

Stoneleigh Residential Care Home Limited

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Inspection report

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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?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

We undertook an unannounced inspection of Stoneleigh Residential Care Home on 23 and 25 May 2017. At the last full comprehensive inspection in May 2016 four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified. Following this inspection, we served a Warning Notice for a breach of Regulation 12 of the Health and Social Care Act 2008 as risk assessments did not protect people against unsafe care and treatment.

We conducted a focused inspection in November 2016 to check if the provider had complied with the warning notice. During this inspection we checked that the provider was meeting the legal requirements of the regulations they had breached. You can read the report from our last comprehensive inspection, by selecting the 'All reports' link for Stoneleigh Residential Care Home, on our website at www.cqc.org.uk

Stoneleigh Residential Care Home provides accommodation and personal care for up to 26 older people. At the time of our inspection there were 24 people living at the service.

A registered manager was in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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 home is run.

The service had made improvements since our last comprehensive inspection in May 2016. Recruitment procedures had been improved and a checklist introduced. Emergency plans were now fully completed and contained individual detail. The service was now working in line with the Mental Capacity Act 2005 and was compliant with the requirements of the Deprivation of Liberty Safeguards.

However, we found further improvements were still needed. The management of medicines required improvement to ensure that systems and procedures were dependable and staff training was embedded. Information recorded within people's daily notes did not always document the outcome. Incident and accident reports required consistent recording.

One notification had not been submitted to the Commission as required and the provider had not displayed their rating within the service. Systems had been improved to monitor the quality of the service. However, further improvements were needed to ensure areas that required action were fully identified and in a timely manner.

The service environment was well maintained. People were encouraged to maintain their independence within the service and the local community. People spoke positively about the activities provided by the service. People were involved in deciding what activities were on offer.

Staff were supported through an effective induction, training and supervision sessions. Systems were in

place to positively engage with staff about how the service was run. This included surveys, meetings and idea forums. Staff were valued and there was a positive team culture.

People were supported with their nutrition and hydration and spoke positively about the food provided by the service. Staff were observed to be attentive to people's daily needs. There had been several positive compliments about the home. People's visitors were welcomed at the service and felt well informed.

The service was caring as people were supported by staff that were kind and respectful. We observed positive interactions and relationships between staff and people living at the service. Staff knew people well and understood their personal preferences. Staff were prompt to respond to people's support needs.

Community links had been established that had a positive impact on people living at the service. Information was communicated effectively to staff. The provider and registered participated in training and development opportunities.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of this 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?

The home was not always safe. Medicines were not always managed safely.

Incidents and accidents were managed safely although the details of how these were recorded required improvement.

Risks to people were identified by risk assessments. Guidance directed staff in risk management. On some occasions this required further specific details.

People were supported by staff who knew how to identify and report safeguarding concerns.

Staffing levels were safe and safe recruitment procedures were followed.

Requires Improvement ●

Is the service effective?

The home was effective.

Consent to care and treatment was sought in line with the Mental Capacity Act 2005.

The service was meeting the requirements of the Deprivation of Liberty Safeguards.

Staff were supported by effective induction, training and supervision.

People were supported with their nutrition, hydration and healthcare needs.

Good ●

Is the service caring?

The service was caring. We observed positive relationships between staff and people living at the service.

People were supported to maintain their independence.

Staff spoke to people with kindness and respect.

Good ●

People's visitors were welcomed at the home.

Is the service responsive?

Good ●

The service was responsive.

Care records gave personal history and preference. However further specific detail to guide staff about people's care was sometimes required.

People and relatives had access to the services complaints procedure.

People spoke positively about activities and were involved in deciding what activities took place.

Meetings took place so people could give feedback about the service and enable changes.

Is the service well-led?

Requires Improvement ●

The service was not always well-led. Further improvements were needed to the systems that were in place to monitor the quality of care.

The provider had not submitted a notification to the Commission or displayed its rating within the service.

Surveys gained feedback from people and action was taken from the findings.

Positive feedback was received about the registered manager. A positive staff culture had been developed.

Staff were valued. Systems were in place to involve staff and people in how the service was run.

Community links had been established.

Stoneleigh Residential Care Home Limited

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 23 and 25 May 2017 and was unannounced. The inspection was carried out by two inspectors 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.

Before the inspection we reviewed previous inspection reports and other information we had received about the home, including notifications. Notifications are information about specific important events the home is legally required to send to us.

