been refused and one which had only recently been granted. We saw documents to support this. The manager had made note of when the granted DoLS authorisation expired so she could reassess the person and make a further application, if necessary. People's care records contained an assessment checklist to assist in deciding if they met the criteria for DoLS and whether an application should be made. The manager told us no one currently living at the home had required a best interest decision. People who used bedrails when resting had capacity to agree to these being in place and had signed consent forms. One person had a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR), which had been discussed with them and they had agreed to it being in place. We reminded the manager about the need to notify the CQC when DoLS applications were granted or withdrawn. This meant people's rights were protected because the service was working within the principles of the MCA and manager had in place systems to review people's capacity and appropriate applications had been made.

People's care records contained copies of consent forms, including consent for the home to share information with other health or social care professionals. People had also signed documents stating if they required their own personal room key. People told us staff always sought permission prior to providing care. We observed staff approached people in a sensitive manner and asked them if they would like to move to the dining room for their meals, or whether they required help whilst walking to the lift. This meant people's consent was sought on a formal basis and during day to day care.

People's wellbeing was supported. Records contained a range of information and letters indicating people had attended local clinics for appointments, or health professionals had visited the home for review. A number of people were attended on a daily basis by district nurses, who came into the home to support people with their health. On the second day of the inspection a specialist from the local general practitioners was assessing people's health needs and a chiropodist was also attending to people. A visiting professional told us, "They will contact me if they are concerned, but they don't do that very often. But it should not be viewed negatively that they don't contact me. They are able to manage most situations." This meant people were supported to maintain appropriate health and wellbeing.

People told us there was sufficient food at the home for their needs. They said food was of an acceptable quality and if there was nothing on the menu they liked there was the opportunity to request an alternative. One person told us, "The food is alright. I like plain food. It's okay." Another person told us how they were concerned they were sending food back because they did not have a big appetite. They said they had spoken to the cook, who had reassured them they would prefer them to return food rather than not have enough to eat. Kitchen staff maintained a record of meals provided and we saw there was a good variety. Daily records also showed people had requested alternatives on a regular basis, such soup, eggs, fish fingers and crumpets. Information was also available about people's individual likes and dislikes.

We observed mealtimes at the home and saw food was presented in an appetising manner and appeared hot. People who requested it could have meals provided in their room. We saw these were taken to them covered, to keep food warm. Some people required a soft or pureed diet. These meals were presented appropriately, within individual portions on the plate. People's weight was monitored and action taken if there were any concerns about people losing weight. This meant people were supported to maintain appropriate intake of food and fluids.

Good

Is the service caring?

Our findings

People told us staff were caring and they were happy with the support they received at the home. People we spoke with said, "I'm looked after better than the Prime Minister. Well, I think so anyway"; "I Like familiar staff. They come in and they say, 'Are you in a feisty mood?' But it's all a bit of a laugh. You have to have a laugh don't you?" and "They are all very pleasant and helpful." A professional, who was visiting the home on the day of the inspection, told us, "The staff seem caring. I have not met a carer yet who I've thought was not right."

We spent time observing care at the home and saw staff treated people patiently and with both respect and courtesy. We observed one meal time and witnessed various friendly exchanges between staff and people they were caring for. One person asked for some bread and butter after their meal. The care worker brought them a plate of bread and butter and said, "I've made you a fresh cup of tea as well." Another person asked a care worker why they were looking at them. The care worker replied, "Because I think you are lovely (name of person)." The person replied, "Well I think you are gorgeous." They then both laughed and embraced affectionately. We witnessed staff greeting people by their preferred names, asking them if they were well and spending some time chatting to them about their families or interests. One care worker told us, "I enjoy chatting to people; they are interesting and fun." This supported the view that staff at the home were caring and considerate.

Staff told us no one at the home had any particular needs related to specific equality and diversity issues. One person told us they were regular supported to attend a luncheon club at a local church.

People told us they were involved in reviewing their care needs and care plans. One person told us, "They do sometimes sit down and review care. The manager does a review of care every so often." People's care records contained documents indicating discussions had taken place to review people's current care, review recent health changes or appointments and agree any updates people wanted to make to their care plans. Issues raised in people's reviews included; how staff could help people manage their anxiety in certain situations and a person, who had made an advanced decision, reiterating they did not wish to be taken to hospital if they became unwell.

