R & E Kitchen

Lavender House Care Home

Inspection report

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Date of inspection visit:
27 February 2017

Date of publication:
30 May 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?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

When we last inspected Lavender House Care Home on 10 and 15 December 2015 we found not all prescribed medicines were recorded when they were brought into the home which meant there was a lack of a robust audit trail for medicines. We also found there was a lack of a robust recruitment procedure to ensure people were supported by staff who were safe to do so.

During this inspection on 27 February 2017 we found the provider had made some improvements but we also identified new concerns. People received their medicines but not everyone had a care plan in place about medicines prescribed as "when required". The recruitment procedures ensured the necessary checks were completed before new staff worked at the home.

Lavender House Care Home offers accommodation and care for up to 20 people who may be living with dementia. At the time of the inspection there were 18 people living there permanently and two who were staying short term. The home is over two floors and the second floor is accessed using a stair lift. The accommodation is provided in five shared rooms and 10 single rooms, four of which had en-suite facilities.

There was a registered manager at the service. 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.

The registered manager had not notified the Care Quality Commission of relevant significant events.

People's ability to make decisions was assessed in line with the Mental Capacity Act 2005 but this legislation had not been considered with regard to the use of sensor mats in bedrooms. We have made a recommendation in respect of this.

The need for some people to live at the home was legally authorised under the Deprivation of Liberty Safeguards. However, there was not a system in place to keep these under review and three had expired.

People were offered choices at mealtimes and were supported to eat when necessary. However, some people were not able to understand the choices due to the way the choices were presented.

Some areas of the home were in need of redecoration.

Care plans included information about people's personal histories, routines, preferences and medical history. However, we observed that one person did not have all of their needs met as detailed in their care plan whilst we were sat near them. Activities were available which people enjoyed but some people living with dementia would benefit from more person-centred activities to engage them in a more meaningful way.

People felt safe living at the home and the registered manager and staff understood safeguarding procedures. There were plans in place to deal with foreseeable emergencies and risk assessments were in place to reduce the risks to people's health and wellbeing. People had access to healthcare services when necessary.

People were supported by staff who had received an effective induction into their role, which enabled them to meet the needs of the people they were supporting. Staff were further supported through supervision, training and appraisal.

Staff developed caring relationships with people using the service. People were encouraged to express their views and be involved in making decisions about their care and support. Staff were mindful of respecting people's privacy and dignity when supporting them with personal care.

The provider had a policy and arrangements in place to deal with complaints. People and their relatives were encouraged to provide feedback and were supported to raise concerns if they were dissatisfied with the service provided at the home. The registered manager also sought formal feedback through the use of quality assurance questionnaires sent to people, their families, professionals and staff.

There were systems in place to monitor the quality and safety of the service provided and to manage the maintenance of the buildings and equipment. There was a clear management structure and staff felt the registered manager was approachable. The provider had recently commissioned a review of the care and support the home provided to people living with dementia and was working towards the suggested improvements in line with good practice.

We identified a breach of the regulations of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People received their medicines as prescribed but there were not always guidelines in place to ensure people were offered medicines when they needed them.

Staff had completed training with regard to safeguarding people and were aware of how to use safeguarding procedures.

People had risk assessments in place to ensure every day risks were identified and minimised where possible.

Staff had been recruited following satisfactory pre-employment checks. There were enough staff to meet people's needs.

Is the service effective?

Requires Improvement

The service was not always effective.

There were procedures in place for when people were not able to make decisions about their care or support but these had not been applied with regard to alert mats in bedrooms. Robust procedures were not in place to review legal paperwork where people were at risk of being deprived of their liberty.

People were supported to eat and drink but choice was not always offered in a meaningful way.

Some areas of the home were in need of redecoration.

People were supported by staff who were trained and supported in their work through the use of supervision and appraisal.

People had access to healthcare services when necessary.

Is the service caring?

Good

The service was caring.

Positive caring relationships were developed with people using the service.

People made choices about how they spent their time.

People's dignity was respected by staff when supporting them with personal care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans detailed how staff were to support people in their daily lives. However, we observed that one person's needs as detailed in the care plan were not always met during our inspection and their records also did not evidence their needs were met.

There was a range of activities available but some people may have benefited from additional support to meet their needs.

There was a complaints procedure in place and people felt able to complain.

Is the service well-led?

Requires Improvement

The service was not always well led.

