

Larchwood Care Homes (South) Limited

Dove Court

Inspection report

Kirkgate Street
Wisbech
Cambridgeshire
PE13 3QU

Tel: 01945474746

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

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

Dove Court is registered to provide accommodation and care for up to 76 people. At the time of our inspection there were 66 people living at the service. The service is a two storey premises located on the outskirts of Wisbech. The service has communal lounges and dining areas on each floor and all bedrooms are single rooms with an en-suite toilet and washbasin. The service is split into units where people are cared for according to their personalities as well as needs and independence.

This unannounced comprehensive inspection was undertaken by two inspectors and an expert by experience and took place on 24 May 2017. At the previous inspection in 6 October 2014 the service was rated as 'Good'.

A registered manager was in post at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission (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.

Staff were knowledgeable about safeguarding procedures and keeping people safe from harm. Staff knew how to contact organisations responsible for investigating safeguarding should any such these incident occur. However, these incidents had not always been reported to the relevant authorities. Accidents and incidents were identified and acted upon when required.

Assessments had been completed to reduce the risk of people being exposed to any potential of harm such as choking, falls, malnutrition and skin integrity. Systems were in place to manage these risks effectively.

People's care needs had been assessed. These assessed needs were supported by a sufficient number of appropriately recruited and suitably skilled staff.

Staff were trained to achieve the required standard before being deemed competent to safely administer people's prescribed medicines. The recording, management, storage and disposal of medicines was undertaken safely.

Staff had been trained on the subjects they needed to be in order to meet people's care needs such as safeguarding, diabetes and moving and handling. People were enabled, as a result of staff's interventions, to access support from external healthcare professionals in a timely manner.

The CQC is required by law to monitor the Mental Capacity Act 2005 [MCA] and to report on what we find. People were supported to have choice and control of their lives. People's ability to make day-to-day and more complex decisions about their care and welfare were assessed by staff. Restrictions on people's liberty had been determined as being in their best interests or in the least restrictive way possible such as the use of bed rails.

People were cared for with kindness by staff who showed them compassion.

People, their relatives or legal representative were enabled to be involved in identifying, determining and planning the review of their care.

People were supported to be as independent as they wanted to be where this was safe. People were actively encouraged to take part in hobbies, interests and pastimes that provided them with social stimulation. However, for those people cared for in bed there was missed opportunities for social stimulation.

People's concerns were documented and effective actions were taken to help prevent the potential for any recurrence.

The registered manager was supported by a deputy manager, senior care staff, care staff, as well as housekeeping, catering and maintenance staff. Staff were supported in their role with mentoring, supervision and on the job training. This helped staff to fulfil their role effectively.

The registered manager and provider had not always notified the CQC about important events that, by law, they are required to do. This limited organisations responsible for people's safety to take appropriate action if this was required.

People, their relatives or representative and staff were involved and enabled to make suggestions to improve how the service was run. Quality monitoring and audit systems were in place to identify and make changes in the way the service was run.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations. We also found one breach 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.

Incidents of harm were recorded and acted upon but the reporting of such events to the local safeguarding authority had not always been completed.

Risk assessments were in place to help staff to support people in a safe way. There were sufficient suitably skilled staff in post to meet people's assessed needs.

Medicines were administered and managed safely.

Is the service effective?

Good ●

The service was effective.

Staff received training on various subjects and as a result they supported people to be independent.

People were lawfully deprived of their liberty and where required people received care that was in their best interests.

People's nutritional and healthcare needs were met.

Is the service caring?

Good ●

The service was caring.

People were cared for with compassion.

People were supported by staff to be involved in planning their care as much as each person preferred.

People were free to be visited at a time they preferred. Advocacy support was available if this was ever required.

Is the service responsive?

Requires Improvement ●

The service was not always responsive.

People's care and support was not as person centred as it could

have been.

A range of hobbies, interests and activities were available but not all people benefitted from these.

Comments and concerns were acted upon before they became a complaint.

Is the service well-led?

The service was not always well-led.

The provider and registered manager had not always notified the CQC about events such incidents of harm that, by law, they are required to do so.

Staff were supported by a registered manager who led by example in an open and honest culture.

A range of audits and quality assurance procedures were in place to help drive improvements in the way the service was provided.

Requires Improvement 

Dove Court

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 24 May 2017, was unannounced and was undertaken by two inspectors and an expert by experience. Their area of expertise was with caring for older people and people living with dementia. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at this and other information we hold about the service. This included information from notifications the provider sent to us. A notification is information about important events which the provider is required to send to us by law.

