London Residential Healthcare Limited

Acacia Care Centre

Inspection report

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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**

Summary of findings

Overall summary

This unannounced inspection took place on 1 November 2018. At our previous inspection in April 2016 we found the provider was meeting the fundamental standards and we rated the service Good. At this inspection we found standards had deteriorated and we rated the service Requires improvement.

Acacia Care Centre is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. Acacia Care Centre provides nursing care. CQC regulates both the premises and the care provided and both were looked at during this inspection. The service provides care for up to 62 older people requiring residential or nursing care. There were 57 people using the service at the time of our inspection.

The home had a registered manager 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.

There were not always enough staff to care for people safely and in a compassionate and personal way. The provider lacked a robust system to assess the staffing needs of the service at the time of our inspection. Some people raised concerns about the length of time it could take staff to respond to call bells and the provider lacked a suitable system to monitor this.

We received mixed feedback about the meals and a person's dietary needs were not met well by the service. Staff sometimes rushed when supporting people to eat and mealtimes were not always used as an opportunity to encourage social interaction. People were not always supported to maintain their independence as far as possible. Although formal complaints were investigated and responded to appropriately, informally raised concerns were not always dealt with well.

The provider carried out recruitment checks on staff. The provider did not always store people's confidential records securely. Care plans were accurate and reliable for staff to following in caring for people.

Most people received their medicines safely although improvements were required to assess risks when a person self-administered their medicines and in relation to covert medicines for one person.

The provider responded appropriately to safeguarding allegations raised during our inspection. However, some staff were unaware of their responsibilities in relation to safeguarding.

Most parts of the home were clean although some areas required more attention. The provider monitored infection control practices in the home we identified an infection control risk which the provider had overlooked.

People's capacity to consent to their care was not always assessed in line with the Mental Capacity Act 2005. The provider did not always promptly identify when people coming to the service required legal authorisation to deprive them of their liberty. The provider had not notified CQC of the outcome of applications to deprive people of their liberty as required by law.

The provider used a number of audits and checks to assess whether the care provided was of good quality. Although these were comprehensive and detailed, they did not always identify shortfalls in quality and were not always effective at driving improvements within appropriate timescales.

People were supported in relation to their day to day health. The premises were well adapted to meet the needs of people with dementia. Staff received a programme of training and supervision to help them understand and meet people's needs. People were supported to plan how they would like to receive care at the end of their lives and the provider followed an accredited end of life care programme.

Most people were positive about the staff who supported them and staff knew people, although people fed back that managers were not very visible. Staff treated people with dignity and respect and people were given the privacy they required. People could take part in a wide range of activities based on their interests.

People, relatives and staff had opportunities to feed back about the service through meetings and surveys, although people were not always aware of these opportunities.

We found breaches relating to staffing, consent and statutory notifications. You can see the action we asked the provider to take at the back of the full-length version of our 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. There were not always enough staff to care for people safely and maintain cleanliness in some parts of the service.

Although some aspects of medicines management were safe, improvements were required in other areas.

Staff did not always understand their responsibilities in relation to safeguarding. The provider took appropriate action following allegations of abuse to keep people safe.

Recruitment checks were carried out to check staff suitability.

Staff assessed people's risks and regularly reviewed plans were in place to mitigate them.

Health and safety checks were carried out on the premises and equipment.

Is the service effective?

Requires Improvement

The service was not always effective. People did not always receive care in line with the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

We received mixed feedback about the food people received.

People were supported by staff who received training and supervision to develop their skills and knowledge.

People's day to day health care needs were met and staff continued to assess people's needs.

The premises were adapted to meet people's needs.

Is the service caring?

Requires Improvement

The service was not always caring. There were not always enough staff to support people in a compassionate and meaningful way. People were not always supported to maintain their independence as far as possible.

People were treated with dignity and respect and their privacy was maintained.

Is the service responsive?

Requires Improvement

The service was not always responsive. Some people felt their concerns were not always listened to. People were not always protected from the risk of social isolation as far as possible.

People were able to participate in a wide range of activities based on their interests.

People's care plans were accurate and reliable in guiding staff to care for people.

People's end of life wishes were recorded and the provider followed an accredited programme for end of life care.

Is the service well-led?

Requires Improvement

The service was not always well-led. The provider had not always notified CQC of the outcome of applications to deprive people of their liberty as required by law. The provider's quality checks did not always identify problems or address them effectively, although the checks were fairly comprehensive.