Some people at the home were not able to tell us about their experiences. We used a number of different methods such as undertaking observations to help us understand people's experiences of the home. As part of our observations we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the needs of people who could not speak with us.

During the inspection we spoke with nine people living at the home, five relatives and eight staff members, this included senior staff, and the registered manager. We looked at ten people's care and support records and four staff files. We also looked at records relating to the management of the service such as incident and accident records, meeting minutes, recruitment and training records, policies, audits and complaints.

Is the service safe?

Our findings

At our last comprehensive inspection of Stoneleigh residential Care Home in May 2016 we found that the service had not met the regulations in regards to safe recruitment procedures and the safe care and treatment of people. The provider had sent us an action plan of the steps they were going to take in order to meet these regulations

We found that improvements had been made to the administration of medicines since our last inspection of the service. However, at this inspection in May 2017 we found that further improvements were still needed. People were asked if they were happy to take their medicines and staff checked that they had swallowed their medicines before signing the Medicine Administration Chart (MAR). Medicines were not left for people to take at a later time.

We observed that the medicines trolley and the door to the medicines room was left unlocked while medicines were taken to people. This meant the medicines trolley was not secure because it was left open in an unlocked room. MARs were signed to indicate people received their medicines as prescribed. However, when people refused medicines this was not documented and neither was the reason for refusal. The provider's policy was not being followed because it stated, 'A record should be made if a medicine is refused including the reason why.' Keeping a record of refusals enables staff to identify trends and can be useful during medicine reviews.

Some bottles of medicines and eye drops had been dated when opened in order to highlight expiry dates, however this was not seen consistently. We saw one bottle of antibiotic medicine which had been used on 22/05/17 when the label said, 'Do not use after 21/05/17.' Eye drops that had been opened had not been labelled when unsealed despite the label on the bottle stating, 'Discard after 28 days.' This meant there was a risk that people had received medicines that had expired and may no longer be effective. Some people had transdermal (skin) patches prescribed. The site where the patches are applied should be rotated to prevent skin irritation. The service had a system in place to record this to prevent patches being put on the same site repeatedly. However, at this time the site of patch application was not being routinely recorded.

There was a process in place for the disposal of medicines that were no longer required. However on the day of our inspection tablets for disposal had been placed in envelopes and the name of the medicines had been written on the front. These were not being stored safely prior to return at this time. We found some envelopes had been placed on the worktop in the medicines room, one was on a shelf and another was in the medicines trolley. In addition, we found two boxes of medicines and liquids on a shelf as well as loose tablets. The registered manager was in the process of training two senior staff to support them in the management of medicines. The registered manager had been on leave prior to our inspection and the system for disposal had not been adhered to in their absence.

Audits for medicines were completed on a weekly and monthly basis. Due to the registered managers leave the weekly checks had not been completed which included the checking of areas such as, labelling of opened medicines, MAR checks and medicine returns.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last comprehensive inspection of Stoneleigh Residential Care Home in May 2016 we found that safe recruitment procedures were not in place as Disclosure and Barring Service checks (DBS) had not been fully conducted before staff member's commenced employment. A DBS check helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with certain groups of people. At this inspection we found the service had introduced a recruitment checklist to ensure safe recruitment processes were followed. Staff files showed photographic identification, a minimum of two references, full employment history and a DBS. We did highlight to the registered manager that the current reference form being used did not always clarify dates of employment accurately. The registered manager said this would be addressed and the form would be revised to ensure that dates of employment were clearly requested.

At the last inspections of Stoneleigh Residential Care Home in May 2016 and November 2016 we found that people did not have personal evacuation plans in place that fully reflected their support needs in an emergency situation. We found these plans had now been completed. Personal evacuation plans detailed people's communication needs, the mobility equipment they would require and the level of staff support to assist them safely. Staff were familiar with the evacuation plans. A business continuity plan was in place which detailed procedures to take in an adverse emergency situation such as a water or gas leak.

People said they felt safe living at the home. One person said, "I do feel very safe here. I used to be prone to falling, but now I have someone with me any time I want to move around." One relative said, "My wife and I are really happy Mum is here. We feel she is totally safe and well looked after."