Prior to the inspection we made contact with the local authorities who commission people's care, including social workers. This was to help with the planning of the inspection and to gain their views about how people's care was being provided.

We spoke with ten people, four relatives and two visiting friends. We also spoke with the registered manager, the deputy manager, two senior care staff, four care members of staff and the deputy chef.

We observed how people were cared for to help us understand the experience of people who could not talk with us.

We looked at six people's care records, medicines administration records and records in relation to the management of staff and the service. We also looked at records of complaints and compliments.

Is the service safe?

Our findings

We found that where harm had occurred these incidents had not always been reported to the local safeguarding authority. Following our inspection we gave the registered manager 48 hours to provide us with details of incidents of harm. They told us that there had been three incidents involving harm to people that had not been reported to them or the safeguarding authority. This lack of reporting put people at risk of further harm.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records viewed showed that staff had been provided with training on how to prevent instances of harm as well as refresher training on this subject. Staff were knowledgeable about identifying signs of harm as well as to whom they needed to report any such occurrence to if this was required. However, staff had not always reported events to the registered manager. One staff member said, "There are quite a few types of abuse, financial, physical, emotional and self-neglect. If I ever identified (any of) these I would report to the [registered] manager, their boss, you (CQC) or the local [safeguarding] authority." The deputy manager told us that the signs of neglect or harm could be "bruising, a person being withdrawn or tearful". They told us that they would not hesitate to report any suspicion of harm straight away.

People told us that they felt safe using the service. One person told us, "I'm safe as there's always someone [staff] here." A second person told us, "My door curtain helps – my family did it. One particular person used to wander in a lot and take things." We found the use of a 'modesty' curtain (this is a curtain across people's doorways) had been effective for this person to keep them safe. A third person said, "I've certainly never seen staff being unkind. People sometimes have a [disagreement] with each other." A relative said, "I think [family member's] safe as [they are] in bed all the time [due to the person's health condition] and can't fall out." Another relative told us, "We've had no concerns about staff handling people or seen anything [of concern]."

We found some areas of the home to be odorous, particularly where carpet was laid and that these odours were present throughout the day. This had also been identified during an audit by the provider in February 2017. A relative told us, "I notice bad smells sometimes in areas but [family member's] room is fine." We noticed that the fabric armchairs in the ground floor lounge all had soiled arm rests and stained head rests, whereas on the first floor, the lounge furnishing were newer and chairs clean. The registered manager showed us the plan for the furniture replacement and carpet refurbishment. This meant that the provider considered the environment people lived in and took action where required.

Risk assessments were in place and staff adhered to the guidance for subjects such as moving and handling, repositioning and nutritional support. People told us that they had the equipment they required and staff helped people appropriately. One person said, "I use my walking stick – I'm careful as I can't see well. I know how many steps it is into the corridor, then how many until the turn and then into the lounge." A relative said, "They [staff] hoist [family member] about and are kind with them. [Family member] seems to have the

equipment they need like the bed rails." A second relative told us, "I've no worries about the way they [staff] handle [family member] – [they are] safe. They hoist [them] safely to weigh [them] now and then."

Most people we spoke with felt that more staff would be of benefit. However, we found and most people told us that they felt that call bells were responded to in a timely manner. One person said, "I press it (call bell) when people (living with dementia) come in my room – they [staff] come pretty quick then." Another person said, "They [staff] keep the call bell near me and will come quite quickly when I ring." A relative told us, "[Family member] can use their bell from the bed and they [staff] come quickly enough." This is what we saw during our inspection.

The registered manager showed us how they assessed people's level of independence and their support needs as well as recruiting staff to support people if permanent staff were absent. Regular reviews of staffing took place to help ensure that people's needs were safely met by staff with the right skills. Staff told us that in the event of staff being absent for any reason they could cover shifts from the staff team. The registered manager told us that agency staff were regular staff who knew people but they would only use these staff as a last resort.

People all told us that staff supervised their taking of medicines and that prescribed painkillers were available if required. We found however, that one person's as and when medicine did not have a written record of how this was to be administered and staff were not aware of the way in which this medicine needed to be administered. The registered manager showed us that they had this protocol in place before we completed our inspection. One person said, "I'm on inhalers and can have a painkiller when I get a bad head. I had a [type of] infection but the antibiotics didn't agree with me so it's on my [care plan] to have a different sort." Another person told us, "Someone [staff] wait with me while I swallow mine." We found that medicines were managed safely, that they were held securely, disposed of safely and accurately accounted for. This was by staff who had been trained and proved to be competent to administer medicines safely.