The manager told us there were no regular meetings for people who used the service. She said they had tried to establish these but people didn't always want to attend. She stated that questionnaires were available to people and relatives to make comment. She said, because the home was small people could raise things directly with her or a member of staff and they could deal with it there and then. We saw one person raised an issue with staff and they dealt with it appropriately and sensitively.

Staff understood about respecting people's privacy and dignity. We saw staff knocked on people's doors before they entered their rooms and exited rooms during personal care in a discrete manner. Staff were able to describe how they supported people whilst delivering care, such as ensuring they were covered. We witnessed one episode where a care worker was assisting a person to the toilet. Having helped the person they then said they would wait outside and the person should call when they had finished. They then closed

the door and waited patiently until called back into the bathroom by the individual. One person told us, "They treat me nicely and with respect." This demonstrated staff supported people in a way that maintained their dignity.

We noted in the main lounge area most chairs had waterproof covers placed on the cushions. The manager said this was to help protect the furniture. We asked the manager if she felt this was dignified for people and she agreed it was not. She said she would remove these items and arrange for further washable furniture to be purchased.

Requires Improvement

Is the service responsive?

Our findings

People told us staff were responsive to their needs. Comments included, "They normally come when I press the bell. Just occasionally when I press the bell they take their time, but that's because they are a bit short. But generally it is okay"; "There is always someone around" and "If I press the buzzer they general come. Sometimes a young one has rung in sick from the night before, but mostly they are there to help me." People confirmed they had access to regular baths or showers. They said they had at least one bath a week, but could request them more frequently, if they desired.

Care plans were person centred and related to the individual needs of the people. Records contained assessments of people's needs, including specific assessments of areas such as health needs, mobility and appetite. The individuality of records was enhanced by the frequent use of photographs to demonstrate people involved in activities, or provide a personal aspect to the records. Records contained a review of people's medical history, to highlight any health concerns that may need support. Plans also contained information about the individual and their social history, such as family, previous interests and work background. People's likes and dislikes were also recorded. This meant care files contained important information about the person as an individual and their particular health and care needs.

From these assessments plans had been devised to address people's particular care needs. Whilst the care plans considered the specific areas people required support with they did not always contain sufficient information for staff to follow and support people safely. For example, one person, who was diabetic, had their blood sugar levels tested by staff in the evening. Staff told us this was to gauge how much supper the person should have. Staff were aware the blood sugar could be too low or too high. However the plan gave no indication as to what was considered a "too low" or "too high" blood sugar. Staff had different views of what was "too high" to the information provided by the manager. Another person's care plan stated they managed a number of their own medicines. We spoke to the person concerned who confirmed they no longer managed medicines themselves and staff took responsibility for this area of their care. We spoke with the manager about this. She agreed care records did not always contain sufficient up to date information and made arrangement for plans to be reviewed. Whilst we could find no evidence people had suffered significant harm because of these omissions, this meant records did not always contain sufficient information to ensure people always received the care they required.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 9. Person centred care.

Care plans were reviewed with people, family members and professionals, as necessary. Documents in people's care records indicated six monthly reviews were undertaken, reviewing the previous six months and identifying and actions that needed to be taken forward for the following six months. People we spoke with confirmed reviews took place. A visiting professional told us staff always seemed aware of the latest issues or the current condition of people when they were asked for updated information.

Staff we spoke with were able to demonstrate they had a good understanding of people's needs, their

particular likes or dislikes and their personalities. They were aware some people preferred to spend time in their own company, some people needed encouragement with meals or people preferred a certain approach with support.

The manager told us that a care worker was able to offer some activities support on a part time basis and we witnessed they engaged in a game with some people. The manager further told us an apprentice member of staff was also available to support people with activities. People told us they could go out if they wished and said they attended local luncheon clubs or went out to local gardens. Some people told us they preferred to sit in their own rooms but others said they sometimes missed company and would welcome staff having more time to sit with them. During the inspection we noted several people sat for most of the day in the lounge or the hall area and did not engage in any meaningful activity. We spoke with the manager about this. She told us one person had been accompanied into the community by staff on the morning of the second inspection day. She also advised us that some people were waiting to be treated by a chiropodist, who was visiting the home on the second day of the inspection. She said she was looking at employing additional staff and perhaps utilising apprentice time to provide additional activity and personal time for people. This meant there was not always access to meaningful activity to support people's social and psychological wellbeing.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 9. Person centred care.

