Mr & Mrs B J Wise

St Andrew's Care Home

Inspection report

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Date of inspection visit: 21 and 24 September 2015
Date of publication: 20/11/2015

Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

An unannounced inspection took place on 21 and 24 September 2015. It was carried out by one inspector. St Andrew's Care Home provides accommodation for up to 23 people and 20 people were living at the home during our visit, which included one person on a short stay.

A registered manager was in post. 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 Care Quality Commission (CQC) is required to monitor the operation of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are put in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect themselves or others. At the time of the inspection, two applications had been made to the local authority in relation to people who lived at the service. The registered manager

Summary of findings

told us these were waiting to be approved. After discussion, she identified further people living at the home who required an application and she stated these would be made.

Improvements were needed to address an environmental risk, improve the complaints system and to provide clear information both to people living and working at the home about the values and ethos of the service. Medication was generally well managed but improvements were needed to make practice safer. Further work was needed to improve how one person's behaviour was monitored to ensure everyone's sense of well-being was maintained. Improvements were needed to ensure there was an effective auditing and maintenance system and that staff performance issues were managed discreetly.

People's opinion were staffing levels were adequate and people told us they felt safe. Staff were caring but occasionally their approach could undermine people's dignity.

Staff knew their responsibilities to safeguard vulnerable people and to report abuse. Recruitment was well managed. People were supported by staff who met their emotional and health care needs. Staff received support to develop their skills.

People were supported to make decisions about their care and support. People were supported to access healthcare services to meet their needs. Action was taken to reduce risks to people's health. The service was responsive to people's changing needs. Staff working at the service were positive and people living at the service commented favourably on their experience. Five people commented positively on the staff with two people describing them as "kind" and "wonderful." The home was clean and there were no unpleasant odours.

We found several breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 linked to the management of complaints, providing accurate information about the service, implementing deprivation of liberties safeguards and how the service was run. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

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

Improvements were needed to make some aspects of the service safe.

Safety checks were in place but action was not always taken to address risk.

Call bells were not accessible in the main lounge and some people's well-being was not appropriately monitored.

Some aspects of medicines management needed improving.

Staffing levels were adequate to meet people's care needs.

Staff knew their responsibilities to safeguard vulnerable people and to report abuse.

Recruitment was well managed.

The home was clean and there were no unpleasant odours.

Action was taken to reduce risks to people's health.

Is the service effective?

Requires improvement

Improvements were needed to make some aspects of the service effective.

People were supported to make decisions about their care and support and staff obtained their consent before support was delivered.

The registered manager knew their responsibility under the Mental Capacity Act 2005 but the Deprivation of Liberty Safeguards had not always been considered for people.

Staff received support to develop their skills.

People were supported to access healthcare services to meet their needs.

Is the service caring?

Requires improvement

One aspect of the service was not caring.

Staff were caring but occasionally their approach could undermine people's dignity.

People told us staff were kind.

Is the service responsive?

Requires improvement

One aspect of the service was not responsive.

Complaints information was not up to date.

The service was responsive to people's changing needs.

Summary of findings

Is the service well-led?

Some aspects of the service were not well-led.

There was not clear information for people living and working at the home about the service's values and ethos.

Improvements were needed to ensure there was an effective auditing system and that staff performance issues were managed discretely.

Staff working at the service were positive and people living at the service commented favourably on their experience.

Requires improvement

St Andrew's Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 21 and 24 September 2015 and was unannounced. There was one inspector who used the Short Observational Framework for Inspection (SOFI) during the inspection. SOFI is a way of observing care to help us understand the experience of people who could not comment directly on the care they experienced.

Before our inspection, we reviewed the information we held about the home, which included incident notifications they had sent us. A notification is information about important events which the service is required to tell us about by law.

During our visit we met with 15 people staying at the home and spoke with six people about their experiences of care. We met with one visitor who shared their views with us. We also met with five staff who carried out a range of roles within the home, and spoke with the registered manager.