Is the service effective?

Our findings

People were in most situations supported by staff with their assessed needs and preferences. This helped people to retain those skills they still possessed as well as nurturing people's levels of independence. Comments we were provided with about staff competence were generally positive. One relative told us, "They [staff] seem very expert – any queries we have, we ask one of the girls in dark blue [senior care staff] and they get it sorted." One person had become skilled at navigating around the service independently. They told us, "I come and go where I want – I know the number of steps I take to different rooms and I use the corridor rail." Staff were seen to respect this person's independence. Another relative said, "They [staff] seem trained well enough to [look after] people." The provider told us in their PIR, "[The provider] has training with observations and learning evaluations to ensure what the staff learn in training is put into practice to uphold good practice."

Records we viewed and staff we spoke with confirmed that the subjects staff were trained on included all those mandated by the provider. These included safeguarding people from harm, moving and handling, person centred care and dementia care. One staff member told us, "I have to do my on-line training that includes the MCA [Mental Capacity Act 2005]." Several staff told us that they had not had training on positive behaviour therapy. This limited staff's ability to manage challenging behaviours. One staff member said, "[Name] can be very intimidating. [They] have assaulted staff and other people." The provider also confirmed in their PIR that no staff had been provided with this type of training. This limited staff's ability to respond to people in a person centred manner and put staff and others at risk. Staff had in the meantime developed their own strategies in calming people who could have such behaviours. Another staff told us, "[Person] is quite a handful as they can be quite intimidating." The registered manager told us that they would use their staff dementia champion to support staff in this area straight away.

We found that staff were supported in their role such as new staff having a period of induction with a more experienced member of staff (shadowing). One staff member said, "I can't fault the support I have had. I feel confident in my job. I had five days in the classroom and then I shadowed experienced staff. I can always ask for help and all the staff do just that." Staff also told us that they had a regular supervision with their line manager. One staff said, "It's my chance to say what works well [about their role] and any support or training I may need. It's definitely not just someone talking to me or telling what to do."

The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. 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 authorisation procedures for this in care homes and are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. We found that appropriate applications had been made to the local authority and that these were being processed. Restrictions that

were in place included key access codes to the units within the service. This was to prevent people leaving the service who were at risk due to a lack of mental capacity.

We found that staff were aware of the MCA and its code of practice. As a result of this we saw that lawful arrangements were in place for those people who required to be supported and cared for in their best interests and in the least restrictive way. For example, through the DoLS process. Staff's knowledge of when, and when not, to support people with their decision making showed us that people's choices would be respected when this was safe.

We observed people being given choices about food and drink preferences, where to sit for lunch and also deciding on when they wished to go outside. One person told us that they "could leave the building if I wished, without an escort". A staff member told us, "I know about the MCA's five key principles. It's all about maximising people's choice but also letting people make a choice that others might find unwise. If I feel people make unsafe decisions I inform the seniors or [registered] manager. We have to keep people safe." We observed that people were free to choose what they wanted to do, where they sat or when they wished to go outside. We found that where restrictions were in place such as a bed rail that consideration had been given to determine if this was the least restrictive option that also safeguarded the person.

We spent time observing lunch being served in all of the service's dining rooms as well as people who preferred to eat in their room. The midday meal was a light lunch with the main meal being served at tea-time as a result of people being offered a choice of when they preferred their main meal. The food looked appetising and a choice of sandwich fillings was offered with a selection of crisps and snacks according to people's preferences.

People and their relatives that we spoke with were generally complimentary about the food choices and variety of options. People were supported to maintain a good nutritional intake and records were kept where people were at risk of weight loss or lack of sufficient fluid intake. Other diets such as low sugar, mashed format or puree were provided and available if required. One person said, "Sometimes I eat as I have to and other times I enjoy it. We get a choice of a sort. I need help feeding as I can't grip a spoon – they [staff] will keep an eye on me." Another person said, "The food is lovely. I go into the dining room. We get a choice of two or you can ask for something else."