People did not always know who the manager was or feel leadership was visible.

People and staff had opportunities to feed back about the service.

Acacia Care Centre

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.

Before our inspection we reviewed information we held about the service. This included statutory notifications received from the provider and the Provider Information Return (PIR). Statutory notifications provide CQC with information about significant events such as allegations of abuse and serious incidents. The PIR is a form we asked the provider to complete prior to our visit which gives us some key information about the service, including what the service does well, what the service could do better and improvements they plan to make.

This inspection took place on 1 November 2018 and was unannounced. It was carried out by two inspectors, an assistant inspector, a CQC specialist nurse advisor and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We spoke with nine people who used the service and three relatives. Due to their needs, some people living at Acacia Care Centre were unable to share their views. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We also spoke with the registered manager, regional director, chef, housekeepers, eight care staff and a visiting healthcare professional. We observed care and support in communal areas, spoke with people in private and looked at the care records for five people. We reviewed how medicines were managed and the records relating to this. We checked five staff recruitment files and the records kept for staff allocation, training and supervision. We looked around the premises and at records for the management of the service including quality assurance audits, action plans and health and safety records.

After our inspection visit we contacted 13 health and social care professionals to gather their feedback and received feedback from two.

Requires Improvement

Is the service safe?

Our findings

There were not always enough staff to care for people safely. One person told us, "There are not as many staff as are needed as most people need help with most things. They work on the 'just enough' theory." A different person told us, "There aren't enough staff for all of us." A relative told us, "Low staffing means that they get behind. Things get done but it can be a wait sometimes. Weekends seem particularly short." Several staff told us there was an issue with short notice staff sickness absence which increased their workload and made it unsafe for people. For example, a housekeeper told us they sometimes supported people to eat when there were insufficient staff to do this. We observed there were not always enough staff to support people safely. For example, at mealtimes staff were not always in communal dining rooms to prompt people to eat and staff sometimes rushed when supporting people to eat individually.

Prior to our inspection we received a concern staff may not respond to people promptly during the late evenings and nights. One person told us, "It makes me feel mad that I have to sit in a dirty pad. They can be very slow to answer the bell but they are quicker if they know someone is here with me." A second person told us, "The call bell is left on the wall so that I can't get to it so I have to stay in discomfort." We observed the call bell had been left on the wall and was out of the person's reach during our inspection. A third person told us, "They can be slow to answer the buzzer at weekends and the buzzer isn't always where I can get it." We observed staff had not left the call bell in reach of the person when we spoke with them although staff noticed this when they entered the room later. We requested call bell records to check how quickly staff responded to people's calls for assistance. However, the registered manager told us they were unable to provide this due to the system in place. This meant the provider could not robustly monitor whether staff responded to call bells promptly.

Rotas showed staff absences were not always covered to ensure consistent staffing levels. For example, in October 2018 there were seven days where three nurses worked the day shifts instead of the usual four. For the same month there were 16 days and 10 nights when one or more shifts remained uncovered due to staff sickness or leave. Staff meeting minutes showed staff raised short notice sickness cancellations as a concern and our inspection findings showed the provider had not responded appropriately to their concerns to keep people safe.

The registered manager told us the service was fully staffed. However, the service lacked a suitable system to determine safe staffing levels. Although the provider used a tool to determine people's individual needs, this information was not used to determine the staffing levels required on each floor and overall. The provider agreed this was an area for improvement and was introducing a staffing tool to robustly consider staffing levels across the home. After our inspection the provider sent us the new tool which they used to assess the staffing levels and told us they would consider feedback from people, relatives and staff in determining the required staffing levels.

These issues were a breach of the breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider carried out recruitment checks on staff including obtaining a full work history and references from former employers, checking qualifications and nursing registrations, criminal records, identification and health conditions. The provider also interviewed staff to check they had the necessary attributes to care for people.
People's records were not always stored securely. We observed confidential information was left on tables at nurses' stations across the service while staff were not present. Keys were also left in filing cabinets which stored people's confidential files at the same nurses' stations. The provider told us they would put improvements in place immediately.