We looked at records which related to four people's individual care, including risk assessments, and people's medicine records. We checked records relating to training, supervision, complaints, safety checks and quality assurance processes. We also contacted health and social care professionals for their views on the quality of the care at home. Health professionals included two local GP surgeries, a member of the community nurse team, a nurse educator and a speech and language therapist. We did not have a response from the local commissioning team.

Requires improvement

Is the service safe?

Our findings

The registered manager told us hot water in the home was controlled by thermostatic valves fitted on the taps. This was to regulate the temperature of the hot water in people's sinks in their rooms and in their bathrooms. However, monthly readings showed the water was hotter than recommended by the HSE and potentially put people at risk of scalding.

A number of people staying at the home were living with dementia and therefore might not be able to recognise or react to water that was too hot. There was a regular audit of hot water temperatures and so it was unclear how these risks had not been previously identified. When we shared our concerns, the registered manager took action to rectify the risks. They told us a plumber had visited and rectified the problem. Other potential risks to people's safety had been managed, for example windows were restricted and radiators were covered. Records showed equipment was serviced and fire safety included staff training and individual evacuation plans for people living at the home.

On both days of our visit the call bell in the front lounge was left hanging on the wall, which was not accessible for five people using the lounge. Staff did not stay in the lounge and one person, who was at risk of falling, got up several times and called for help. We intervened to help keep them safe; a person using the lounge said they generally went to find staff to help this individual. The registered manager said staff had been instructed to spend more time in the lounge and to ensure the call bell was in reach. She advised she would look at providing accessible calls bells for people in the lounge who were dependent on staff assistance to move.

Staff were knowledgeable about how to recognise signs of abuse and how to whistle-blow on poor or abusive practice. They knew who they should contact to make a safeguarding alert either within the company or via an external agency. They knew where the safeguarding policy was kept, which included contact details for external agencies. We asked staff for their opinion on whose behaviour might impact on other people's well-being. They told us about one person and changes in this person's behaviour were logged in their care records. The person also told us about systems which were in place to monitor their well-being and actions; this showed they had been involved in their care planning.

However, systems were not in place for monitoring the behaviour of other people living at the home. For example, after spending time in communal areas, we were concerned how one person's negative comments could impact on those around them. Staff were not always present in the dining room and therefore did not observe when a person made comments that undermined other people's well-being. The registered manager was aware of this issue and as a result one person's care plan made reference to this concern. But there was not clear guidance to how staff should respond to help ensure a consistent approach to manage the person's comments. Monthly reviews did not make a judgment if the care plan was working to monitor their behaviour. A record had been completed on three occasions relating to comments made to another person but the second person's care plan did not detail how they should be monitored by staff to protect their well-being.

A person told us "it is really good" and several people said they felt safe; this included a person who used equipment to help them move. Staff took time to check with them about how they wanted to be moved and explained what they were doing. Staff did not rush them. On one occasion footplates were not used when a person was moved in a wheelchair, which was not safe practice. But the next time another staff member corrected their colleague and ensured the footplates were in place. Moving and handling up dates were booked for staff. People who chose to spend time in their bedrooms showed us call bells which were accessible. One person was cared for in bed and staff completed regular checks to ensure they were safe and comfortable.

The registered manager described the changes they had made following a pharmacy audit in April 2015 to help ensure medicines were managed safely. Medicines were administered by senior staff who had received training from a range of sources, including the local pharmacy. There were systems to encourage safe practice such as photos of people living at the home in the medication records, a list of staff signatures to help ensure an audit trail and a log of people's allergies. There were no gaps on the medication administration records and medicines were kept securely.

However, there were areas of practice that required improvement. A thermometer had been placed in the storage area to monitor the temperature to ensure the medicines were not compromised by the heat. But the

Is the service safe?

readings had not been recorded; by the second day a chart had been put in place for this to happen. There were several examples where handwritten entries regarding medicine doses had not been double signed by staff, which potentially could lead to recording errors. Two staff had signed for a specific medicine to be administered but the total left had been wrongly recorded and therefore did not tally with the remaining stock. Staff had not picked up on this error when they had signed, which meant they did not understand the purpose of the second signature.