Care plans contained risk assessments for areas such as skin integrity, malnutrition, moving and handling and falls. These had been reviewed monthly. When risks had been identified, care plans provided guidance for staff on how to reduce the risks. For example, one person had fallen five times during 2017 and the plan informed staff to ensure the person had their call bell, that a member of staff supported them to move around and that night medicines should be administered when the person was in bed. However, other plans were not always as detailed and it was sometimes difficult to locate the guidance within the plans. For example, when people had been assessed as being at risk of pressure sores, the action plan guidance was generic. Two care plans that we reviewed showed the action plans were not specific enough to clearly direct staff on how to reduce the risks for people. This detail was found for one person in a different care plan titled, 'Overall Health.' Staff were not always aware to look in this additional care plan for the required information. Manual handling risk assessments had been completed. When people had manual handling requirements, these were displayed behind the door in people's bathrooms which meant that staff had a convenient way to access the information they needed.

Staff reported and recorded any accidents or incidents. We found that accident and incident reports did not always contain full and detailed information. For example the circumstances of the accident or incident, who was involved and what had been done to manage the incident. The management review section of the accident and incident form held on the computer system was not consistently being completed. For example, we viewed three accident and incident forms for one person. None had been fully completed with the follow up section or management review, which may mean immediate actions to keep people safe are not taken. The registered manager said this would be addressed. However, the registered manager did have a full event analysis held separately which detailed any accidents or incidents that had occurred on a monthly basis and the actions taken to prevent reoccurrence. One person who was being specifically monitored due to behavioural incidents had full information held about these but recorded outside the

usual incident and accident reports.

We reviewed the staffing rotas from the previous four weeks and saw that the number of staff was consistent with the planned staffing levels. People and staff spoke positively about staffing levels. One staff member said, "Staffing levels are good, there is always enough staff." Another staff member said, "There is always extra staff so people can go out." During the inspection we observed that call bells were answered promptly and people were given support when needed.

The provider had policies and procedures in place for safeguarding vulnerable adults. This contained guidance on what staff should do in response to any concerns identified. From the training records we reviewed we saw staff received training in safeguarding vulnerable adults. This was confirmed with the staff with spoke with. Staff said they would report any concerns to a senior member of staff. One staff member said, "I would document the detail, inform staff in the communication book and report to my manager."

We reviewed records which showed that appropriate assessments and checking of the environment and equipment had been conducted. This ensured equipment was maintained and safe for the intended purpose. This included safety testing of mobility aids, electrical equipment and the stair lift. People and staff reported that maintenance was carried out promptly when any issues were identified. Fire safety equipment was regularly tested which included the emergency lighting, alarms and extinguishers. Regular practice fire drills had been undertaken. The environment was clean, tidy and well kept. One person said, "It is always so nice and clean and never any odours like some homes."

Is the service effective?

Our findings

At our last comprehensive inspection of Stoneleigh Residential Care Home in May 2016 we found that the Mental Capacity Act 2005 (MCA) was not being followed. 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. During this inspection, consent to care and treatment had been sought in line with legislation and guidance. Care plans contained mental capacity assessments.

The registered manager had met their responsibilities with regard to the Deprivation of Liberty Safeguards (DoLS). DoLS is a framework to approve the deprivation of liberty for a person when they lack the mental capacity to consent to treatment or care and need protecting from harm. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. One person had an authorised DoLS in place and the conditions attached to this authorisation were being met.

We reviewed the staff training records and saw that staff received on-going training in areas such as moving and handling, safeguarding adults, fire safety, diabetes and person centred care. One staff member said the training provided was, "Great" and another said, "The training is good." The provider had undertaken a train the trainer course in moving and handling. This enabled small group training which was more personalised to people's current care needs. Some staff had completed recent training in dementia and spoke positively about this. The information they had gained was being shared with the staff team at their next meeting. Staff had good knowledge in regards to the MCA. However, we did highlight to the registered manager that some staff members were not as confident in their knowledge as others. Training had already been scheduled for the following month.

New staff completed an induction programme which was aligned with the Care Certificate. Induction records showed that the process was thorough and detailed. Staff completed a number of shadow shifts, where they were supported by a more experienced staff member as part of their induction. Staff said they felt confident at the end of the induction and it had prepared them well for their role. One staff member said, "I definitely felt ready at the end."

Staff said they received regular supervision and this was confirmed in the records we reviewed. Supervision is where staff meet one to one with their line manager to discuss their development. We saw that supervisions discussed areas such as training, development, work practice and staff well-being. One staff member said, "I feel well supported."