Most people received their medicines safely although some improvements were necessary. One person told us, "Pain control can be erratic. It depends on the duty nurse." A person had a history of removing their pain relief skin patch. The provider had not assessed this risk to ensure they identified whether the person had removed their patch. The person was at risk of withdrawal symptoms from the medicine as well as increased pain if their patch was removed and not replaced. A second person self-administered their medicines and staff told us they often ran out of an inhaler as they used too much each time. The provider had not assessed the risks relating to the person self-administering. A different person was administered 'covert medicines', with medicines hidden in their food or drink. However, the provider had not put in place a protocol to guide staff on administering the covert medicines safely and in the person's best interests. The provider told us they would review their medicines practices when we raised our concerns.

Other aspects of medicines management were safe. We observed a medicine's round and saw staff administered medicines competently and recorded administration appropriately. Our checks of medicines stocks against records indicated people received their medicines according to their prescriptions. Medicines were stored securely. The provider had systems to check medicines management followed best practice with a range of audits. Staff received training in medicines management and the provider checked they were competent to administer medicines safely.

The provider followed systems to safeguard people from abuse and neglect. Two people raised allegations of abuse to us and the provider took the right action in response to keep them safe. Staff received training in safeguarding adults at risk and knew the signs people may be being abused although some staff did not appreciate the importance of not investigating safeguarding allegations themselves which is against policy. The registered manager told us they would coach staff to help improve their understanding of their responsibilities. The provider learnt lessons from previous safeguarding allegations to reduce the risk of reoccurrence.

People received care from staff who followed suitable infection control procedures, although some improvements were required. Several domestic staff told us they were unable to keep the premises sufficiently clean when their workload increased due to frequent staff sickness. We observed some areas of the premises were unclean and alerted to the provider to these. Some bed rails were in poor condition with scratches and indents making good infection control difficult. Audits of bed rails had not rectified our concerns. The provider told us they would look into our concerns and replace bed rails across the service.

Staff received training in infection control and followed suitable practices such as wearing personal protective equipment (PPE). We found infection control procedures in the kitchen were suitable and the service recently achieved the highest rating from the Food Standards Agency. The provider undertook monthly infection prevention and control audits to check staff followed the right procedures.

Besides risks relating to medicines management for some people the provider managed risks relating to people's care well. The provider assessed risks for people such as those relating to their medical conditions

including diabetes, dementia, mobility and risk of falls, moving and handling, bed rails, pressure ulcers, catheter care, malnutrition and dehydration. Guidance was in place for staff to follow in reducing risks to people. The provider assessed the risks regularly and reviewed guidance if risks changed, such as if their condition deteriorated.

People lived in premises which were maintained safely and securely. A health and social care professional told us they carried out an audit of the environment and cleanliness and the home engaged well, putting their recommendations in place. The provider carried out a range of checks to monitor the safety of the premises and equipment. Checks included the environment, water hygiene, water temperatures, gas safety, electrical installation, electrical equipment, fire safety and call bells and lifting equipment. A contingency plan was in place for staff to follow in the event of an emergency and each person had a personal emergency evacuation plans (PEEPs). Chemicals were stored safely in the service.

Requires Improvement

Is the service effective?

Our findings

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. We checked whether the service was working within the principles of the MCA.

The provider did not always assess people's capacity in line with the MCA. The provider did not always consider whether the person had capacity to make decisions relating to their care including understanding and retaining information and taking steps to help the person understand. In the MCA assessments we viewed the provider only considered whether the person had an impairment of the mind and whether it was essential the decision was made at 'this time'. This meant the provider may have incorrectly assumed people lacked capacity to make decisions because they had impairments such as dementia or a learning disability removing their right to make their own decisions. An MCA assessment was lacking for a person in relation to covert medicines. For a person who came to live at the service a few weeks before our inspection the provider had not assessed their capacity in relation to their care, even though there was reason to believe they lacked capacity to make some decisions. When we discussed our concerns with the provider they told us they would review their policy and procedure. Staff received training in the MCA and understood how the Act applied to their day to day role.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met. The provider applied to deprive some people of their liberty as part of keeping them safe. However, the provider had not applied for a person recently admitted to the service a few weeks before our inspection and we observed the provider may have been depriving the person of their liberty. When we discussed this with the provider they told us this was an oversight and they made an application during our inspection. However, this oversight indicated the provider did not always routinely consider whether people required DoLS when they came to live at the service.

