Shaftesbury Care GRP Limited

De Baliol

Inspection report

Woodham Road
Newbiggin By The Sea
Northumberland
NE64 6HN

Tel: 01670852017

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

De Baliol is located in the coastal town of Newbiggin by the Sea and provides care for up to 54 people who have nursing care needs. There were 41 people using the service at the time of the inspection.

The inspection took place on 13 January 2016 and was unannounced. The service was inspected in June 2014 and met all of the regulations we inspected at that time.

A new manager was in post and was in the process of registering with the Care Quality Commission (CQC). 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.

Safety concerns were identified following a fire safety audit. The provider was sent a report by the fire safety officer which highlighted some areas for improvement. They had begun addressing some of these issues during our inspection and were aware of the action that needed to be taken to ensure the safety of people staff and visitors.

People told us they felt safe, and there were suitable safeguarding policies and procedures in place. Staff had received safety training, and risk assessments in relation to the care needs of people and premises and equipment had been carried out. Records of accidents and incidents were appropriately maintained.

We found that there were suitable numbers of staff deployed and checked staffing rotas to confirm this. A small number of concerns were expressed by staff and relatives, that at times staffing numbers appeared low. We have made a recommendation that the provider keeps staffing under review in light of these concerns.

There were safe procedures for the storage and administration of medicines although we found gaps in a small number of records. The nurse and manager assured us that these would be addressed and we made recommendation about this.

The home was clean and there were no malodours. Appropriate infection control procedures were in place.

People were happy with the care they received. Staff had received regular training including training specific to their role. We found gaps in training and supervision records which meant that staff were not adequately supported with their performance and development needs.

People had access to a range of health care professionals. We saw that people were referred promptly in the event of any concerns about their health and visiting professionals spoke highly of the effectiveness and responsiveness of staff. The Mental Capacity Act was applied appropriately and capacity assessments had

been completed.

Nutritional needs were assessed, and people were supported well with eating and drinking. Dietary concerns were addressed appropriately by referring people to the appropriate professional such as GP or dietician.

People looked well cared for and were comfortable. Staff spoke kindly with people and treated them with respect, and also promoted choice and independence. When a person was distressed we saw that staff supported them skilfully and with warmth.

The service engaged well with the local community and supported people to maintain outside interests.

Pre admission assessments were carried out to ensure the service could meet the needs of people. Person centred care plans were in place and were reviewed regularly. A varied programme of activities was available. A complaints procedure was in place and people knew how to make a complaint if they needed to.

A number of routine audits and checks were carried out to ensure the safety and quality of the service. People, staff and relatives had regular opportunities to share their views about the running of the service. These included questionnaires and meetings.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to safe care and treatment and staffing. You can see what action we told the provider to take at the back 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

Not all aspects of the service were safe.

A fire safety audit identified areas that required improvement.

Safe recruitment procedures were followed which meant people were protected from abuse.

Risks to people were assessed and regularly reviewed to ensure the safety and comfort of people living in the service.

Medicines were managed safely and a procedure was in place to ensure the competency of staff administering medicines.

Is the service effective?

Good

The service was effective.

We found gaps in staff supervision and appraisal records but a system was in place to address this.

Staff training was in place including role specific training which enabled people staff to further develop their skills.

People's capacity levels had been considered and the Mental Capacity Act (2005) (MCA) was applied appropriately.

Is the service caring?

Good

The service was caring.

People looked clean and comfortable.

We saw that staff spoke kindly with people and treated them with respect.

Dignity was preserved and personal care and support with meals was offered discreetly and sensitively.

Is the service responsive?

Good

The service was responsive.

Pre admission assessments were carried out which meant that the necessary care plans and equipment were in place when people arrived at the service.

Care plans were person centred care plans were in place and were regularly reviewed and updated.

A varied activities programme was in place.

Is the service well-led?

Good

The service was well led.

There was no registered manager in post. The new manager was in the process of registering with CQC.