A relative told us that their family member "eats up ok and has put weight on since being here." Another relative said, "I've no worries that [family member] gets given enough to drink." And, "[Family member's] always encouraged [by staff] to drink up." People could be assured that their nutritional support needs were met. The chef told us that they also catered for people who required a vegetarian or low sugar diet. They said, "If I'm making a pastry something, I'll do a vegetable tart for a change so they've got something nice. We've got [a meat substitute] instead of meat so they have more or less the same menu, just with their version."

People were supported with their healthcare needs. People told us that they had access to healthcare practitioners or could use their own practitioner. One person told us "I'm under the hospital for my [health condition]. I have the chiropodist who comes here though." Another person said, "The district nurses come three times a day for my [medicine]. I see the NHS podiatrist and go for the [type of] scan at the hospital." A third person said, "They [staff] understand my health issues, which is good." A relative told us, "They contact the GP as soon as there's any concern. [Family member] had the optician in recently too."

Is the service caring?

Our findings

People told us that most staff were kind and friendly. One person said, "Most [staff] seem very kind and have time for you, even when they're busy. Another person told us, "Most are nice and some are really, really kind." Staff were seen to respect this person's independence. A third person however, told us, "One or two [staff] can be a bit curt."

People we spoke with said that staff were caring. One person said, "I feel pretty much okay with everyone [staff] – a few have more time for us." Another person told us, "The majority (of staff) are nice and I feel at home with them." A relative said, "We've found the friendliness of them [staff] is great. Top banana! We've been coming so long, we [have a laugh] with the girls [staff]."

We saw that in some but not all of the units in the service that people's privacy and dignity was respected. We also saw staff walk past people who had uncovered themselves in bed and not address the matter. We brought this to the RM's attention and she remedied the situation and assisted people to be dignified. One person told us, "They'll [staff] shut my curtains and door if we're getting washed or dressed." Another person told us, "I only have privacy if I shut my door [this was the person's choice]. They [staff] do knock though." A relative said, "They [staff] always knock on [family member's] door and I see them close the curtains when it's time for care." Another relative told us, "They [staff] knock even if [person's] door's open. They close the curtains when they move [person] and I step outside."

We noticed that a number of people on one unit had a privacy net curtain fitted across their bedroom door – either a full curtain or waist height – to deter people from wandering into their room. One person said, "Yes, sometimes other people come in my room and sit down but I don't mind they are never any trouble." For some people's circumstances this net curtain had been effective in deterring unwanted guests. However, one person told us, "They [staff] didn't tell me it was [a unit for people living with dementia] over here. One or two people just walk in my room and fiddle with my things. I say, 'get out!' It happens three to four times a day. I've not got a door curtain as a deterrent – you have to buy it yourself."

We saw that people were cared for in a kind manner. For example, the hairdresser was accompanying two people back to the lounge, giving calm unhurried supervision as they walked slowly together, chatting. This was as well as compliments relatives had sent to the provider such as, "Thank you to all the staff for looking after my [family member] so well and treating them as a person." We heard staff complimenting people, about their appearance. At lunchtime we observed staff bring a person into the dining room. They helped the person in a very sensitive manner to maintain their dignity. This was by crouching down and holding the person's hand. Another relative told us that their family member used to have their own hairdresser come in but staff now washed the person's hair in their room. The relative said their family member preferred this.

Staff made people feel that they mattered in various ways such as speaking with people in a kind, sensitive and clear way and by making eye contact. People were also supported to keep those skills they possessed and staff respected people's abilities. One person said, "I'm very much encouraged to manage what I can – like I can shower myself and sort my room." Another person told us, "They [staff] let me try to wash my face

and help with getting up. I can't manage dressing all by myself and need help with my trousers." A relative said, "We're happy with the care [family member] gets. I'd give all the girls [staff] a humungous pay rise as they deserve every penny!" One staff member told us, "If it was my mum or dad living here I would expect the best. If any staff didn't provide their best then I would speak with the deputy manager or [registered] manager. I am completely confident that action would be taken."

People with sensory impairments were supported to undertake activities by staff who did this with sensitivity and kindness. There were large playing cards and large print book available and staff spent time reading to some of the people.

Advocacy was provided and information was made available about this service to people and their relatives, friends or representatives. Advocacy services are independent and support people to make decisions and communicate their views and wishes. One person said, "I am very able and I can speak up for myself." Another person told us, "They [staff] explained everything to me if I felt that I needed any help to communicate my wishes."