People's nutritional needs had been assessed. At the time of our inspection, no-one using the service were having their food or fluid intake monitored. We observed people having their lunch. The dining room was

used by the majority of people, although some people chose to eat in their rooms. The dining tables were laid; people had access to condiments and drinks. Comments from people eating lunch included, "It's delicious" and "It's always very nice". People were offered a choice and were able to choose an alternative if they did not like what was on offer. One person said, "We get a choice of meal but today I didn't like what was on offer so I am having something different, lasagne." People with allergies were catered for. For example, one person was allergic to eggs and we overheard the chef discussing with them what they would like instead of the omelette that was on the menu. We saw that fresh drinks and fruit were available in different communal areas for people to help themselves.

People's weights were monitored monthly and care plans contained graphs to show staff whether people were gaining or losing weight. We saw for one person, who had significant weight loss, this was explained. It was detailed how the service was supporting the person to increase their weight and the other health professionals involved.

People had access to ongoing health care. Records showed when people had been reviewed by other members of the multi-disciplinary team, such as the GP, the diabetes nurse or the mental health team. People had a document prepared in case a hospital admission was needed which included essential information. One relative said, "When [name of person] was poorly we got a call straight away and the GP was called quite quickly, they always are."

Is the service caring?

Our findings

People were supported by staff who were kind and caring. One person told us, "They [staff] are always so kind and respectful, always asking what you would like." Another person said, "Nothing is too much trouble, it is always with a smile." A relative said, "[Name of person] is very happy and well looked after."

We saw that people's privacy was respected. Staff knocked on people's doors prior to entering. We saw people chose where they wanted to be within the service, in communal areas or their own rooms. One person said, "There are lots of people around but you have your own room if you want to be separate." Staff told us about how they protected people's dignity. For example, when giving personal care, ensuring doors and curtains were closed. However, we observed one person on several occasions whose clothing did not fit correctly and kept slipping down. This compromised their dignity and staff did not address it at the time. This was highlighted to the registered manager.

We observed positive interactions between people and staff. Staff ensured they did not rush people and gave people their full attention. We observed that staff crouched down to people when speaking to them to maintain eye contact and we saw staff sitting with people, talking and having a cup of tea. One person had become tearful and upset. A staff member immediately went and sat with them to offer reassurance which calmed the person down.

In some care plans we saw that discussions had taken place with people around their preferences in relation to their end of life care preferences. When these discussions had taken place, the documentation was clear and detailed, including listing people's preferences for when they would prefer to go to hospital and when they would prefer to remain at the service.

The atmosphere was calm and friendly. One member of staff described the atmosphere as, "Happy, friendly and welcoming." One person said, "It is nice to be amongst friends, you can be so happy like that." One person told us that they were staying for a short break. The person said, "I didn't know what to expect and was a little fearful, but staff and residents have been so kind it has been like a three week holiday."

We saw that people engaged in the services with different activities. For example, we saw one person out in the back garden watering the plants. We observed a member of staff ask if a person would like to come and help plant some flowers.

We saw people were sat in the garden around the table as it was a warm day. We observed staff ensure people had sun protection cream and a hat on. We saw that drinks were taken to people in the garden. One person said, "We sit outside, it's nice when the weather is warm."

People were supported to remain independent. One person told how they used the stair lift, "I can use the chair lift to go downstairs on my own too, but there is help if you need it." People could access the café in the park opposite the service which was also owned by Stoneleigh's provider. People told us how they enjoyed going over to the park. One person said, "I went to the park this morning and had a coffee. We don't

have to pay as the owner of the home also owns the café." A relative said, "It is nice that the residents can go over to the café in the park. We often take [name of person] there when we visit."

The service had received a number of compliments since January 2017. One compliment read, "Thank-you so much for the love and care you gave Dad during his three year stay at Stoneleigh." Another compliment said, "We really appreciate your input and knowledge, it was a great conversation and we gained much from it." A commissioner had left a comment saying how pleased they were with the care provided at the service.

Family and friends could visit when they wished. One staff member said, "There are no restrictions on visitors." One person said, "My family can visit at any time and the communication with the family is good." A relative told us, "We are always helped if we want to take [name of person] out and if we have a question or request staff will make time to help or answer."