These issues were a breach of the breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received mixed feedback regarding the food and drink people received. Several people commented on the lack of fresh vegetables and fresh fruit and the frequent service of baked beans and spaghetti hoops. One person told us, "They dish up the cheapest things they can get away with." A second person told us, "They don't starve us here. Quite a variety. It's alright." Another person said, "You can ask for something you fancy to be on the menu. I asked for liver and bacon a while back and it's been on." Another person with an illness which required a specific diet told us, "It's a problem. The chef has no idea how to cater for me and so I frequently have to take medication to counter the effects of the food here. I have photocopied bits from an

advice book for staff but it doesn't seem to get through. Acacia do not adjust the food for my diet and I leave a lot." The registered manager told us they believed they accommodated the person's dietary needs well, in contrast to the person's feedback, when we raised our concerns. The chef understood people's needs relating to advice from dietitians and speech and language therapists to reduce their risk of choking. People received a choice of food and alternative meals were available by request. People were able to select meals from their cultural backgrounds on some days as these were incorporated into the menu. We observed people were provided with food and drink throughout the day.

People were supported to maintain their health. A person told us, "I can see anyone else I need. They just get them in. You go on a list to see the doctor." A second person told us, "I had new glasses from a visiting optician. It's easier than going out to them." A healthcare professional told us staff understood people's needs and always looked at ways to improve people's care. The provider assessed people's healthcare needs before they came to live at the service and kept their needs under review. Our discussions with staff and observations showed staff understood people's healthcare needs. Records showed staff monitored people's health. The 'rapid response' team visited the service each week to check whether people's conditions and see whether they required any additional healthcare services. A GP also visited the service when required. People were supported to access specialist healthcare professionals. People's care plans were reviewed to reflect any advice from healthcare professionals so staff had clear guidance to follow.

The premises were adapted to people living with dementia and other needs. As an example, the provider used colour to help people recognise doors and entrances. As another example, the flooring avoided patterns which may confuse people with dementia. Places to rest were available at the end of the corridors and handrails were in place to help people mobilise. Visual signage was in place to help people orientate themselves around the service. A bar was available for people to purchase alcoholic drinks and a café area where people and their visitors could make their own hot drinks was also available by the reception. However, while smokers were asked to smoke outside there was no coverage for people in bad weather.

People were supported by staff who received training and support to meet people's needs. Staff told us they were found the training to be suitable and met their needs. Staff received annual training in topics including safeguarding adults at risk, fire safety and basic first aid. Staff also completed training in dementia awareness and end of life care. Nurses completed additional clinical training including pressure ulcer care and venepuncture. Staff received an induction in line with the Care Certificate. The Care Certificate is a nationally recognised training programme which sets the standard for the essential skills required for staff delivering care and support. The provider monitored staff training needs and we viewed the tracker which showed staff training was up to date. Staff were supported to complete diplomas in health and social care to deepen their understanding of their roles. Staff received regular supervision from their line manager and annual appraisal during which they discussed any issues relating to people's care and their own development.

Requires Improvement

Is the service caring?

Our findings

There were not always sufficient staff to support people in a compassionate and personal way. We observed a staff member begin a conversation with a person but after a short time ended the conversation telling them they had to attend to other people. The person called after the staff member "One last thing.." as they walked away but the staff member did not respond. The staff member told us there were insufficient staff so they did not have time to sit and talk with people, only to do their allocated tasks. At lunchtime we observed there were insufficient staff in communal dining rooms to encourage people with dementia to eat. We observed staff sometimes rushed when supporting people to eat, offering overloaded spoonful's and pushing food into people's mouths when their mouths were already full. Some staff were kind and compassionate in the way they spoke to people when supporting them to eat, while other staff seldom spoke to people during this task. A member of staff told us they sometimes helped people to eat when there were insufficient staff, even though this was not their role, because they did not want to see people go hungry. We observed a person became unable to find an available staff member to take them outside to smoke and they became anxious due to this. Staff told us this happened most days.

These issues form part of the breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people were positive about the staff who supported them. One person told us, "They know my family and are brilliant to me. They listen to me and I don't just have to fit in with what they want." A second person said, "Everyone is lovely. They keep my things nicely." However, one person told us, "I rely on a couple of well trained and lovely nurses. We get cleaned and fed to suit them and some do it well." A healthcare professional told us staff were always compassionate to people and staff understood people's needs. A second healthcare professional told us there were some regular and long serving nurses which helped consistency and continuity of care. They told us these nurses were very committed to their work and compassionate towards people. Our discussions with staff and our observations showed they knew and understood the people they cared for. The registered manager gave us examples of when they showed compassion in encouraging relatives to stay overnight with people when they were ill or at the end of their lives. People's visitors could visit at any time and were made to feel welcome.