The home was clean and there were no unpleasant odours either in communal areas or in people's bedrooms. Care staff had been temporarily covering cleaning duties; we highlighted one person's carpet looked unclean. Staff explained it was difficult to deep clean the room as the person chose to stay in their room and liked a routine, which was confirmed when we met the person. The registered manager had identified infection control as an area for staff development and planned training in November 2015. Two bathrooms were without paper towels and although there was hand gel it was not by the signing in book and main door, which would have promoted good infection control practice for people entering and leaving the home.

People said there were enough staff, although several people commented staff did not have much time to sit and talk with them, which was confirmed by our observations. However, another person said they did not feel rushed by staff. Staff acknowledged it was sometimes too busy for staff to sit with people; health professionals visiting the home did not raise concerns about staffing levels. Rotas showed there were fluctuations in staff levels during the day because of staff recruitment issues. For example, on one morning shift there were four care staff on duty and on another morning this dropped to three care staff members. At other periods night staff were staying later to cover gaps in the morning shift. One afternoon dropped to three care staff rather than four staff. However, since the inspection the registered manager has advised new staff have been recruited and completed shadow shifts, which has meant staffing levels have now increased. She stated this was needed because some people's health needs had also increased.

Three recruitment files for recently employed staff showed the recruitment processes within the service were well managed, which helped ensure suitable staff were employed by the service. New staff members were not employed until information from the Disclosure and Barring Scheme (DBS) had been received and reviewed. These checks identify if prospective staff had a criminal record or were barred from working with vulnerable people. Newly recruited staff had produced relevant identification documents and provided an employment history. References were requested from previous employers to assess potential staff members' suitability and their feedback was recorded.

Risk assessments were in place to monitor people's risk of malnutrition and people's weights were regularly monitored. People were provided with fortified drinks and meals to increase their intake of calories when they were at risk of weight loss. Staff described how additional supplements such as ice cream and milkshakes with cream were provided, which we saw people enjoying and requesting. Health professionals were generally contacted in a timely manner when risks were identified. For example, a GP had been contacted for advice when a person who been discharged from hospital and had experienced a significant weight loss during their admission to hospital. Food and fluid charts were completed and up to date for several people living at the home, which included specific amounts of fluid. However, there was not a daily goal for fluid so there was no system in place to measure if the person's daily fluid intake was adequate. The registered manager said she would seek advice from the community nurses.

Risks assessments were in place and were up to date for people whose skin was at risk of pressure damage. Action had been taken to reduce the risk. For example, people were sitting on appropriate cushions and where necessary additional equipment was in place. Turn charts were completed and health professionals were contacted for advice when there were changes to people's health.

Requires improvement

Is the service effective?

Our findings

The registered manager told us they had applied for authorisation for two people under the Deprivation of Liberty Safeguards (DoLS) but said these had not yet been approved. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. The safeguards exist to provide a proper legal process and suitable protection in those circumstances where deprivation of liberty appears to be unavoidable and, in a person's own best interests. We met both of the people, observed them trying to leave the building and saw how staff intervened but offered to go for a walk with them. However, the registered manager was unaware that the Supreme Court in 2014 had widened and clarified the definition of deprivation of liberty to include any person subject to continuous supervision and control. Other people using the service were being monitored and/or supervised. For example, having their movements monitored for their safety. For this reason the registered manager should have applied for authorisation.

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

Maintenance work did not happen in a timely manner. A person told us they were cold and had gone back to bed to stay warm. One of their windows had not closed properly since 18 August 2015. Staff explained how they had tried to block the draft on 20 August 2015. We expressed concern about the delay and the impact on the person. There were no permanent staff members to address maintenance or refurbishment issues in the home. Instead, an outside contractor visited but staff said the contractor was often busy and could not always respond quickly. The registered manager said they had checked the person's heating was turned up and by the second day of the inspection on 24 September 2015 the contractor arrived to fix the window.