Members of the management team were visible and accessible to people staff and visitors.

A number of routine audits and checks were carried out to ensure the quality of the service was maintained.

People, staff and visitors were given regular opportunities to share their views about the running of the service.

De Baliol

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 13 January 2016 and was unannounced. It was carried out by one inspector and a specialist adviser with specialist knowledge of nursing care.

We displayed a poster to inform people that we were inspecting the service that day and invited them to share their views.

We spoke with seven people who lived at the service on the day of our inspection. We spoke with three relatives and contacted one relative by telephone following our inspection to find out their opinions of the service provided.

We spoke with the manager, three care staff, two nurses, two kitchen staff, one domestic and two activities coordinators.

We spoke with two care managers who visited people in the home regularly. They told us that they were happy with the knowledge and skills of staff and the way they supported the people they had placed in the service. We spoke with a community nurse and a dentist visiting the service on the day of our inspection.

Prior to the inspection we contacted Northumberland local authority contracts and safeguarding officers. They told us that there had been safeguarding issues in the last 12 months but that these had been addressed with the provider. Investigations were nearing completion and appropriate action had been taken. They had no further concerns about the 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 checked four care plans, four recruitment files, and records relating to the safety of the premises. We also checked records relating to the management of the service including staff training and supervision, and meeting minutes.

Requires Improvement

Is the service safe?

Our findings

Not all aspects of the service were safe. A fire safety audit was completed by the fire service on the day of the inspection. They were accompanied by a buildings inspector and a member of the service's maintenance staff. The fire safety officer reported that there were a number of areas requiring attention and that this was in part due to the change of use of rooms. This meant that the rooms did not meet the required fire standards and should be changed back to their intended use, or upgraded to ensure fire safety standards were fully met. There were also other areas which required improvement. The fire service provided their own report and detailed actions to be taken. These actions were necessary to ensure the safety of people using the service, staff, and the general public were protected.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014 Regulations. Safe care and treatment.
We saw that there had been regular fire drills and safety checks of equipment. Staff had received annual fire safety training.

People told us they felt safe. One person told us, "I feel safer and happier here." Another person told us, "I like it here because I've got no worries." A relative told us, "My relative needed assistance to manage their medicines and they addressed it straight away. I know that she's safe here." A safeguarding policy and procedure, which informed staff how to recognise and report suspected abuse or neglect, was in place. Staff knew what to do in the event of concerns and told us, "I've done the training online, I would report anything straight away to my manager." We saw that there was a whistleblowing policy in place and a whistleblowing poster was displayed in the foyer. Training in safeguarding vulnerable adults was provided to all staff. We spoke with a member of the safeguarding team in Northumberland who told us that there had been concerns raised with them but that these had been investigated and that no further action was required. They had not completed their report but said appropriate action had been taken by the provider.

People told us, and records showed, that there were suitable numbers of staff on duty. One person said, "I'm sensible enough to know that I have to wait my turn, but I have never had to wait for an unreasonable length of time." Another person said, "I use my buzzer a lot during the night because I can't get comfortable. Staff always come, and I might not always be first in the queue but they will always come to tell me if they aren't coming immediately." A relative told us, "Sometimes my relative needs to wait and there don't appear to be enough people (staff). They don't have to wait that long, but it does concern me." Staff told us that there had been some issues with short staffing and said, "It's okay if we are fully staffed but if we are short it is hard work but we manage." Another staff member said, "We could do with more staff, but it's safe." We spoke with a care manager who visited the service regularly who said, "There are always staff available when I visit. They are very responsive."

We spoke with the manager about staffing. She confirmed that there had been issues with staffing and that this had improved as new staff had been employed and had just completed pre-employment checks. She had also increased the number of care staff on duty and appointed additional bank staff to provide cover for unexpected absences. The manager was reviewing staffing with the regional manager. The dependency

levels of people living at the service had been regularly reviewed. This helped to determine the number of staff required to care for people based upon the amount of help they needed. We spoke with the regional manager who confirmed that staffing levels provided were in excess of the number of hours identified using the dependency tool. The manager confirmed they would continue to monitor staffing levels.