The registered manager had not notified the Care Quality Commission of relevant significant events.

The management team encouraged staff and people to raise issues of concern with them.

There were systems in place to monitor the quality and safety of the service provided.

Lavender House 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.

The inspection took place on 27 February 2017 and was unannounced. The inspection was undertaken by two inspectors.

Before the inspection, we reviewed the information we held about the service. This included notifications about important events which the service is required to send us by law and our previous inspection report. The registered manager completed a Provider Information Return (PIR) prior to the inspection, which we also reviewed. 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.

During the inspection we spoke with one person living at the home, a visitor, three care staff, a cook, the deputy manager, registered manager and a visiting health care professional. We could not directly communicate with some people to ask them about their experience of care and support but we observed staff interaction with them and the care and support they offered in the communal areas of the home. We looked at a range of records including the care plans and associated records for three people, four recruitment files and quality assurance audits.

Requires Improvement

Is the service safe?

Our findings

When we last inspected Lavender House Care Home on 10 and 15 December 2015 we found not all prescribed medicines were recorded when they were brought into the home which meant there was a lack of a robust audit trail for medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014 and the previous manager sent us an action plan stating how the medicines were to be audited. During this inspection we found auditing systems were in place but the current medication administration records did not show the number of tablets in stock or carried over from previous cycles. The stock of medicine was kept in two different places and the stock from one cupboard had not been included in the daily tally of medicines. We tracked the stock numbers back through older records and found the numbers to be correct. Providers have a duty to ensure they can account for all medicines kept in the home but without a clear record, this meant staff could not see easily if any tablets were missing. We found there was no longer a breach of this regulation but improvements were needed.

The local authority audited the service in October 2016 and identified the need for some improvements regarding medicines, such as detailing how a person showed "signs of anxiety" in their care plans. The registered manager provided an action plan to the local authority and we saw improvements had been made. We looked at records for two people who were prescribed medicines "when required" to support them when they became agitated. We found a care plan in place for one person, which enabled staff to decide when it was appropriate to offer the medicine but needed more information about the signs of agitation displayed by the person. There was not a care plan for the other person. The person was prescribed "one or two" tablets but there were not any guidelines in place to assist staff in deciding how many would be necessary to offer the person or when to do so. However, records showed the person had not received any tablets during the current medicine cycle so staff had not needed to make the decision. Medication administration records were completed to show people had received their medicines and staff monitored the temperature of the fridge used for storing some medicines.

During our last inspection we also found a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014 because there was a lack of a robust recruitment procedure to ensure people were supported by staff who were safe to work in a care setting. During this inspection we found there were processes in place to ensure new staff were suitable to work with the people they supported. All of the appropriate checks, such as references and Disclosure and Barring Service (DBS) checks were completed for all of the staff. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Staff confirmed these processes were followed before they started working at the home. We found the provider was no longer in breach of this regulation.

The registered manager told us they calculated the staffing levels by the number of people living in the home at the time. When numbers were higher, the registered manager put in place "twilight staff" to support people at a key time of day when they needed more support. The registered manager also said they decided staffing levels by talking with staff in their supervision and meetings. One person told us, "The staff are so busy, but we do have our chats in-between [attending to other people]. [When I use the] call bell, they come

quickly." A visitor said, "99% of the time it runs smoothly, but sometimes they could do with more staff." Staff generally felt the staffing levels were appropriate but one said, "Sometimes we do get stretched but we do get time to chat to people. I would like more time but generally it is good."

The provider employed care staff as well as ancillary staff, which included housekeeping, maintenance and catering. There was a duty roster system, which detailed the planned cover for the home. This provided the opportunity for short term absences to be managed through the use of overtime and agency staff. The registered manager and the deputy manager were also available to provide extra support when appropriate.

One person told us they had a key to their bedroom door and this enabled them to feel safe. People experienced care in a safe environment because staff had the knowledge necessary to enable them to respond appropriately to concerns about people's safety and were aware of people who were at particular risk of abuse. All of the staff, including staff not in a care role, and the registered manager had received appropriate training in safeguarding. Staff knew how to raise concerns and to apply the provider's policy. One member of staff was able to give us a historic example of where they had raised a concern about a colleague which was taken seriously by the registered manager and dealt with. Another member of staff told us, "If I had any concerns I would involve my senior and take it further if needed. I would keep it confidential; do a report and go to the provider if nothing happened". Where safeguarding concerns were raised the registered manager conducted thorough investigations and worked with the local safeguarding authority to keep people safe from harm.

