Crown Care IV Limited

Windsor Court

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?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This was an unannounced inspection carried out on 19 September 2017.

This was the first inspection of Windsor Court since it was registered with the Care Quality Commission in February 2016. The premises had previously been owned by another provider.

Windsor Court is registered to provide personal and nursing care to a maximum of 44 older people, including people who live with dementia or a dementia related condition. At the time of inspection 42 people were using the service.

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.

People said they felt safe and they could speak to staff as they were approachable. We had concerns however that there were not enough staff on duty to provide safe and effective care to some people.

People were protected as staff had received training about safeguarding and knew how to respond to any allegation of abuse. When new staff were appointed, thorough vetting checks were carried out to make sure they were suitable to work with people who needed care and support.

Appropriate training was provided and staff were supervised and supported. Staff had a good understanding of the Mental Capacity Act 2005 and best interest decision making, when people were unable to make decisions themselves.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible, the policies and systems in the service supported this practice.

People received a varied and balanced diet to meet their nutritional needs. Improvements were required to people's dining experience. Activities and entertainment were available to keep people engaged and stimulated.

People had access to health care professionals to make sure they received appropriate care and treatment. Staff followed advice given by professionals to make sure people received the care they needed. Systems were in place for people to receive their medicines in a safe way.

Risk assessments were in place and they accurately identified current risks to the person as well as ways for staff to minimise or appropriately manage those risks. Staff knew the needs of the people they supported to provide individual care, however records did not always reflect the care provided. We have made a

recommendation that staff receive training about person centred care and personhood. Care was provided with kindness and people's privacy and dignity were respected.

Changes had been made to the environment. Some areas had been refurbished. However, not all areas of the home were clean and well maintained for the comfort of people who used the service. The home was not designed to promote the orientation and independence of people who lived with dementia, although plans were in place to address this. We have made a recommendation that the environment should be designed according to best practice guidelines for people who live with dementia.

A complaints procedure was available. People had the opportunity to give their views about the service. There was regular consultation with people and/ or family members and their views were used to improve the service. People had access to an advocate if required.

Staff and relatives said the management team were approachable. Communication was effective to ensure staff and relatives were kept up to date about any changes in people's care and support needs and the running of the service.

The home had a quality assurance programme to check the quality of care provided. However, the systems used to assess the quality of the service had not identified the issues that we found during the inspection with regard to staffing levels, people's dining experience, environmental design and record keeping.

During this inspection we found breaches of Regulations 17 (governance) and 18 (staffing) 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 the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Not all aspects of the service were safe.

People told us they felt safe. However staffing levels were not sufficient to ensure people were looked after in a safe, effective and person centred way. Staff had received training with regard to safeguarding. People were protected from abuse and avoidable harm. Staff were appropriately recruited.

Checks were carried out regularly to ensure the building was safe and fit for purpose. A programme of refurbishment was taking place around the home. However, some areas of the home required more immediate attention as they were not clean and they were showing signs of wear and tear.

Risk assessments were up to date and identified current risks to people's health and safety. People received their medicines in a safe way.

Is the service effective?

Requires Improvement

Not all aspects of the service were effective.

A programme of refurbishment was taking place around the home. Further improvements were planned to ensure it was designed to promote the orientation of people who lived with dementia. We have made a recommendation that the environment should be designed according to best practice guidelines for people who live with dementia.

Staff received supervision and training to support them to carry out their role effectively.

People's rights were protected. Best interest decisions were made appropriately on behalf of people, when they were unable to give consent to their care and treatment.

People received a varied and balanced diet. Support was provided for people with specialist nutritional needs.

Is the service caring?

Good

The service was caring.

Staff were caring and respectful. People and their relatives said the staff team were compassionate, kind and cheerful.

Staff were aware of people's backgrounds and personalities. Good relationships existed and staff were aware of people's needs and met these in a sensitive way that respected people's privacy and dignity.

People were encouraged and supported to be involved in daily decision making.

Is the service responsive?

Requires Improvement

Not all aspects of the service were responsive.

Staff were knowledgeable about people's needs and wishes. Care plans were in place, but they were not all detailed to reflect people's care and support requirements.

There was a programme of activities and entertainment to stimulate people and to help keep them engaged.

People had information to help them complain. Complaints and any action taken were recorded.

Is the service well-led?

Requires Improvement

Not all aspects of the service were well-led.

A registered manager was in place. Staff and relatives told us the registered manager was readily available to give advice and support. They were appreciative of the improvements that had been made by the registered manager.

Staff informed us that they enjoyed working at Windsor Court and morale was good.