We recommend that staffing numbers remain under review.

Risk assessments of the premises had been carried out and we saw records of regular safety checks. These included gas and electrical safety checks and routine inspection and servicing of equipment used by people and staff, including hoists and wheelchairs. This meant that the provider sought to ensure that the safety of people and staff was protected.

Individual risk assessments and checks had been carried out, including assessment of the risks from people's own furniture and equipment such as glass cabinets or portable heaters. We also saw that a mattress used to prevent the development of pressure ulcers, was checked daily by staff to ensure that it was set to the correct weight of the person. This meant that staff checked that it was working effectively and safely. Individual risk assessments included risks associated with eating and drinking, moving and handling, mobility, falls, and skin integrity (risk of skin damage). Risk assessments in relation to the use of bed rails were in place and regularly reviewed.

A business continuity management plan was in place. This outlined the procedure to follow in the event of an emergency such as loss of heat to the building, serious staff shortage or severe weather. This meant that staff knew the procedure to follow in such circumstances to ensure that risks to people staff and visitors were reduced. We saw that this had been regularly reviewed. A personal emergency evacuation plan (PEEP) was available for each person, taking into account their mobility and moving and assisting needs. These were reviewed monthly to ensure they were up to date. The purpose of a PEEP is to provide staff and emergency workers with the necessary information to evacuate people who cannot safely get themselves out of a building unaided during an emergency.

Records of accidents and incidents were maintained. These had been analysed to identify any trends or concerns. Daily "flash meetings" were held. This was an opportunity for all heads of department to discuss any risks or safety issues. We observed a flash meeting and saw that accidents and incidents were a standing agenda item although there had been none on the day of the inspection.

We looked at the way medicines were managed. Systems were in place to ensure that the medicines had been ordered, stored, administered, audited and reviewed appropriately. Appropriate arrangements were in place for the administration, storage and disposal of controlled drugs, which are medicines which may be at risk of misuse. Staff showed us how unwanted or out of date medicines were disposed of and records confirmed this. People had 'medicine capacity' assessments in place to record if they were able to administer their medicines independently or needed support. We were told that no-one self-administered their medicines. Medicines audits had been carried out monthly and we saw that where issues had been picked up during the audits that these had been addressed. We saw that medicine administered through a patch applied to the skin was appropriately recorded including the use of body maps to show the location of the patch.

There was a small number of gaps in medicine records including the recording of fridge temperatures. These checks are important to ensure that medicines are stored at the correct temperature as some medicine deteriorates if not stored in suitable conditions. Medicine administration records (MAR) were checked and found to be in order. The recording of the application of creams was also inconsistent. We spoke with the

nurse and manager who said they would address these issues.
We recommend that safe practices are followed in relation to the administration of medicines.

We checked staff recruitment records and found that safe systems were in place for the recruitment and selection of staff. The provider had undertaken an audit of all recruitment files. These included the files of people recruited before the provider took over the service. They had found some gaps in recruitment including gaps in employment history. Where possible, they had retrospectively added this information. The recruitment files of those people employed since the provider took over contained all of the required checks and information. They had been screened by the Disclosure and Barring Service (DBS) to ensure they were suitable to work with vulnerable people. DBS checks ensure staff working at the home have not been subject to any actions that would bar them from working with elderly or vulnerable people. This helped to protect people from abuse. Two references were obtained for each applicant and there were no unexplained gaps in employment.

The premises were clean and tidy and there were no malodours. Staff were aware of infection control procedures and a policy was in place. We saw cleaning schedules and records of regular infection control audits. An outbreak policy was in place which advised staff how to avoid cross contamination and the spread of infection. Staff told us, "We know about barrier nursing and the equipment to use like gloves and aprons." The kitchen was clean and we saw that regular checks of food, fridge and freezer temperatures had been carried out. The service had been awarded an environmental health level five food hygiene rating on a scale of 0-5, with 5 being the highest.