The registered manager had assessed the risks associated with the environment and the running of the home; these were recorded along with actions identified to reduce those risks. These included the use of electrical equipment, the kitchen and the stair lift.

There were plans in place to deal with foreseeable emergencies. Staff had been trained to administer first aid and there was a programme of fire safety training and fire drills in place. Fire safety equipment was maintained and tested regularly. There was an emergency box by the front door that contained individual personal emergency evacuation plans, which detailed people's ability to respond in case of a fire and the support they would need if they had to be evacuated in an emergency.

Requires Improvement

Is the service effective?

Our findings

People's ability to make decisions was assessed in line with 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 decisions made on their behalf must be in their best interests and as least restrictive as possible. The provider had clear policies, procedures and recording systems for when people were not able to make decisions about their care or support. We saw staff usually followed these policies by consulting with relatives and professionals and documenting decisions taken, including why they were in the person's best interests. However, no consent or best interests decisions were obtained in respect of the use of alert mats to monitor people's movements. We raised this with the registered manager who told us they were unaware of the need for a best interests decision regarding the use of alert mats as they were there to protect people.

We recommend the provider assess individual capacity with regard to the use of alert mats; and take action to improve their practice. We will follow this up at the next inspection.

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 are called the Deprivation of Liberty Safeguards. 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 registered manager did not have a robust system in place to review the authorisations once they had been granted. We found three authorisations which had been granted for a 12 month period had expired. We raised this with the registered manager who told us that they were unaware they had expired as she was working to dates given to her by the local authority, which were different by around a week. By the end of the inspection the registered manager had commenced the process of renewing the authorisations.

Staff had been trained in MCA and Deprivation of Liberty Safeguards; where Deprivation of Liberty Safeguards had been authorised they were aware of the people that these restrictions applied to and the support they needed as a consequence. People's families and other representatives had been consulted when decisions were made to ensure that they were made in people's best interests and the least restrictive option.

The provider had installed closed circuit television (CCTV) cameras in communal areas of the home. The registered manager told us a consultation had taken place before the cameras were activated. We were shown the policy regarding the use and storage of CCTV which stated the provider was registered with the relevant organisation, the Information Commissioner's Office. There were signs displayed at the entrances to the home so that visitors would know the cameras were in place.

People's experiences of mealtimes varied. One person told us they were offered a choice from the menu and that they could ask for something else. They confirmed they were offered enough food and were given their hot drink of choice as they did not like tea and coffee. A visitor said "The food is good, but it goes cold and

then [person] doesn't want it. They will give [person] something snacky and warm the dinner later. They encourage pudding as [person] likes that, or a soup. They give [person] extra of what she does eat."

However, we observed interactions between staff and people living with dementia where staff were offering choices to people. People were offered choices for their cooked meal but the choices were not offered in a meaningful way for people living with dementia. During the morning, staff verbally offered people the choice of gammon, ham (which are similar cuts of meat) or corned beef hash. People asked further questions as they could not understand or visualise what each option was and therefore found it difficult to decide. Similarly, people were offered verbally a choice of three flavours of squash and could not remember the first on the list. After repeating the list to no avail, we saw a staff member get two jugs of squash and the person made a simpler choice based on the colour of the squash. During the morning people were offered hot drinks and most people drank them independently. However, one person sat at a dining table with their drink and they pushed it away. Staff did not remind or encourage the person to drink and they eventually left the table without drinking it.

Conversely, we also observed positive interactions at lunch time. We saw staff supporting two people to eat their meal. One person's care plan said they were more likely to eat if their meal was served on a small plate and we saw they did have a small plate. Another person required food to be cut into small pieces and did not like to be rushed and we saw the person was supported in the way they preferred. We heard staff ask a person who had not eaten their meal if they would like anything else, perhaps a sandwich. The person asked for banana, which they were given as well as being offered custard with it. Staff brought out two different sizes of desserts so people could choose according to their appetite. Staff sat with people to eat their own lunch and we heard staff asking a person who was sat alone, "Can I come and sit with you?" The person sounded pleased at this request and chatted to staff meaning they had a positive experience whilst eating their meal.