Regular meetings were held so people could express their views and opinions and give feedback about the service. We saw that these meetings were well attended. Items such as call bell systems, food, the environment and care were discussed. There were clear actions recorded from the meeting. For example, one person has asked for a specific fruit to be available now the weather was getting warmer. We saw that this fruit was available to people.

Is the service responsive?

Our findings

The service was responsive. Care records contained a photograph of people, essential information and their life history. Care documentation gave staff an overview of people and the things that were important to them. This included things such as their previous occupation, religious needs and family members. For example in one person's care record it described which paper they had delivered daily and that they liked reading romantic novels. Another care record described the person's relative and highlighted certain things about particular relationships.

We found some inconsistencies in the level of detail found in care plans. For example dementia care plans were found to be comprehensive. However, actions staff should take in relation to specific health conditions and behaviours were not always clear. For example, in one person's care plan information for staff on the checks they should complete in regards to a person's diabetes was not always clear. In another person's care plan we found little information around the triggers for certain behaviours and the strategies staff should use to support the person. Despite the lack of detail in some of the plans, the staff that we spoke with, knew people well and demonstrated a good knowledge of their care needs.

We saw that the service was responsive to people's preferences and routines. One person told us, "I go to bed about 6pm but I wake up early. I usually get up about 5.30am." In the morning there were people in the lounge area from early in the morning. People we spoke to said they chose to get up early. We observed a person having their lunch sometime after others. They told us how they enjoyed a glass of wine with their lunch and ate at a time that suited them. The handover file contained information about people's preferences around people's personal care.

The service had not received any complaints in the previous 12 months. Relatives told us they would be happy to raise any concerns if necessary. A person said, "I would be happy to talk to staff or the registered manager if I needed. They are all very approachable, but I haven't had a concern or a complaint to make because all the staff are so lovely." One relative said, "I've not had to raise a complaint but would be happy to do so. All the staff are nice and approachable."

People, staff and relatives spoke positively about the activities on offer to people. One staff member said, "People are taken out on a daily basis. People are offered activities within the house." Another staff member said, "There is enough for people to do." We saw an activities board that showed there was a film evening, bingo, religious services, relaxation session and a visit to the park. We observed an external group come and facilitate a singing session for people. People told us they had enjoyed this. One relative said, "There are activities most days." Records were kept about what activities people had been offered and how people responded to them. This meant activities people enjoyed could be repeated such as, theatre trips and music events.

People's rooms were personalised with furniture, ornaments and pictures. People told us they were happy with their rooms and liked their space. One person said, "When we were looking for a home for me to move into, my daughter knew when she saw the staff, the home and this room, that this was the right place to

come to."

People's views were sought in regards to different areas of their care and experience of the service. Questionnaires had been thoughtfully designed, keeping them simple to maximise responses. People were asked for feedback in areas such as laundry, food, activities, cleanliness, care and respite stays. The results were overall positive with comments including, 'Staff are wonderful' and 'Everyone is very nice and helpful.' We saw that actions were taken as a result of the feedback gained. For example we saw that an exercise class was cancelled and replaced with a different activity as people said they were not enjoying it. For one person who was not clear about the complaints procedure a member of staff sat down and went through it with them.

Is the service well-led?

Our findings

At our last comprehensive inspection at Stoneleigh Residential Care Home in May 2016 we found that audits were not effective in identifying areas of improvement. In addition people's records were not always accurate or fully completed. At this inspection in May 2017 we found audit systems had been improved, but further work was still necessary to ensure areas that required action were fully identified and in a timely manner. Regular audits were undertaken by senior staff, the registered manager and provider. These covered areas such as health and safety, medicines, care records and infection control.

The registered manager acknowledged that further detail in the audits would be beneficial to allow for more in depth information to be recorded about what had been found and actioned. For example, whilst care plan audits were undertaken and showed that each person's care plan had been checked it did not show the amendments made. Therefore the specific details needed to guide staff in risk assessments and care plans were not always identified. Senior staff were being trained to undertake medicine audits as at the present time the system was not dependable in the absence of the registered manager. It was imperative that the medicine audits identified any areas that required action promptly. Staff had received annual competency checks in medicine administration. However, as training had not always been embedded into practice further checks may be necessary. Mock inspections were conducted to check if the service was meeting the required standards. For example, we saw that electric tests were identified as required. This had been actioned.

A notification had not been submitted to the Commission as required in regards to one person's DoLS authorisation. A notification is information about important events which affect people or the service which the service is legally obliged to submit to the Commission.