Good

Is the service effective?

Our findings

People told us they were happy with the care they received at De Baliol. One person said, "I find it very good here and the staff are so nice, I'm waited on hand and foot. I've improved since I've been here." A relative told us, "Staff are very good here, I feel they listen to us and you can visit any time of the day. They ring if they have any concerns, they keep us informed." A care manager told us, "Staff come to you as soon as you go through the door. Many of the carers are excellent, they have been there a long time and know the residential side well."

There were gaps in staff appraisal and supervision records. The provider told us that this was due to a lack of permanent manager for a period of time prior to the new manager taking up post. We saw that plans were in place to ensure appraisals and supervision were brought up to date and staff told us they felt well supported by the new manager.

Staff training was in place. We saw a training matrix, and staff confirmed that they had received regular training. Staff files contained records of training including fire safety, safeguarding, moving and handling, mental capacity act, first aid, falls prevention, nutrition and end of life care. Training specific to the needs of people living in the service was provided, such as catheter care. Two staff were accredited Care Certificate assessors and a plan was in place to put all care staff through Care Certificate training. The Care Certificate provides standardised training in fifteen key areas to enable staff to work in a high quality and caring way. The manager was an NVQ assessor (a national vocational qualifications assessor) and was an accredited person centred dementia care trainer through the University of Stirling. This meant that training could be provided more flexibly in house by appropriately trained staff.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS are part of the Mental Capacity Act 2005 (MCA). 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). One person had a DoLS authorisation in place, and the Care Quality Commission (CQC) had been notified of this in line with legal requirements. A number of applications had been made and these were in progress with the local authority.

Records confirmed that, where necessary, assessment had been undertaken of people's capacity to make particular decisions. For example, risk assessments in relation to the use of bed rails included a record of the person's capacity to consent to their use or confirmation that the bed rails were being used in the person's best interest. Consent to treatment records were in place and some people had signed these. Where it had been identified that people lacked capacity, records had been signed on their behalf by a relative or

representative. Consent was also sought for photographs.

People's records showed details of appointments with and visits by healthcare professionals. We saw evidence that staff made sure people accessed services in cases of emergency, or when people's needs had changed, for example General Practitioners (GPs), district nurses, occupational therapists and dietician. Care plans reflected the advice and guidance provided by external health and social care professionals. One person received a visit from a community nurse on the day of the inspection which we were told was part of an ongoing treatment and care plan. This demonstrated that the provider sought to ensure that the individual needs of people were being met, to maintain their health and wellbeing. A relative told us, "My relative has had a couple of infections. They were dealt with very quickly, staff were straight onto it."

We spoke with a dentist who visited the service. They told us, "I visit every week. There is a good vibe about the whole home, I have no concerns." Another visiting professional told us, "They [staff] are very good at ringing us appropriately and they do seem to have the right charts and they're accurate." We spoke with a care manager who said, "I reviewed someone in the service quite recently, and staff have been very on the ball. They are aware of their needs and have been liaising appropriately with the relevant people and have picked up issues quickly such as changes in their mood."

People were supported with eating and drinking. One person told us, "The meals are excellent, I've just ordered my tea and instead of what was on, I'm going to get a cheese and onion omelette. In the mornings I can have porridge and a full English breakfast or just sausages and eggs, or anything along those lines." Another person told us, "You can't beat the food, my favourite is the savoury rice."

There were systems in place to ensure people identified as being at risk of poor nutrition were supported to maintain their nutritional needs. People were routinely assessed against the risk of poor nutrition using the Malnutrition Universal Screening Tool (MUST). MUST is a five-step screening tool to identify if adults were malnourished or at risk of malnutrition. Where people were identified as being at risk of poor nutrition staff completed daily 'food and fluid balance' charts. We saw that these had been completed. Care records contained kitchen notifications to alert kitchen staff of people's special diets, likes and dislikes. For example, one person had a notification to say they particularly liked leek pudding. We saw that there were copies of these documents in the kitchen.