The provider employed a staff member to prepare and cook meals. Care staff served a teatime meal, such as soup, prepared by the cook or prepared food such as cheese on toast which could not be cooked in advance. There was a board in the kitchen which identified who needed a special diet, such as people with diabetes. Foods were fortified with full cream milk, cream, butter and cheese and the cook was aware of people's likes and dislikes regarding food preferences and alternatives were available. Nutritional risk assessments were completed and food and fluids recorded.

People were supported by staff who had received an effective induction into their role, which enabled them to meet the needs of the people they were supporting. Each member of staff had undertaken an induction programme, including a period of shadowing a more experienced member of staff who assessed their suitability to work on their own. Staff who were new to care received an induction and training, which followed the principles of the Care Certificate. The Care Certificate is a set of standards that health and social care workers adhere to in their daily working life. The registered manager told us, "I have all of my staff doing [the sections of the care certificate relating to] dignity, respect and person centred care as these are important".

The provider had a system to record the training that staff had completed and to identify when training needed to be repeated. This included essential training, such as medicines training, safeguarding adults, fire safety and first aid. Staff were supported to undertake vocational qualifications and had access to other training focused on the specific needs of people using the service, such as, dementia awareness, meaningful activities for people living with dementia and skin tissue viability. One member of staff told us, "We have training throughout the year. My mandatory training is up to date. We have all done dementia training courses and if we want other bits and pieces [of training] we can ask for it". Another member of staff said,

"Yes, I have done my induction training and have regular training as well".

Staff had regular supervisions with the registered manager. Supervisions provide an opportunity for management to meet with staff, feedback on their performance, identify any concerns, offer support, assurances and identify learning opportunities to help them develop. Staff said they felt supported by the management team and senior staff. There was an open door policy and they could raise any concerns straight away. One member of staff told us, "I have regular supervisions where I can raise a concern if I need to. I have always found anything I have brought up has been dealt with". They added, "I have just had my annual appraisal as well". Another member of staff said, "The management is approachable. There is an open door policy and you can always ring [the registered manager] day or night if you need them".

People had access to healthcare services when necessary. A district nurse told us, "Staff will call us if they have any concerns. When I arrive they always know where the people are and why we are here. They follow up on my advice." A visitor told us their relative had been unwell and that staff "do monitor" their relative's health. Records were kept which showed various health professionals had regularly visited people at the home.

Some areas of the home were in need of redecoration, for example, paintwork was chipped and woodwork exposed. We looked at four bedrooms and saw they were all personalised but needed refurbishment. For example, in one room, the paintwork was chipped, the walls were stained and had a hole where screws had been removed. Although the chairs in the conservatory where clean, all of the seat cushions and the seats underneath were badly stained and worn. The seat covers placed on the seat cushions were also old, worn and frayed. We raised this with the registered manager who told us they had put in a request to have them replaced. We noted the lighting in the dining area was not very bright to enable people living with dementia to see clearly and a visitor felt the lights could be brighter. The registered manager had started to make cosmetic changes to the environment to better meet the needs of people living with dementia, for example, full size door stickers had been used on some doors so they looked like individual front doors. This could make it easier for people to recognise their own bedroom.

Good

Is the service caring?

Our findings

Staff developed caring relationships with people using the service. One person told us, "The staff are so good, so kind, they look out for us all the time…they are concerned for our welfare." A visitor confirmed staff were "definitely" caring and that they "couldn't be more pleased that my [relative's] here." We saw that staff had time for people, for example, a staff member who was asking people what they would like for lunch spent time with one person who was unable to express a choice, stroking their shoulder and holding their hand, which the person appeared to enjoy. Later we observed the staff member supporting the person to eat and interacting with them. The person said something which made the staff member laugh and the person's facial expressions showed they were happy with making the staff member laugh. The staff member told us the person really "relates to us talking and holding their hand." We observed another person interacting with a staff member by playing a game with each other using facial expressions, which again appeared to enhance the well-being of the person.

People were encouraged to express their views and be involved in making decisions about their care and support. People got up and went to bed when they chose. One person told us they got up earlier than they would like, but that this was because they needed to because of a physical issue but they said they would be able to stay in bed if they wanted to. A staff member said, "I understand not everyone has capacity. We try and keep [people] as independent as possible; at the end of the day it is their home and they can choose."

At lunchtime we saw people were asked where they would like to sit. Some people were offered a clothes protector and we heard a staff member asking someone, "Would you like help to put it on?" to which they answered "Yes please" and the staff member supported them to do so.
People's bedrooms were personalised to their own tastes, for example, one person's room had been decorated to reflect the colours of the football team they supported.