The home had a quality assurance programme to check on the quality of care provided. However the systems used to assess the quality of the service had not identified the issues that we found

during the inspection to ensure people received safe care that met their needs.

Windsor Court

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 19 September 2017 and was unannounced. The inspection team consisted of one adult social care inspector and one expert by experience. An expert-by-experience is a person who has personal experience of caring for someone who uses this type of care service for older people including people who live with dementia.

Before the inspection, we had received a completed Provider Information Return (PIR). The PIR asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the service as part of our inspection. This included the notifications we had received from the provider. Notifications are reports of changes, events or incidents the provider is legally obliged to send CQC within required timescales. We contacted commissioners from the local authorities and health authorities who contracted people's care.

During this inspection we carried out observations using 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 communicate with us.

During the inspection we spoke with 13 people who lived at Windsor Court, eight relatives, the registered manager, the area manager, the administrator, two registered nurses, seven support workers including one senior support worker, one domestic and one member of catering staff. We observed care and support in communal areas and looked in the kitchen. We reviewed a range of records about people's care and how the home was managed. We looked at care records for five people, recruitment, training and induction records for five staff, four people's medicines records, staffing rosters, staff meeting minutes, meeting minutes for people who used the service and relatives, the maintenance book, maintenance contracts and quality assurance audits the registered manager had completed.

Requires Improvement

Is the service safe?

Our findings

People who used the service and relatives expressed the view that they and their relatives were safe at the home. One person told us, "I'm quite safe here." Another person commented "I trust the staff." One relative said, "We are confident that [Name] is looked after whilst we aren't here." A second relative commented, "We visit at all times of the day and evening and there have never been any issues." Other relatives' comments included, "I have never seen a situation that the staff have not been able to deal with", "I think the home would benefit from more staff, they are pretty busy", "[Name] is safe and well cared for" and "I think they could do with more staff." Our observations during the inspection showed there were insufficient numbers of staff available to keep people safe and provide effective care to people in all parts of the home, especially to the top floor.

There were 42 people living at the home at the time of inspection. Staffing rosters and observations showed on the top floor 16 people, who lived with dementia were supported by two support workers including one senior support worker. On the middle floor 16 people were supported by one registered nurse and three support workers, including one senior support worker. On the ground floor 10 people were supported by one registered nurse, who also covered the top floor, and two support workers including one senior support worker. Overnight staffing levels included one registered nurse and five support workers.

The registered manager told us a staffing tool was used to calculate the number of staffing hours required. Each person was assessed for their dependency in a number of daily activities of living. The dependency formula was then used to work out the required staffing numbers. Immediately after the inspection we were told staffing levels had been increased as an additional 42 hours a week had been added to the staffing hours to ensure people's care and support needs were met more effectively. However, staffing levels needed to be consistently maintained to ensure they met people's needs.

Our observations at the lunchtime meal on the top floor did not show that sufficient staff were available to supervise people and provide effective care. Staff were not available to supervise and provide support to people as they waited for their meal or during the meal as the two staff were busy. We observed staff did not have time to monitor and prompt people and encourage them to eat their meal after they had delivered their meal to them. Eight people sat in the dining room for lunch and they were left unsupervised for most of the mealtime, after their meal was served. We observed they required encouragement and prompts to eat their meal as it was not eaten in some cases. We intervened to find staff when people required some assistance or cutlery as staff were not in the room.

On the ground floor we observed some people, who lived with dementia and required some support, were not supervised and one person was upsetting a person who responded and shouted at them. Later in the day we intervened, to make the registered manager aware as a person was undressing in the lounge and no staff were available, to help maintain the person's dignity.

This was a breach of Regulation 18 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

After the inspection we were told staffing levels had been addressed as an additional 42 support worker hours had had been provided to ensure people's care and support needs were met. However, staffing levels needed to be consistently maintained to ensure they met people's needs.

People were positive about the refurbishment that was taking place and the standards of hygiene in the home. One relative told us, "The home's much better since the new manager took over, it's cleaner and she's had a lot of decorating done." Another relative told us, "When I visit here, the place is always clean and tidy." However, at the time of inspection not all areas of the home were clean. Some areas were showing signs of wear and tear and there was a malodour on the ground floor and middle floor of the home. Some communal bathrooms and lavatories also required attention and some bedroom carpets and walls were marked. We were aware a programme of refurbishment was taking place but some areas required more urgent attention. The provider submitted an action plan straight after the inspection. This showed the timescale for refurbishment, including issues identified, at inspection would be completed within three months which we considered to be reasonable with more immediate issues of hygiene being addressed immediately.