Although most people we spoke with could not recall having regular review meetings or had seen a care plan we found that they were involved in determining their care needs. For example, one person said, "My [family member] comes in each week and does my money and care [planning]." Another person told us, "My [family member] has power of attorney but I'm not aware of any meetings they've had." A relative told us, "We went through [family member's] care needs. I helped quite a bit as [family member] needs my support." We found that where a person had a lawful representative that this had been identified.

We found, and people and relatives told us that visiting times were unrestricted and that the person came first. One person told us, "I have large family and they do come when they can. I love seeing them all and staff bring them to see me." Another person said, "My wife visits whenever she wants." One relative said, "We visit regularly and we are always made to feel completely at home."

Is the service responsive?

Our findings

We found that not all people were satisfied with the way their care and support was provided. This was especially for most people living on the first floor. A number of people had experienced other people living with dementia entering their bedrooms uninvited. This was because some people's needs were not being met. One person told us, "It's always 'in a minute' when you ask [staff] for something. They [staff] don't spend time with you." Other comments we were given included a relative who said, "[Family member is] just left alone in bed mostly. No-one [staff] comes to do anything special, like to calm her, holding her hand." We observed a person who was often going into other people's rooms and several times we heard two people shout at the person to get out of their room. This meant that staff did not always respond to people's needs in a timely manner to prevent these events.

We found that care was not always as person centred as it could have been. Examples of this were staff giving a person the wrong sort of nutritional support which was not in line with the information and guidance in the person's care plan. Another example was where a person who was being cared for entirely in bed although there was no record of why this person needed to be in bed. The registered manager told us that in future they would record what the community nurse advised so that staff were aware of how to meet the person's needs.

We observed on several occasions that staff appeared to be task-led for much of the time and did not spend quality time sitting with people or supervising the lounges. For example, we observed in the Jasmine lounge that no staff members were there between 9.30am and 11.30am with the seven people who had chosen to be there. In another situation a person was assisted by staff to be safe but there was no further interaction to find out if the person wanted something or support from staff. There were also missed opportunities for staff to engage with people in a meaningful way. We observed staff say "hello" to people but this was in passing without any attempt at engaging with the person. This put people at risk of social isolation and at risk of their care needs not being responded to in a way which people could benefit from.

We found that there were a lack of activities and social stimulation for some people. An example of this was where we identified that a person who had a favourite pastime had not been supported with this. Their relative told us that they had informed staff who were aware of this pastime. The day after our inspection we were informed by the registered manager that as a result of their intervention the person had been supported with their favourite pastime which they were happy with. However, until we highlighted this point staff seemed to accept that the person's needs could be met in bed. This meant that people's needs were not always responded to in a person centred way and put people at risk of receiving care that was not always appropriate.

Two activities staff supported people with hobbies and interests such as a visiting 'Zoo lab' as well as arts and crafts, raffles and baking. One of the activity staff told us that they tend to have one-to-one chats or interaction in the morning and an organised activity in the afternoon. People gave us examples of how staff responded to their individual needs such as one person saying, "I loved the trip to Hunstanton and also the singers who come." Another person told us, "I like my newspaper. I like my own space and watching my TV."

Some people and relatives expressed concern at a lack of activities. One person said, "[Having an impairment] it's a bit limited what I can join in. I can manage bingo (by being adaptable)." We did however find that other stimulation and activities were provided. A visiting friend told us that, "There was generally a communal activity everyday such as a quiz or one to one time for a manicure or hand massage." Another person said, "I go out for [pastime] two to three times a day. Someone [staff] has to take me out and set me up then they leave me. I've seen rabbits and a fox in the garden – lovely and quiet." A third person told us, "They [staff] have various things on that I might join in. I had a family picnic in the garden here the other day which was a surprise for me. It was nice that we could use the garden for it." A relative said, "[Family member] can't join in now as [they're] in bed. [Activities staff] always waves when [they are] passing and comes for a chat with [them]. The cleaners chat too."

People we spoke with had either not felt a need to complain or any issues that had been raised had generally been addressed. The complaints process was displayed and provided to people in a service user guide as well as larger print versions when required. One person told us, "If I have any concerns I just speak with them [staff]. They sort things out quickly so I have never need to complain. Another person said, "No worries on that point. I am happy with everything here." A third person told us, "I complained to the [registered] manager about a couple of staff who were rude and couldn't be bothered. I've not seen them lately." Relatives told us that they had, "Never had to complain" and "I've not had complaints at the moment. I saw the [registered] manager about [family member's] medication as I'm not sure [about the side effects] – I was told they only give [them] the [correct type of] medication." We saw records that showed complaints were managed within the provider's policy and to the complainant's satisfaction.