We found the provider did not always support people to maintain their independence. One person told us, "I am not able to practice making a drink or simple cooking which may prevent me from going home. There's nobody here to help with that." People were not always supported to maintain their independence at mealtimes, in line with dementia best practice. For example, the provider did not use coloured placemats or crockery which have been found to make it easier for people with dementia to eat as they can see their food better. The provider confirmed they had ordered some dementia-friendly implements after our inspection.

Besides the examples above, staff treated people with respect. We observed staff spoke with people respectfully. People were well dressed and staff took care to clean their glasses. People's belongings were also well cared for and systems in the laundry meant people's clothes did not go missing. Staff supported people to keep their clothes clean with aprons and supported people to wipe their hands and face during

their meals when necessary.

People's privacy and dignity were maintained by staff. A person told us, "They keep me covered up when I'm having a wash. Saves my blushes!" Staff closed doors when providing personal care. Other people and relatives told us staff were respectful during personal care. We observed staff were discreet when offering and providing personal care to people, ensuring doors were shut for privacy. We also observed staff knocked on people's doors before entering.

Requires Improvement

Is the service responsive?

Our findings

While the provider investigated complaints raised formally they did not always address concerns raised informally. People did not always feel comfortable complaining and some felt nothing was done when they raised concerns. One person told us, "I've tried to complain [about a particular issue], but you don't seem to get anywhere and you can't keep on." A relative told us, "I have said a few things but I don't think that the nurse can do much [about waiting a long time for staff to answer call-bells]." The provider's complaints policy was on display in communal areas for people to refer to. We found the provider recorded and investigated formal complaints, taking action to improve and keeping people informed of the outcomes.

People were not always protected from the risk of social isolation as far as possible. One person told us, "Staff are nice but they get on with the job and It's hard not to feel lonely, even in a busy place." The activity officers understood the importance for some people to engage in conversations and scheduled chats for those who were unable to join in group activities. The activity officers encouraged staff to engage with people although we found staff did not always have the time to do so due to staffing levels. We observed most people ate their lunch alone in their rooms and were not encouraged to eat in the dining area. This meant the provider did not always use mealtimes an opportunity to encourage social interaction.

People were provided activities they were interested in. One person told us, "We are always invited to join in and feel very included here. It's lovely to share things instead of just sitting by the bed." A second person said, "I need hoisting to get up and join but they never make it a problem. The staff encourage me to join in. You feel welcome and part of things." Other comments included, "I really enjoyed the trip to the South Norwood lakes", "I have the choice of quite a few things", "I get up for the quizzes", "There's a great library and I can get in there myself to borrow the books" and "The Halloween party was well done". Two activity officers led a wide range of activities, including day trips, which people were encouraged to take part in. The provider was initiating the 'Oomph programme' to enhance activities, exercises and outings for people. The activity officers reviewed people's hobbies and interests in developing the activity programme. Chickens and rabbits lived in the garden and people were encouraged to tend to them. One person told us, "I love helping to look after the animals. It's like a little job."

People's care plans reflected their needs so were reliable in guiding staff. People and relatives were involved in care planning as they were encouraged to share information about their lives including significant events, people who were important to them, their aspirations in relation to their care and their preferences in 'knowing me' books for staff to refer to. The provider included information about people's conditions, emotional and social needs in their care plans with guidance for staff to follow in meeting their needs. Staff understood people's needs and preferences well and followed their plans in delivering care to individuals. Staff reviewed people's care plans each month to ensure information remained accurate. Relatives told us staff communicated any changes in their family member's care to them well and monthly reviews with a nurse were offered to some relatives.

People's preferences in relation to their end of life care were recorded. The provider was accredited by the Gold Standard Framework (GSF) for end of life care. As part of this people and their relatives were

encouraged to record their preferences for their end of life care in advanced care plans. Staff monitored people's conditions and held monthly meetings to assess how close people were to the end of their lives and any additional support they required. The provider worked with the local hospice who attended the monthly meetings as far as possible. Staff received training in end of life care and nurses received training to use equipment used in end of life care such as syringe drivers to administer pain relief.