Staff were clear about the procedures they would follow should they suspect abuse. They were able to explain the steps they would take to report such concerns if they arose. They expressed confidence that allegations and concerns would be handled appropriately by the registered manager. One person told us, "I'd report any concerns straight away to the senior on duty." Staff informed us they had received relevant training. We saw the registered manager made alerts to the local authority and investigated all concerns.

Risk assessments were in place that were regularly reviewed and evaluated in order to ensure they remained relevant, reduced risk and to keep people safe. They included risks specific to the person such as for falls, pressure area care and nutrition.

Records showed if there were any concerns about a change in a person's behaviour a referral would be made to the positive behaviour team. Detailed care plans were in place for people who displayed distressed behaviours. Staff were aware of the interventions and the support a person required to keep them safe. However, we observed two staff members escorted one person to keep them safe when they went outside for a cigarette and this was not reflected in their care plan. The registered manager told us the care plan would be amended immediately to reflect the additional staff member.

Staff told us they followed the instructions and guidance of the behavioural team for example to complete behavioural charts if a person displayed distressed behaviour. This specialist advice, combined with the staff's knowledge of the person, helped reduce the anxiety and distress of the person because the cause of distress was then known. One relative told us, "The staff can manage challenging situations, they are always very good." Another relative commented, "We have never seen a situation that the staff have not been able to deal with." A third relative said, "We have seen the staff defuse some difficult situations."

Medicines were given as prescribed. We observed part of a medicines round. We saw staff who were responsible for administering medicines checked people's medicines on the medicine administration records (MARs) and medicine labels to ensure people were receiving the correct medicine. Staff who administered the medicines explained to people what medicine they were taking and why. People were offered a drink to take with their tablets and the staff remained with the person to ensure they had swallowed their medicines. Medicines records were accurate and supported the safe administration of medicines. There were no gaps in signatures and all medicines were signed for after administration.

Medicines were stored securely within the medicines trollies and treatment rooms. Medicines which

required cool storage were kept in a fridge within the locked treatment rooms. Records showed current temperatures relating to refrigeration were recorded daily. Appropriate arrangements were in place for the administration, storage and disposal of controlled drugs, which are medicines which may be at risk of misuse.

Records showed that where people lacked mental capacity to be involved in their own decision making, the correct process had been followed. For example, with regard to the use of covert medicines (covert medicine refers to medicine which is hidden in food or drink). We saw 'best interest' decision making adhered to the National Institute for Health and Care Excellence (NICE) guidelines as a best interest meeting had taken place with the relevant people.

We spoke with members of staff and looked at personnel files to make sure staff had been appropriately recruited. We saw relevant references and a result from the Disclosure and Barring Service (DBS) which checks if people have any criminal convictions, had been obtained before they were offered their job. Records of checks with the Nursing and Midwifery Council to check nurses' registration status were also available and up to date. Application forms included full employment histories.

A personal emergency evacuation plan (PEEP) was available for each person taking into account their mobility and moving and assisting needs. The plan was reviewed monthly to ensure it was up to date. This was for if the building needed to be evacuated in an emergency.

We saw from records that the provider had arrangements in place for the on-going maintenance of the building and a maintenance person was employed. Routine safety checks and repairs were carried out, such as for checking the fire alarm and water temperatures. External contractors carried out regular inspections and servicing, for example, fire safety equipment, electrical installations and gas appliances. There were records in place to report any repairs that were required and this showed that these were dealt with. We also saw records to show that equipment used at the home was regularly checked and serviced, for example, the passenger lift, hoists and specialist baths.

Requires Improvement

Is the service effective?

Our findings

A refurbishment of the home was taking place. Lounges and dining rooms and some bedrooms had been refurbished. One person told us, "The rooms are comfortable and I have my own television." We considered the environment required more attention as it was not "enabling" to promote people's independence, and involvement. Although doors such as lavatories and bathrooms were a different colour, signage was not available for people to identify the room and to help maintain their independence. Pictures and signs for people to identify their bedroom were also not all in place to help maintain their independence. Memory boxes were not available that contained items and information about people's previous interests to help them identify their room. They would also give staff some insight into the person's previous interests and life when the person could no longer communicate this information themselves. There were no displays or themed areas of interest on the top floor corridors and no seating areas for people around the home as they moved around. We discussed this with the registered manager who told us the environment was going to be designed to ensure it was stimulating and therapeutic for the benefit of people who lived there.

We recommend the service finds out more about current best practice regarding the design of accommodation for people who live with dementia.

Staff had opportunities for training to understand people's care and support needs and they were supported in their role. Support staff said they received regular supervision from one of the home's management team every two months and nurses received supervision from the registered manager. One staff member told us, "I receive supervision every two months." Another staff member commented, "I supervise some of the support staff." A third member of staff said, "I've just had a supervision."