The registered manager provided us with a refurbishment plan for 2015; we visited rooms that had been decorated and re-carpeted in line with the plan. However, there were other areas of the home where work had been delayed. The last CQC inspection in July 2014 highlighted that the home's bath was chipped and the flooring in the bathroom was split. The bathroom had been refurbished with a new specialist bath and new flooring; this work was completed 14 months later. Further work was still needed to fix a toilet roll holder and complete the decoration. Wood had been bought to create a fence to make the garden secure but there was no date for when this work would be completed. Staff commented that a number of people would have benefited from the additional space during the summer as some people were active but needed a safe area. Additional garden furniture had been bought but further work was still needed to make the garden accessible and safe for all the people living at the home.

Some people were living with dementia but the environment had not been adapted to promote their independence. For example, people were not assisted to find specific rooms. One person walked around the upper corridor trying different doors. They told us they were looking for their room. We walked along with them and we eventually identified their room because of their name on their door, although they only appeared to recognise their room once the door was opened and they saw their belongings. The service had not considered how to promote people's independence by helping them find their way around the home.

Five people told us they were satisfied with the quality of the food and the choice of food. We spent time in the dining room at different times of the day. Meals were served directly onto glass tables; there were no place settings or condiments in place. People were not always offered the opportunity of a choice of drinks and people were not provided with jugs on the tables so they could help themselves. One person commented to their neighbour it would be nice to have some music. It was generally quiet although one person shared information about their past with a person sitting next to them.

The lack of atmosphere did not encourage people to linger or relax over their meal. A health professional commented that meal times did not appear to be a pleasurable experience for people. They suggested the registered manager might benefit from visiting other services where the atmosphere at mealtimes was more positive and inclusive. They also said it felt intrusive as a visitor to enter directly into the dining room when people were eating. Since the inspection, the registered manager has sent photographs to show the improvements made to the dining room including flowers, placemats, condiments and napkins on the table, which she confirmed had been discussed with people living at the home.

The registered manager said five of the fourteen staff had left recently. However, she gave us details of six new staff

members who were in the process of being recruited or undergoing an induction. Records showed new staff had previously worked in a care setting and brought previous care knowledge and care qualifications with them. Minutes from team meetings showed there was an acknowledgement that staff morale had been low in August 2015.

People confirmed new staff were introduced to them, several commented they appeared to have the right approach and skills. Some staff said new staff needed time to settle in and become part of the team. One staff member acknowledged teamwork needed to be built rather than just happened. Another staff member felt they would have benefited from more support and supervision when they started working at the home. But they also described how an experienced staff member had been a good role model to them and had provided helpful advice. Staff said they had access to supervision and appraisals, which was confirmed by records in staff files. This enabled staff to consider their role and training needs they had to do their job more effectively.

People said they made decisions relating to their life in the home and how they spent their time. For example, a person told us about how they were involved in decisions regarding their health and showed us the equipment they needed to prevent pressure sores. Records showed staff listened to people's views on their care. For example, a person assessed as having mental capacity had requested bed rails as they made them feel safer in bed. The minutes from a staff meeting in June 2015 reminded staff to record that people's consent was gained, for example with assistance with personal care. The minutes from a team meeting in July 2015 recorded the registered manager had audited daily notes and this form of recording was improving. Daily records showed staff were recording consent. Discussion with staff showed they listened to people's opinions, for example knowing how different people had responded to the new specialist bath and what their preferences were.

The registered manager and staff demonstrated an understanding of the Mental Capacity Act (2005) (MCA) in their discussions about people's ability to make decisions and how they should be involved in day to day decisions. Records showed staff had completed training in this area of care. Records showed that people's mental capacity was assessed for their ability to be involved in specific decisions and the outcome was incorporated into their care plan with records of best interest decisions, for example relating to personal care. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant.

Staff talked to us about their training opportunities and several had been given extra responsibilities in recognition of their skills, for example arranging inductions and auditing medication. A staff member praised the encouragement they were getting from the registered manager and the access to training. The registered manager said all but one staff member had either completed or were in the process of completing a national qualification in care.

The registered manager said staff were paid for attending training, which was evidenced by staff meeting minutes. She said she was committed to providing training from a range of sources, which included theory and practical training. Staff training files reflected this range of training. The registered manager recognised the importance of updating her own training and was in the process of completing a nationally recognised management course. A health professional confirmed that the registered manager was proactive in requesting suitable training for new staff, such as pressure care training.