Staff were mindful of respecting people's privacy and dignity when supporting them with personal care. One person said that when staff supported them with personal care, "we do [this] as a combined effort, they help me wash and dress. We go to the lengths of choosing clothes between us."

A visiting health professional told us they had "no concerns regarding privacy and dignity." A staff member gave an example regarding how they respected people's dignity. They said, "We had a lady in the lounge who needed an injection. She did not want to go to her room. I discussed it with the nurse and she agreed to do it in the lounge. I got a screen [put around the person] to protect her dignity and privacy." Other staff told us, "I make sure the curtains and doors are shut and knock on the door before entering", "I check they are happy with why I am there. I know it can seem strange to them having someone helping them; I show them two items of clothes or more depending on their capacity to give them a choice", "I would recommend the home to my family and friends, I know they would all be treated well and well respected," "I always ask them and give them a choice, like a drink or what they want to eat or when they go to bed or get up" and "I make sure the doors are closed, shut the windows and cover the parts I am not [washing]; I talk to them so they know what you are doing when you do it"

Requires Improvement

Is the service responsive?

Our findings

A person told us that living at the home was "Absolutely wonderful, it's like living in a first class hotel. The place is kept well, the staff are so good." People's needs were assessed before they moved to the service to ensure staff could meet their needs. Staff involved people and their relatives, if appropriate, in assessment and planning care. Care plans included information about people's personal histories, routines, preferences and medical history.

We looked at three care plans which reflected the care and support people needed. There were moving and handling assessments in place which identified what equipment staff needed to use to support people and we saw this equipment was used. However, one person needed staff support to reposition in bed and the care plan stated this was needed every two hours. One staff member told us staff assisted the person every four hours, although it had previously been every two; another told us it was three to four hours. We sampled records for seven days and found the times varied between two, three, five, six and on one occasion, thirteen and a half hours. The registered manager said staff supported the person more frequently than this and that their skin was intact, which was evidence that the person was receiving enough support. Additionally, the care plan stated the person should be assisted with their continence every two hours. However, during our inspection we saw that the person was not assisted to their room where this could be done in the three and a half hours we were sat in the communal lounge, next to the person. Records showed the same time frames as when the person was assisted to reposition in bed. Staff knew the signs of the person becoming tired if they were sat in a chair for too long and assisted them to bed. A district nurse told us, "Staff know their residents very well and know their needs. They are good with skin care."

One person's communication care plan specifically said staff were to give the person time to express themselves, spend time talking about their interests and make time to joke and laugh. We saw staff interacting in this way with the person and they responded well to this level of nurture.

We saw two people engaged in activities of their own making but their energy could have been better channelled into activity more meaningful and safer for people living with dementia. For example, one person was putting a paper serviette inside their mouth and pieces were breaking off, meaning they then tried to get the bits out of their mouth. The person had a hot drink next to them which they were not drinking and staff did not intervene to assist or distract the person from putting the serviette in their mouth. We were told it was a behaviour which was known to staff and therefore it was not the first time the person had done this. Another person placed the serviettes in a pile and then flicked through them as if they were a magazine. Staff could have provided a magazine or book for the person, which may have improved their sense of wellbeing as well as maintaining the cleanliness of the serviettes which were to be used by other people.

A person told us they spent their time how they wished. They tended to go downstairs for the morning and went back to their room later in the day. A relative visited them one day a week and they stayed in their room for privacy with their visitor. One person told us there were activities which included "a music lady every week, [music] tapes, we do a memory quiz to music, we have films, games of 'I Spy' to keep our minds

working." A visitor confirmed this and added they had seen people colouring, having their nails manicured and had seen someone visit the home with an owl and staff had taken photographs. They said "The staff are very good, especially with someone new, they accompany them around, that's very good." A visiting health professional told us there was, "Very good entertainment. The atmosphere is lively. [People] are not just sitting watching TV." We heard a staff member start a game of 'I Spy' and some people who were sat nearby became involved. We also heard a staff member ask, "Does anybody want to help me lay the table?" and one person chose to help. Some people liked to help out in the kitchen or laundry and were supported to do so.

The provider had a policy and arrangements in place to deal with complaints. We spoke with a person living in the home and a visitor who both felt they would be able to complain. The policy included detailed information on the action people could take if they were not satisfied with the service being provided. The information on how to make a complaint also included details of external organisations, such as the Care Quality Commission and the Local Government Ombudsman. The registered manager told us they had not received any formal complaints and explained the action they would take if they did receive one.