We spoke with the cook who was knowledgeable about how to fortify foods for people at risk of losing weight. He said, "I make fortified milk shakes, and add cream or extra butter to mashed potato for example." He was also aware that certain foods may interact with medicines, he said, "I'm careful with people, I know that if someone is taking warfarin, we can't give them cranberry juice, but otherwise I always go out of my way to give people what they want just as if they were at home. I do home baking every day."

We saw the cook speaking with people and asking them about their food choices. One person told us, "The cook comes to see me and asks what I want. I asked for a small plate because I can't face a big plate so that is what I get. He knows I like éclairs so he gives me one every night! The staff make a note of everything you eat and leave. They are meticulous about that."

The premises were suitable for people living at the service. Bedrooms were nicely personalised. Some areas were in need of updating, due to wear and tear to paintwork for example. We saw that maintenance staff had a plan for routine redecoration and maintenance. We heard these being discussed by the head of maintenance during the flash meeting.

Good

Is the service caring?

Our findings

We saw that people looked clean and comfortable. People told us they were well cared for, one person said, "The individual staff here are ever so dedicated." Another person told us, "Oh yes, the staff are very nice here; well there is maybe the odd one that's not so nice, you get that everywhere but I tell the manager if I'm not happy with anything because otherwise how will she know?" A visiting professional told us, "People are well looked after, there's always a glass on their table to have a drink of water with their meals, things are being done and it's calm".

Throughout the visit, the interactions we observed between staff and people who used the service were friendly, respectful, supportive and encouraging. We observed a mealtime and we saw that people were supported sensitively and discreetly to eat their meal. Staff sat beside people and offered gentle encouragement and chatted with them about their food. One staff member said, "I've got your lunch for you, it's a lovely roast dinner." Another said, "Is your gravy nice? It looks lovely." This helped people who might have become distracted, to focus on their meal. They were gently prompted and reassured throughout. Some people were interrupted during their meal to be given medicine, which some people could have found distracting or it might have affected their enjoyment of their meal.

We saw one person become distressed and that they were responded to by a staff member with warmth, affection and good humour. The staff member used their knowledge of the person to support them (on this occasion with a hug and a private joke) and we saw that this worked well.

At the mealtime, staff asked people if they would like to wear an apron to protect their clothes. People were offered choices of food and drinks and staff demonstrated a good understanding of people's individual needs. One person told us, "I prefer to eat my meals in my room." We asked about how people chose their meal. Staff were aware of which people were able to choose their meal in advance but told us, "There is one person who needs to choose their meal on the same day. We make sure that they are asked closer to the mealtime as this helps them to make the decision more easily." We looked at the menu choices form and saw that this information was recorded. This meant that opportunities for people to be involved and make choices were maximised by staff.
No one using the service was accessing any form of formal advocacy service but staff were aware of how to access the service if necessary. An advocate is someone who represents and acts as the voice for a person, while supporting them to make informed decisions.

People were supported to make choices. We observed that people were asked what they wanted to do and staff listened. In addition, we observed staff explaining what they were doing, for example in relation to medicines. When staff carried out tasks for people they bent down as they talked to them, so they were at eye level. They explained what they were doing as they assisted people and they met their needs in a sensitive and patient manner. Privacy and independence with regards to personal mail was promoted as people had their post delivered to their room for them to open.

We spoke with people about the choices they had with regards to personal care and dressing. One person

told us, "I haven't had a shave today, but that's my choice. I quite like to go for a few days without one, I'm a bit lazy!" Another person told us, "I choose my own clothes and things like that. The staff are canny and will help me if I need it." We saw that dignity was promoted and that staff knocked and asked permission before entering people's bedrooms or bathrooms. There were personal care in progress signs to ensure privacy and dignity was maintained when people were being supported with personal care. A relative told us, "My relative is always clean and tidy and has two showers every week."