Staff confirmed handovers took place and there was also a communication book for different shifts to alert each other to actions that needed to take place, such as monitoring health changes. It was not always clear from the communications book if staff had followed up on the concerns, although when we spot checked people's care records staff had addressed the concerns or taken action to contact health professionals.

A health professional said generally staff contacted them in a timely manner and appropriately. However, they were concerned that recently communication may have deteriorated between shifts, and between the seniors and the registered manager because of staff changes, which had the potential to impact on people's health and well-being. Two local GP practices gave positive feedback about the service. One surgery said referrals from the service were good because they were thorough and detailed. They commented staff were up to date with

Requires improvement

Is the service effective?

information and in their experience there was good communication between staff. They confirmed staff followed their advice. The second practice said communication between the surgery and the service had improved, particularly following a meeting with the home's manager. Neither surgery raised concerns about the standard of care.

Care records showed staff monitored people's emotional health. For example, one person told us how supported they were by their care worker. They said the staff member understood their anxieties and supported them with hospital visits. Staff recognised some people liked to help around the home, which had a positive impact on their emotional health. People told us they enjoyed this form of activity as it gave them a sense of purpose. This was documented in people's care plans.

Requires improvement

Is the service caring?

Our findings

Occasionally the language of some staff members used or wrote undermined the general caring approach of staff working at the home. For example, a person was described as a "feed" by one staff member and in another person's care plan it was recorded this person 'does not need any feeding'. On another occasion, a staff member undermined a person's dignity and was over familiar in their approach. The registered manager told us they were already monitoring one staff member's style of communication. Another staff member showed awareness of the anxieties of a person living with dementia but they responded to their concern in a jokey manner, which did not reassure the person. A health professional commented that the staff were usually a happy team but was concerned they seemed more stressed recently and maybe overburdened by supporting new staff.

Five people commented positively on the staff with two people describing them as "kind" and "wonderful." One person singled out the role of their keyworker who gave them reassurance and support. They said their keyworker understood them and gave them the help they needed in a caring manner, including help with a bath. A health professional also praised this staff member's approach. A visitor praised the staff members care of their relative, which included the attention given to their appearance and hair. They described the staff team as "brilliant" and "friendly." GPs from a local surgery told us staff treated people with dignity and respect. Written feedback from relatives included comments such as "we always knew she was in good hands whilst she was with you".

Staff and the registered manager spoke about people in a caring and compassionate manner. Conversations with staff showed they knew people well or were building on their knowledge, which reflected our conversations with people and the content of their care plans. Some staff were particularly emphatic and gentle in their manner. For example, a staff member listened attentively and respectfully as a person described their health problems. They made suggestions but ensured they had the person's agreement before they carried them out. The person was at ease with them and looked relaxed after the conversation. Conversations between staff and people living at the home showed there were positive relationships.

Staff had undertaken recent training in developing their dementia practice. One staff member was positive about the impact the training had in their understanding of people living with dementia. But further work was needed to ensure all staff members' practice was person centred and respectful. The registered manager acknowledged her role to provide a positive role model to staff in the way she interacted with people. She explained some people had known her prior to her role as manager and this changed the way she spoke with them. However, she appreciated some staff needed guidance to create relationships with people to ensure they approached everyone respectfully and with consideration.

Staff involved people when they were using equipment by explaining each step. They discreetly encouraged people to maintain their continence and checked with them how they wanted health problems resolved. For example, staff took the time to listen to people and reassure them. A visitor said they were impressed by the patience of staff and their commitment to maintaining their relative's ability to walk rather than using a wheelchair.

Requires improvement

Is the service responsive?

Our findings

People told us they had no complaints about the service and there were staff who they could speak with if they had concerns. A person visiting the home said the registered manager was approachable. However, information about how to make a complaint was not on display. By the second day of the inspection, the complaints policy was on display but it was out of date, had the name of the previous registered manager as a contact and was not written in an accessible manner. The current registered manager said people had this policy in their rooms to help them make a complaint. She confirmed their copies of the policy were also out of date and therefore would not effectively enable people to understand how the service managed complaints. The registered manager told us they had hoped to reword the complaint's policy but had not been supported in their plans to change the wording. Since the inspection, the registered manager has updated the policy and confirmed this was now on display.