People told us they were able to make choices. They said they could choose what meals they had, how they spent their time, when they got up in the morning and whether they took their breakfast, or other meals, in their rooms. Staff approached people in a manner that offered people a choice, by enquiring if they wanted to come to the dining room for their meal, or whether they wanted help returning to their room. One person told us they spent some time most days in the garden watching the ducks, as they enjoyed spending time in this way.

The provider had a complaints policy in place and information about how to raise a complaint was available around the home. The manager told us there had been two formal complaints in the last twelve months, one of which she had moved on to a safeguarding matter. We saw this action had been appropriate. The manager maintained a complaints log, which contained extensive details of the nature of the complaint and the action taken. People we spoke with told us they had not raised any recent complaints. Comments included, "I've not complained. I've got to the age now where I'm not frightened. I wouldn't hold back"; "I'm happy with the care. If I wasn't I wouldn't have been here eight or nine years. I've no complaints. Everything is alright with me"; and "I'm quite happy here. I can't think of anything I would complain about." This meant the provider had in place a system to manage and deal with any complaints or concerns.

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection there was a registered manager in place. Our records showed she had been formally registered with the Commission since December 2012. The registered manager was present and assisted us with the inspection.

The manager demonstrated a number of checks and audits were carried out at the home. These included checks by herself and the home's handyman and also monthly checks by the home's provider. The manager showed us a hand-written list. She said this was a list of items the provider had agreed needed addressing, but had not had time to formally email it across to her. We noted a number of decorative items had been highlighted and there was to be a new carpet ordered for the dining room. However, the check had failed to identify the cleanliness and safety issue we had raised as part of the inspection. We also found a copy of a cleaning audit for the home. The document was not always well completed. For example, out of 28 possible days the disinfection and cleaning of the sluice area had only been signed for eight times. We also noted areas where we had found issues had been identified as being acceptable, in terms of the audit process. The manager agreed these issues should have been identified as part of the audit and checking process. This meant audit processes did not always identify concerns or deficits.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 17. Good Governance.

Records were not always well maintained or stored correctly. Although daily records were well kept and contained good detail, we found medicine administration records had been altered using correction fluid and care plans did not always contain sufficient information for staff to follow. We also noted people's care record were stored in a cupboard in the corridor outside the home's office. This cupboard did not have a lock on it meaning people's personal information was not stored confidentially and was potentially accessible to others who lived at the home or members of the public. We spoke with the manager about this and she agreed this was not acceptable. She told us she had immediately arranged for a new, lockable cupboard to be purchased.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 17. Good Governance.

The manager told us the ethos of the service was to maintain a homely feel. She said even though the range of care needs for people living in residential care were increasing in complexity she and the provider did not want it "to look like a nursing home."

Staff told us there had been one recent senior staff meeting in February 2016 and a full staff meeting in April 2016. The last full staff meeting had been 12 months previously in 2015. Items covered included a review of fire procedures, an over view of people's care needs, the home's policy on the use of mobile phones and cleanliness issues. Staff told us that not having a staff meeting was not a major issue as they could raise issues anytime and a number of staff were at handover meetings, so any urgent issues could be raised here.

The manager confirmed there was only one staff meeting per year, but felt there was opportunity at other times to discuss matters. This meant there were limited formal avenues for staff to input into the running of the home.

People and staff had a positive view of the manager and her style. Comments included, "(Manager) is very nice. She is really good. You can go to her with any problems"; "(Manager) is very supportive. She always has her door open. If you are honest with her, she will help you" and "(Manager) is lovely. She is lovely and is good at diplomacy. She just loves the residents. She will always help out, if necessary." A visiting professional told us, "The manager is always aware of what is going on and will follow any suggestions that are made." Staff also told us there was a good staff team at the home and staff members were supportive of one another. This meant staff and people were positive about the day to day leadership at the home.

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 9 HSCA RA Regulations 2014 Person-centred care Care and treatment was not always appropriate, meet their needs or reflect their preferences. Regulation 9 (1)(a)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not in place to ensure compliance with regulations because audits had failed to assess, identify and mitigate risks. Records were not always complete and were not stored securely. Regulation 17(1)(2)(a)(b)(c).

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not protected from unsafe care and treatment because effective measures to ensure the premises were safe had not been put in place, risks had not always been assessed, medicines were not managed safely and effectively and appropriate measures were not in place for preventing, controlling and detecting infections. Regulation 12 (1)(2)(a)(b)(c)(g)(h)

The enforcement action we took:

We have issued a Warning Notice against the provider.