Staff members were able to describe their role and responsibilities. A number of staff members had worked at the home for several years. Newer staff told us when they began work at the service they completed an induction programme and they had the opportunity to shadow a more experienced member of staff. This ensured they had the basic knowledge needed to begin work. A staff training matrix showed that some courses took place to ensure staff had the knowledge to meet people's care and treatment needs. Staff training courses included dementia care, palliative care, mental capacity and deprivation of liberty safeguards. One relative told us, "The staff seem well trained and able to manage situations."

Staff told us and training records showed they were kept up to date with safe working practices. One staff member commented, "There are good opportunities for training." Another staff member told us, "Training is face to face and we also do e-learning training." A third staff member said, "We get loads of training." Other staff members' comments included, "I've just done dementia awareness training" and "We're always doing training."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as

possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

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. 37 DoLS applications had been authorised by the relevant local authority. There was evidence of mental capacity assessments and best interest decisions in people's care plans.

People were supported to maintain their healthcare needs. One relative commented, "Since [Name] has moved here the staff have arranged for a dentist and speech and language therapist to see him." People's care records showed they had regular input from a range of health professionals such as, General Practitioners (GPs), psychiatrists, dieticians and a speech and language team (SALT). Records were kept of visits. Care plans reflected the advice and guidance provided by external professionals. The registered manager told us a nurse practitioner from two GP practices visited most days to give advice and treatment where required.

We checked to see how people's nutritional needs were met. We looked around the kitchen and saw it was well stocked with fresh, frozen and tinned produce. We spoke with the cook who was aware of people's different nutritional needs and special diets were catered for. One relative told us, "The cook separates [Name]'s food into portions so that they get the taste of the different food even though it's pureed." The cook told us people's dietary requirements such as if they were vegetarian or required a culturally specific diet were checked before admission to ensure they were catered for appropriately. They told us they received information from nursing staff when people required a specialised diet.

People who were at risk of poor nutrition were supported to maintain their nutritional needs. This included monitoring people's weight and recording any incidence of weight loss. Referrals were also made to relevant health care professionals, such as dieticians and speech and language therapists for advice and guidance to help identify the cause. Records were up to date and showed people with nursing needs were routinely assessed monthly against the risk of poor nutrition using a recognised nutritional screening tool. Care plans were in place that recorded people's food likes and dislikes and any support required to help them to eat.

On the day of inspection, due to a problem with the gas supply in the home, which was being rectified, the lunch was unable to be cooked so fish and chips were served for lunch from the local fish and chip shop. People and relatives were positive about food prepared at the home saying there was enough to eat and they liked the food. One person told us "I get three square meals a day, although there isn't much choice." Another person commented, "I get good meals." A third person said, "The food is okay, but there isn't any choice." Other comments included, "The meals are quite good, something different every day" and "[Name] is well fed." Menus advertised a choice of two options at the lunch time and evening meal.

We observed the lunch time meals in the dining rooms. We considered improvements were required to the organisation of people's dining experience. On the day of inspection one hot trolley was used to transport food around the home therefore people were sitting waiting at the table for a length of time until meals had been served in the other dining rooms. Menus were not available to help inform people about the food. People sat at tables that were set with tablecloths that were marked and not changed after each meal, napkins and condiments were not available. Some people remained in their bedrooms to eat or in the lounges. We observed the tables were not set before people sat down to lunch. Cutlery and glasses for

drinks were not available for everyone. Staff did not remain in the top floor dining area to provide help and encouragement to people. People in this dining room who were left to eat their meal independently were later supported by staff, by which time their meal was not hot. Staff when they did provide assistance or prompts to people to encourage them to eat, did this in a quiet, gentle way. Staff talked to people as they helped them. For example, "Is that enough" and "Can I cut that up for you?" The meal time organisation was discussed with the registered manager who told us it would be addressed immediately.

Staff told us communication was effective to keep them up to date with people's changing needs. One staff member told us, "There is a handover from day staff to night staff and night staff handover to staff coming on duty." Another staff member commented, "Communication is good." A third staff member said, "We get a handover that tells us what's been happening when we've been on our days off." A handover session took place, between staff, to discuss people's needs when staff changed duty, at the beginning and end of each shift. This was to ensure staff were made aware of the current state of health and wellbeing of each person.

Good

Is the service caring?