People and their relatives were encouraged to provide feedback and were supported to raise concerns if they were dissatisfied with the service provided at the home. The registered manager sought feedback from people and their families on an informal basis when they met with them at the home or during telephone contact. They had also recently held their first 'relatives meeting' which they planned to hold every three months. They told us this was to, "encourage [relatives] to be involved in their relative's care and work in partnership".

The registered manager also sought formal feedback through the use of quality assurance questionnaires sent to people, their families, professionals and staff. We looked at the results of the latest sets of questionnaire and found they were all positive. Comments from people and their families included, "Excellent. Staff very friendly and helpful", "Very professional but in a kind and caring way", "Extremely understanding" and "seem very knowledgeable to resident's needs". Comments from professionals included, "Feels like a family team" and "Dedicated staff". The registered manager told us that if anyone raised a concern they would contact them and try to resolve the issue.

Requires Improvement

Is the service well-led?

Our findings

The provider and the registered manager did not fully understand their responsibilities in respect of notifying us of significant events in line with the requirements of the provider's registration. We identified a safeguarding concern which had not been reported to us. We also found ten people had been deprived of their liberty under the Deprivation of Liberty Safeguards but we had not been notified. We raised our concerns regarding the failure to notify CQC with the registered manager who told us they were unaware of the need to do so in these circumstances. The registered manager provided us with the paperwork regarding the Deprivation of Liberty Safeguards the next day.

The failure to notify CQC of significant events was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

There was a clear management structure, which consisted of the registered manager, deputy manager and senior care staff. Staff understood the role each person played within this structure. The management team encouraged staff and people to raise issues of concern with them, which they acted upon. Comments from staff included, "[Registered manager] is very good; she is always out and about and helps if you need her to" and "[Registered manager] is very easy to talk to; approachable; she has an open door policy."

The registered manager told us their philosophy of care was enabling people living with a cognitive impairment to have a healthy and fulfilled life. Staff were aware of the vision and values and how they related to their work. The provider had commissioned a "Dementia Care Settings Review" in January 2017, which was conducted by an independent company. The review looked at various aspects of the service provided to people living with dementia and offered advice to improve the service, based on good practice. The registered manager was committed to making improvements in line with the report and some improvements had already been made. An example of this was that staff joined people to eat their meals with them.

Regular staff meetings provided the opportunity for the registered manager to engage with staff and reinforce the provider's values and vision. Staff spoke positively about the culture and management of the service. They confirmed they were able to raise issues and make suggestions about the way the service was provided in their one to one sessions or during staff meetings and these were taken seriously and discussed. One member of staff told us, "We have regular staff meetings. You can raise ideas and everyone gets to have their say, which is good. [The registered manager] is always good at praising us at staff meetings. She tells us we are doing things well, as well as where there are issues". We were told that there were also meetings held for senior staff where concerns or ideas could be raised.

The registered manager told us they felt supported by the provider, who was engaged in running the home. They said the provider visited the home regularly and was always available at the end of the phone. They were able to seek support from other managers of the homes owned by the provider as well as keeping themselves up to date through 'provider meetings' led by the local authority and use of the internet.

There were systems in place to monitor the quality and safety of the service provided and to manage the maintenance of the buildings and equipment. The registered manager carried out a series of audits, such as cleanliness, the kitchen, medicines, care records and accidents and incidents. The provider's maintenance lead also carried out an annual health and safety audit and an environmental audit. There was also a system of audits in place to ensure that safety checks were made in respect of water temperatures and fire safety. The registered manager also carried out an informal inspection of the home during a daily walk round. In addition, audits were carried out by external organisations, inducing the pharmacy used by the home, the local commissioning group and the fire service. Where issues or concerns were identified an action plan was created and reviewed regularly by the registered manager.

The home had a whistle-blowing policy which provided details of external organisations where staff could raise concerns if they felt unable to raise them internally. Staff were aware of different organisations they could contact to raise concerns. For example, care staff told us they could approach the local authority or the Care Quality Commission if they felt it was necessary.

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 18 Registration Regulations 2009 Notifications of other incidents The provider and the registered manager did not fully understand their responsibilities in respect of notifying us of significant events in line with the requirements of the provider's registration.