Staff told us they enjoyed their work. We read a staff survey which said, "I think we have a lovely home and a happy home. The staff all put in extra effort." A staff member told us, "I love my job. The staff here all go above and beyond. If we want something extra special for the residents we fund raise ourselves. We did a sponsored walk to extend the patio and to raise money for a movie screen."

Staff had received training in end of life care. A staff member told us, "One person came to us for palliative care but they aren't palliative anymore! We have a good reputation for getting people back up and out of their room and socialising where they weren't before they came here." We saw end of life care plans for people. This meant that healthcare information was available to inform staff of the person's wishes at this important time, to ensure that their final wishes could be met.

The service engaged well with the community which was home to many of the people using the service and the staff. Two community support officers called at the service during our inspection to introduce themselves and they were encouraged to remain in contact and invited to attend events organised by the service. A staff member told us, "Because people are in a home it shouldn't mean they have to miss out on things like going to church for example. If they can't go out, we bring people in."

Good

Is the service responsive?

Our findings

People told us that their needs were responded to. One person told us, "I feel it is good here. The staff are very nice and there's plenty to do." We saw that people received care and support when they needed it. Examples included staff saying, "I'll get this table for you"; "Do you want us to pull the curtain for you, is that better for you?"; "Have a drink and a munch on your biscuit" and "We'll get a lovely blanket for you."

Records showed that pre-admission assessments were carried out and people's needs were assessed before they moved into the service. This ensured that staff could meet people's needs and that the service had the necessary equipment to ensure their safety and comfort. Following an initial assessment, care plans were developed detailing the care needs to ensure personalised care was provided to people. The initial assessment was also signed by the person.

Care records were person centred. This meant that people's personality, behaviour, likes, dislikes and previous experiences were taken into account when planning care. Choices and preferences care plans were in place. Staff provided flexible and responsive care to people. Communication care plans were in place and we saw specific detail for staff to follow in relation to how they should communicate with people. We saw records of when people had made advanced decisions on receiving care and treatment. The care files held 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) decisions for people and we saw that the correct form had been used and had been fully completed and contained the required information.

People's care plans contained a social profile (This is me, this is my life), where the information had been collected with the person and their family and gave details about the person's preferences, interests, people who were significant to them, spirituality and previous lifestyle. 'This is me', is for people with dementia who are receiving professional care in any setting including at home, in hospital, in respite care or a care home. People with dementia can use it with help from their families, to tell staff about their needs, preferences, likes, dislikes and interests. The agency nurse on duty told us the document was very helpful to staff who did not work permanently in the service.

Care plans were reviewed monthly and on a more regular basis, in line with any changing needs. Staff told us that they were responsible for updating designated people's care plans and we saw that care plans had been reviewed. Records showed that the person and relatives had been involved in their care planning. This meant that people were consulted about their care. Some care plans were complex, which meant that reading and reviewing them was time consuming due to the level of detail and number of plans in place. The manager told us that they were refining their care planning system and we found care plans for people who had recently been admitted to the home to be more succinct.

A varied activity programme was in place. We saw that a copy of the activity programme was available in people's bedrooms. There were two activity coordinators on duty during our visit. We observed a reminiscence session, facilitated by MIND Active on the morning of the inspection. MIND Active supports local volunteers to improve the lives of older people living in residential homes. During the inspection they showed a film of the local area. People thoroughly enjoyed the session and staff asked questions to

facilitate further discussion and to jog more memories. One staff member said, "Can you remember the shows and getting your fortune told?" In the afternoon we observed a game of quoits, music and dominoes. We found that the activities we observed matched those advertised.