Prior to this inspection, a relative contacted CQC because they were unhappy about how a complaint had been managed by the providers in the past. When we reviewed the responses from the provider to the relative's complaint we judged they had not acted in a timely manner and had not provided clear information about how the concern had been investigated.

This is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

However, despite a poor complaints system, there were examples of good practice by the registered manager in addressing concerns, for example linked to food preparation or staff practice. She showed a commitment to addressing concerns when they were brought to her attention. She also offered to meet with a bereaved relative who had concerns about the standard of care prior to the registered manager's appointment. In her response to this matter, she showed she was compassionate and understood the person's emotional needs.

A visitor queried whether there was enough stimulation for people, particularly people who needed additional support to participate in activities. The registered manager told us they were reviewing how activities were organised at the home as they recognised there were still times when people spent periods with little stimulation apart from the television. A staff member had been recruited in July 2015 to specifically provide an activities role for three days a week. One person said they chose not to have contact with this staff member, which was respected. However, another person regularly played cards with them and other people's records showed they participated in a variety of activities including art, cooking, board games, singing and quizzes.

During the inspection, no activities were provided as the activities person was not on duty. Instead people spent time in their rooms or spent time in the main lounge. In the afternoon, a few people watched the television and some people slept. There was little conversation, apart from a person sighing intermittently and asking the time and saying they might go to bed. The position of five of the armchairs made it difficult for people to see the television; one person commented on what they heard but could not see the screen unless they turned in their seat. The registered manager said they would review the position of the television.

Several people responded positively to staff when they came into the lounge and looked more alert showing they benefited from interaction with staff. However, in the time we spent in the lounge most staff only stopped for a few minutes to check if people needed a drink and or help, and then left again. One staff member took a little more time and had a chat with people and was gentle and thoughtful in their approach.

A few people were able to talk about how they had moved to the home or had come to stay at the home. Written assessments were in place to show how the registered manager made sure they could meet the needs of people before they moved to the home. The registered manager said their aim for people's care plans was to ensure they were personalised and not just about people's physical care needs. A relative confirmed they had been asked to supply information about their relative's background; they commented this was a good idea. The registered manager had delayed writing a full care plan until she had received social history information. An assessment and temporary care plan was in place to advise staff of the help the person needed. The registered manager told us she recognised timescales needed to be improved and she planned to document that the person who was living at the home had agreed to their relative being involved.

Two people were unsure if they had seen their care plan and when we checked several people had not signed their

Requires improvement

Is the service responsive?

care plans, although the registered manager said the content had been discussed with them. However, people told us the staff knew how to care for them. People's daily records were up to date and care plans held personal information, including people's likes and dislikes.

Staff members demonstrated their knowledge of the people they cared for in their discussions with us and by their actions. For example, one person had struggled to access their room because of a change in their physical health. After the person was reluctant to use equipment to assist their mobility, the health professional involved in their care was contacted and discussion took place with the person about how to maintain their independence. The person agreed to try another more accessible room. They told us they were very happy with their new room and were positive about their experience living at the home saying "I'm delighted to be back to my normal self."

Requires improvement

Is the service well-led?

Our findings

The systems to monitor the quality of care were not always effective. For example, maintenance issues and improvements to the environment were not routinely addressed in a timely manner which impacted on the lives of people living at the home. Hot water temperatures were recorded as above the recommended Health and Safety Executive temperature but neither the registered manager nor the providers had taken action to address the risk over a period of two months. Therefore work was needed to make audits effective. There were no records to show that the provider carried out their own audits to ensure the service was operating safely.