Is the service well-led?

Our findings

Not all events that the provider and registered manager must tell us about had been reported. This was for subjects such as incidents of harm. This limited the Commission's ability to alert organisations responsible for investigating safeguarding to take appropriate action if this was required. This was as well as limiting our ability to take action if this was required to keep people safe.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

At the time of our inspection, Dove Court had a registered manager in post. They were supported by representatives of the provider, a deputy manager, senior care staff, care staff, two activities co-ordinators and ancillary staff including a catering and housekeeping team. We found that the registered manager and provider were prominently displaying their previous CQC inspection rating in the home as well as on their web site.

The registered manager kept their knowledge and skills up to date by attending the provider's forums where other registered managers could share their views on subjects such as sharing good care practise. The provider told us in their Provider Information Return that, "The [registered] manager encourages staff to develop and reach their potential through training, which boosts staff morale and feeling of value whilst providing residents with skilled staff." This is what we found during our inspection.

A range of options and methods were available for people to contribute how the service was run. These included relatives' and residents' meetings as well as daily contact with staff. A survey of people's and relatives' satisfaction had identified what the service did well and where improvements were needed. The registered manager had just received the results on the day of our inspection and was identifying actions that may need to be taken such as activities for people's stimulation.

Relatives we spoke with confirmed that their views had been sought in the last six months and that their minor issues had been resolved such as having more choice of sandwiches. Other methods were used to gain a view about people's satisfaction such as day to day contact with the staff team. This was as well as shift handover records if people's needs had changed such as changes to prescribed medicines or equipment. Compliments were also used to identify what had worked well. An example of this included, "Thank you all [staff team] for your kindness, support and professionalism in looking after my [family member]."

People told us that the registered manager was not always available but most people felt they could talk to them about any concerns they may have had. One person told us, "You see her by request. She's nice enough to talk to." We saw that during our inspection that the registered manager spent time around the home monitoring staff as well as speaking with people and their relatives. A relative said, "[Name] is an approachable [registered] manager. She is very good if you have a concern and she listens."

There was an open staff team culture and staff told us they enjoyed their work and caring and supporting

people who lived at the home. Staff were supported by the registered manager and they received regular support in the form of supervision, training and attendance at meetings. One staff member told us, "We have staff meetings and these are our chance to speak up about anything that needs changing."

The registered manager led by example and all staff we spoke with felt that they were well supported by them and their colleagues. Staff also told us that the registered manager was available to them for any advice or guidance. The deputy manager told us that the registered manager was, "Very supportive and they were, at most, a phone call away." Staff told us that their suggestions for improvements were always considered and that they felt valued and listened to by the registered manager and provider.

Links were maintained with the community with a variety of trips out such as shopping or a visit to a hairdresser and support for people's religious beliefs. This was as well as visiting singers and entertainment and pets as therapy dogs. One person said, "I enjoy going out with my daughter. It's nice to see what's going on in the world."

All of the staff we spoke with felt confident that if they identified or were concerned in any way about the quality of care that was provided; they would report their concerns immediately. This was by whistle blowing. Whistle blowing can occur when an employee raises a concern about a dangerous or poor practice that they become aware of through work.

Staff meeting minutes we looked at showed that staff were reminded of their responsibilities and of the standard of care that was expected such as using non slip mats. Topics discussed during staff meetings included ensuring protective clothing was worn and that staff had to contact the registered manager in person if they needed to be off work for any reason.

A range of quality audits and procedures were in place to help drive improvement in the way the service was run. For example a programme of clinical audits was in place to accurately monitor people's health conditions as well as audits for the administration of medicines. This was planned to make sure that appropriate and timely healthcare referrals had been made and that the actions in place were effective such as pressure sore prevention equipment. We found that this was the case. However, we found that audits of records and people's care had not always identified omissions in reporting incidents to the registered manager. One relative, as a result of on-going improvements described the service as, "It's a pretty good feeling [knowing family member is looked after well]." "It's a lovely place." And, "It's quite a good atmosphere." Another relative told us, "We're kept informed on the noticeboard and we did a dementia awareness week recently. They [registered manager] takes on board what gets said at the meetings so that's good."

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 registered person had not always notified us about events that, by law they are required to do so.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Incidents of harm had not always been reported to the appropriate authorities. This limited the identification of trends and also how people were safely supported.