When a provider has been given a rating by the Commission it is required to be conspicuously displayed within the service and on its website. This information was clearly displayed on the provider's website but not within the service. This was highlighted to the provider and the rating was displayed immediately.

In a survey in October 2016 three people had raised that laundry was going missing or being returned to the wrong person. We saw that actions had been taken and letters had been sent to relatives about clothes labelling. However, we found this was still occurring as a family member showed us that their relative was wearing clothing items that were not theirs. This can impact on people's dignity. This was highlighted to appropriate staff members who said it would be addressed.

We highlighted to the registered manager information contained within people's daily notes where an outcome for the person had not always been recorded. For example in one person's daily notes information was recorded that could have been considered a concern and for the complaints and concerns process to be utilised. The registered manager had followed up this information but the outcome for the person had not been noted. For another person, it was recorded in their daily notes that they had raised with staff a possible health concern. Staff we spoke could not clarify the actions that had been taken. Because of the lack of documentation, it was unclear if appropriate support had been sought for this person.

People, staff and relatives spoke positively about the registered manager describing her as, "Involved, approachable, friendly and hands on." Another staff member said, "The manager is doing a good job. She is easy to speak to." A relative told us, "I find the registered manager very approachable."

Staff said their input was valued and they were well supported. Staff told us there was a positive working culture. One staff member said, "We pull together and work as a team." The provider had arranged for social events so the staff team could spend time together. Staff were visiting a theme park together that weekend. The registered manager hours of work were designed so that they were at the service early on a daily basis so they engaged with the night staff team. Staff said this was positive. An on call system was also in place in case staff required support out of hours. We saw records of where this had been used.

Staff were encouraged to give their feedback through different methods. A suggestion box was in place for staff to leave feedback or to suggest ideas. We were told this was used well. Ideas that had been raised were discussed at staff meetings, explanations were given if ideas could not be taken forward. A staff award scheme was in place. Staff members were nominated and recognised for their work and contribution to the service. We saw that staff members were thanked for their work and support of the service in meeting minutes.

The registered manager organised regular team meetings. Staff spoke positively about the meetings and said they could raise any issues or suggestions. We reviewed recent minutes and saw that areas such as staffing, training and record keeping were discussed. These were also used as a learning opportunity. We saw that two policies of the service were reviewed to ensure staff were familiar with their contents. In addition we saw areas such as equality, diversity and human rights and safeguarding were on the agenda to ensure knowledge was embedded. The registered manager organised specific meetings which were dedicated to 'brainstorming'. These meetings were to focus on new ideas and suggestions and enable staff to be involved with decisions made about the service.

Relatives said they were kept well informed. One relative told us how they were always contacted if there was a need. Another relative said, "If there is a problem that is serious enough, they will call us immediately to tell us otherwise they will tell us as soon as we come in." A newsletter was produced by the service and copies were available for people to look at and collect. We saw that details about activities, meeting dates, birthdays and special events were communicated.

Information was communicated to staff. A written and verbal handover took place at the start of each shift so staff were kept informed of people's current support needs. A diary contained appointments for people. For example we saw health review noted for one person and a hospital appointment for another person. A communication book informed staff of any changes to people's care and support needs. A staff allocation system was used. This detailed who specific staff would be supporting on their shift. This ensured accountability and senior staff were able to follow up any issues. Senior staff had a separate communication book which detailed items for them to carry forward.

The provider had developed a document that set out the vision of the service and the aims it would achieve. This was discussed with staff so staff were clear on the direction of the service and the culture it created. This included areas such as creating a bright and cheerful environment, empowering people to make their own choices and the involvement of staff in decision making. From this the registered manager had a three month plan setting out practical ways to achieve these aims. For example, how health and safety information would be recorded in more detail and the type of training for staff which provided the best learning.

The provider and registered manager attended training and opportunities to develop their skills. For example, they had recently attended a care conference for managers in London and managers training provided by the local authority in the Mental capacity Act 2005. They also regularly attended local providers meetings to share good practice and keep up to date with care requirements.

The service had also developed positive community links with the museum, local school and religious organisations. A local school had attended the service and joined in with arts and crafts and singing with people. A local person had brought in war memorabilia which people enjoyed viewing. An annual summer fete was held, BBQ's and a Christmas party. People, the community and family and friends were invited to attend.

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 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 (g) The provider had not ensured the proper and safe management of medicines.