Requires Improvement

Is the service well-led?

Our findings

The provider had failed to notify the CQC of any the outcomes of DoLS applications 'without delay' as required by law. The registered manager told us they were unaware of this requirement and sent us the notifications the next day.

These issues were a breach of the breach of Regulation 18 of the Care Quality Commission (Registration) Regulations.

The provider carried out a number of regular checks and audits to assess the quality of the service. Although these were fairly comprehensive, they had not identified and resolved all the issues we found including staff levels, consent and Deprivation of Liberty Safeguards (DoLS) applications. The registered manager told us there were no issues with staff levels and staff sickness when we raised our concerns, in contrast to our inspection findings. The provider had a business continuity plan covering possible emergencies that might threaten the service's ability to operate and we noted that this did not include unexpected staff absence or shortage although the evidence we found showed there was a risk of this happening.

We also found that quality assurance systems were not always effective at driving prompt improvements when problems were identified. For example, a 'full service audit' that took place a month before our inspection identified that cabinets containing people's personal records and other confidential information were not kept securely locked. We found the same concern during our inspection. The same provider's report noted a shortage of staff at certain times of the day, which we also found during our inspection. We saw results of a residents' and relatives' survey the provider carried out six months before our visit. Most responses were positive, but we noted that one of the lowest scoring areas was around food. Although we saw evidence that the provider had taken action such as holding consultation meetings with people about the improvements they wanted in this area. However, the feedback we received from people at this inspection suggested that improvements were still needed. Two members of staff told us the registered manager and senior staff listened if they raised concerns but did not always act on them or follow up on their assurances. However, when we contacted a representative of the local authority, they told us the registered manager engaged well with them and followed up any action points or recommendations they made.

People did not always know who the registered manager was and told us leadership was not very visible. One person said, "The manager is not a regular visitor, she doesn't come up here" and another told us, "I've no idea who the manager is." However, activities staff felt the registered manager was supportive and they were able to approach her if they needed additional resources for activities. A healthcare professional who regularly visited the home also told us the manager was approachable and communicative.

We saw evidence of daily, weekly, monthly and quarterly checks of areas such as health and safety, care planning, call bells and the mealtime experience. The provider also focused quality checks on a different Health and Social Care Act regulation each month and had been looking at safeguarding people from abuse in the month leading up to our visit. There was a matrix the registered manager used to check all their audits

were completed on time. There was a monthly visit from the provider to check several aspects of the care being provided at the home. These covered a variety of different areas including activities, compliance with the Mental Capacity Act and residents' meetings. The provider also had a continuous improvement plan, which the registered manager updated at least every two weeks, to monitor progress on action points. However, we noted that several of the action points were not dated and were instead labelled "ongoing." Completion target dates may be necessary for the provider to track whether improvements are made within appropriate timescales and to plan for the future.

The registered manager had the opportunity to attend quarterly managers' meetings that the provider hosted to support them in their role. Staff felt the provider was a good employer and was supportive with regular visits to the service. They told us the provider had clear values, which included providing high quality individualised care that made a difference to people's lives. The provider had strong links with the local community including visits from schools and colleges where students did activities with people and put on concerts and shows in the home.

Records showed a meeting for residents and relatives took place three months before our visit. This was used to update people and their relatives about upcoming events at the home and the registered manager also noted any concerns and suggestions made by relatives. We also saw evidence of a quarterly survey of people and their relatives. Where the provider acted on people's concerns arising from the survey, they showed this on a "you said, we did" poster displayed in the home so people and their relatives could see their response.

To help ensure each person had equal access to good quality care, the service had a "resident of the day" scheme which involved all heads of department within the home, including domestic, clinical and maintenance staff. The resident of the day had their choice of meal and staff reviewed their care plan. Any redecorations required in their bedroom was also initiated. A healthcare professional told us the staff team was stable and consistent, which helped facilitate good communication.

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 Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered person did not always notify CQC without delay of the outcome of any request to deprive a person of their liberty. Regulation 18(1)(4)(a)(b)(c)(d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered person did not ensure care and treatment was only provided to people with the consent of the relevant person and the Act was not always followed if a person was unable to give consent. Regulation 11(1)(2)(3)(4)(5)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person did not always ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed at the service. Regulation 18(1)