The complaints process was not effective and the providers' response to a complaint was not managed well. For example, information was out of date and the provider's response did not meet the timescales stated within the policy.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

The registered manager did not have support systems within the organisation to review her work and help her develop her skills further. For example, we highlighted that staff performance matters should be handled in a confidential manner not through a staff communication book as we found an example of this during our inspection. A visiting professional also raised concern that the registered manager's public approach to correcting staff practice had impacted on the confidence of some staff. The registered manager understood these concerns and could give examples when they had previously recognised when to make changes and learn from mistakes. The registered manager met with the providers and showed us a list of goals that they had agreed to complete rather than a review of the quality of her work and areas for development.

Documentation about the service did not promote a person centred and open culture. People moving to the service were not provided with up to date information about how the service was run and what the ethos of the home was. The registered manager said a brochure was available. However, she said it was out of date, which she had highlighted to the provider. Therefore she usually directed relatives to the home's website for information. The brochure named a manager and a staff group of 12 but the manager had left two years previously and only one of the named staff still worked at the home.

The wording of the brochure was not written in an accessible manner, for example 'all residents are competent or moderately confused' and 'many residents have sought admission to the home as an escape from elements in their previous living arrangements, which threatened their safety or caused them fear'. There were several references in the brochure to managing complaints including 'readily accessible channels', but the complaints policy did not support this claim.

This is a breach of Regulation 12 of the Care Quality Commission (Registration) Regulations 2009

There was not a clear ethos within the service regarding respecting the people that worked at the home. New staff to the service were provided with a folder about their role and the expectations on them. The registered manager said she had inherited the format and wanted to improve it but had been more focussed on the day to day running of the home. The wording in the folder for new staff did not promote an inclusive or positive culture, where staff were valued. Instead, the focus was on the management of disciplinary procedures and information was worded in a formal and unwelcoming manner. However, most staff commented on the positive teamwork, one saying "we get on really well" but some were concerned that the numbers of new staff meant the team needed time to establish consistent ways of working.

Audits were carried out by the registered manager and records showed she ensured equipment was serviced. The registered manager explained how they observed staff members' practice, and how they had undertaken performance management for staff when their practice was unsafe. The registered manager showed a strong commitment to making improvements and provided us with examples after the inspection of work she had undertaken. This included updating the home's complaints policy, making applications for deprivation of liberty safeguards and meeting with staff to discuss good practice to promote dignity and respect.

The registered manager said they felt supported by the providers. She said she was committed to her own development, including working towards a management

Requires improvement

Is the service well-led?

qualification and linking with other registered managers to learn from those with more experience. An example of this was adapting the home's assessment form to make it more comprehensive based on the work of a visiting registered manager from another care home.

Several health professionals commented that the registered manager was receptive to learning and open to advice. One said she was "very positive and keen for training." One health professional said the registered manager quickly made changes when they were highlighted but suggested she could become more proactive rather than reactive. Another said the registered manager acted and listened to advice and once she was aware of concerns she was "on it" to ensure the concern was addressed.

Staff generally felt they could approach the registered manager with queries or concerns. They told us the home's policies were accessible, although we highlighted to the registered manager the whistle-blowing policy needed up dating to provide appropriate external contact numbers. Staff told us they had access to supervision sessions, which was confirmed by staff records This enabled them to feedback on their role and to make suggestions for improvement. Team meetings took place on a monthly basis and feedback was given by the registered manager to staff, which included praising staff performance, as well as highlighting areas for improvement.

One person told us "nothing could be improved." People were positive about the care, although several people mentioned they would like a bath more often. Annual surveys had taken place for both people living at the home and working at the home. The feedback was positive and had been collated and displayed in a communal area of the home. The registered manager said they encouraged staff to make suggestions, for example the installation of a specialist bath had been suggested by a staff member to benefit the people living at the home. Several people commented how they enjoyed the experience of the new bath, which had stimulating jets of water to promote good skin care. The registered manager had sought advice from health professionals before buying the bath to ensure it was appropriate to the people living at the home.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Further work was needed to ensure Deprivation of Liberties Safeguards were applied for appropriately.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints There was not an effective complaints system to address people's concerns.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance There was not an effective system to regularly monitor and assess quality of the service and the risks to people living at the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 CQC (Registration) Regulations 2009 Statement of purpose People were not provided with up to date information about the home.