Photographs of recent activities were displayed and we read the newsletter from the previous month which had details of Christmas parties and activities. These included; Christmas crafts, Alice in Wonderland pantomime and the Mind Active Christmas party. Musicians had played at the service and there had been visits from local children. A list of up and coming events was also displayed, including celebrations for the Queen's 90th birthday, and the Tall Ships visiting the area. The service was a member of the National Activity Providers Association (NAPA) and we saw a certificate confirming this. NAPA is an organisation promoting high quality activities for older people. The weather forecast for the "next few days" was also displayed, helping to keep people in touch with what was happening outside the home. A relative told us, "My relative joins in most activities but maybe needs a bit more stimulation." The manager told us there were plans to improve activities to ensure they were available to all people and over seven days a week. They were in the process of appointing a lead activities coordinator at the time of the inspection.

A complaints procedure was in place. We saw that there had been one informal complaint which had been addressed. A copy of the complaints procedure was available. One person said they knew what to do if they wanted to make a complaint, "I just tell the manager. She comes to see me to check how things are so I would tell her then."

Good

Is the service well-led?

Our findings

At the time of our inspection there was a newly appointed manager in post who told us they were in the process of applying to CQC to become the registered manager of this service. The previous registered manager left in June 2015. The service was supported by a peripatetic manager and the regional manager who visited regularly until the new manager was appointed.

Staff, visitors and people told us they welcomed the appointment of the new manager. One staff member said, "We see the manager every day, she comes to see if there is anything we need and says good morning and goodbye at the end of every shift." Another staff member told us, "The new manager is good, she sits and talks to the residents every time I am in." Another added. "She interacts well with the residents, they respond well to her, one person threw their arms around her neck when they saw her."

Regular meetings were held with staff, people and relatives. We saw meetings minutes confirming this. Topics discussed in relatives and residents meetings included, training about dementia for families, an infection control inspection, the updating of one page personal profiles at review meetings and future activities and events. This meant that there were mechanisms in place to communicate with people and their relatives and involve them in decision making.

Staff meeting minutes were also available, and items discussed included the introduction of the manager and deputy manager, budgets, the care act, care champions, confidentiality, team working and communication, morale and stress management. Separate meetings were held with nurses and included discussing nursing revalidation (the new process nurses must go through to demonstrate that they are fit to remain on the professional register), clinical review, infection control, nutrition and hydration, respite care, first aid and care champions. This meant that staff also had the opportunity to contribute to the running of the home and were kept up to date with key changes in legislation.

We also saw that quality assurance questionnaires had been completed by people, relatives and staff. We spoke with a relative and asked them if they would know how to make a complaint. They said, "Yes I was aware from the relatives meeting and know the manager has an open door policy. I always speak to the nurses if I need anything." Forms were available in the foyer asking people "How was your visit?"

We saw that a number of audits and checks were completed by the manager and senior managers from the provider organisation. We saw records of provider visits which included the use of a themed provider audit tool. We saw that areas looked at during previous visits included the involvement of people, transparency, community links, whistleblowing, values and culture, and communication. They had also checked clinical risks such as weight loss, pressure ulcers or infections affecting people in the home on the day of their visit, and whether appropriate action had been taken. They also checked whether there had been any formal complaints but also checked up on any minor niggles. This meant that the provider was proactive in the monitoring of the service's culture and values, clinical risks and complaints and concerns. A director's liability report was completed and updated weekly. This meant that the directors were kept up to date regarding risks to the service.

The nominated individual held a weekly teleconference with all care home managers. The manager told us that these were very supportive as she was new in post and that the other managers in the group were also very supportive and had offered advice and assistance. The area manager was present during the inspection and was in regular contact with the service. A member of kitchen staff told us that they saw the senior management team on a regular basis. They said, "Yes we see the senior managers very often, they are really nice and always check that everything is okay." This meant that the manager and senior management team were visible and accessible to staff.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The premises do not meet the required standard of fire safety. Regulation 12 (2 (d)