Our findings

Staff appeared to have a good relationship with people and knew their relatives as well. People and relatives we spoke with all said staff were kind, caring and patient. One person told us, "It's alright here, the staff are very good." Another person commented, "I'm quite happy here." A third person told us, "I like it here, nice staff and when you ask for anything they do it straight away." One relative said, "The staff are caring and the place is homely." Another relative told us, "We visited the home unannounced and were made very welcome." Other relatives comments included, "I think [Name] is very well cared for", "Staff are all sociable and friendly", "They [staff] are always cheerful" and "Staff are very caring."

The atmosphere in the home was calm, friendly and welcoming. Staff promoted positive and caring relationships. People were spoken with considerately and staff were polite. We observed people were relaxed with staff. One relative told us "[Name] is more settled here." Staff interacted in a caring and respectful manner with people. Staff acted with professionalism, good humour and compassion. A relative told us, "You can tell the staff are the right quality to work here, their mannerisms are very good." Another relative commented, "I was apprehensive at first, but I find staff to be really nice caring people. I am comfortable I can go on holiday now with my family knowing [Name] is so well cared for."

People's privacy and dignity were respected. People told us staff were respectful. We observed that most people looked clean, tidy and well presented. A relative commented, "[Name] is always clean and well dressed." Another relative told us, "The staff make sure [Name] is wearing a shirt when younger children visit." A third relative said, "Staff make sure [Name] has a really good shave every day." However, we observed that not all people had manicured and clean fingernails. We discussed this with the registered manager who told us some people refused assistance at times with their personal care. We checked people's care records and they showed when people may refuse assistance. We observed staff knocked on people's doors before entering their rooms, including those who had open doors. A relative told us "Staff always makes sure there's no one else in the room when they're providing personal care. They close blinds and curtains."

People who were able to express their views told us they made their own choices over their daily lifestyle. They told us they were able to decide for example, when to get up and go to bed and what they might like to do. One person told us, "I get woken up in the morning but I can stay in bed for a lie in if I want." Another person commented, "I can have a shower every day." We heard staff ask people for permission before supporting them, for example with personal care or offering them protective clothing at the lunch time meal.

Care plans provided information about how people communicated. For example, one care plan stated, '[Name] is able to communicate their choices with very minimal or irregular communication, blinking, hand gestures and vocalisation.' Staff described how they supported people who did not express their views verbally. They gave examples of asking families for information, showing people options to help them make a choice such as showing two items of clothing. This encouraged the person to maintain some involvement and control in their care. Staff also observed facial expressions and looked for signs of discomfort when people were unable to say for example, if they were in pain.

There was information displayed in the home about advocacy services and how to contact them. The registered manager told us people had the involvement of an advocate, where there was no relative involvement. Advocates can represent the views for people who are not able to express their wishes.

Records showed the relevant people were involved in decisions about a person's end of life care choices when they could no longer make the decision for themselves. People's care plans detailed the 'do not attempt cardio pulmonary resuscitation' (DNACPR) directive that was in place for some people. This meant up to date healthcare information was available to inform staff of the person's wishes at this important time to ensure their final wishes could be met.

The registered manager told us they were supported by McMillan nurses who were involved with people when they received end of life care. Fortnightly meetings took place with the palliative care team, that included McMillan nurses, to help co-ordinate the delivery of end of life care to people when they reached this end stage of their life.

Requires Improvement

Is the service responsive?

Our findings

Staff knew the individual care and support needs of people, as they provided the day to day support and they had worked at the home for some years. One relative told us, "The staff have been here a long time, this makes a difference." Another relative commented, "Staff don't change, there is a good consistency and this helps care for people."

Assessments were carried out to identify people's support needs and they included information about their medical conditions, dietary requirements and their daily lives. One relative commented, "I met with staff and the assessor to discuss [Name]'s care." Care plans were developed from these assessments that outlined how these needs were to be met. For example, with regard to nutrition, personal care, communication and moving and assisting needs. Records showed that monthly assessments of peoples' needs took place with evidence of evaluation that reflected any changes that had taken place. Evaluations included information about people's progress and well-being. Reviews of people's care and support needs took place with relevant people. A relative commented, "My husband has a meeting annually to discuss [Name]'s care, he has a lot of input into [Name]'s needs."

Care plans were in place that provided some details for staff about how the person's care needs were to be met. For example, a social care plan recorded, '[Name] is given the opportunity daily to be escorted by a member of staff to the local newsagent to buy newspapers, chocolate and cigarettes.' However, not all care plans were person centred. For example, during the inspection one relative advised us they had asked staff to take a person to their bedroom and to play some soothing music, as the lounge was becoming noisy and the person became distressed if there was too much noise due to their visual impairment. We checked the person's care plans and this information was not documented so staff would know how to support the person, if they could not tell staff themselves. For another person, a care plan for personal hygiene recorded, 'I need help to get dressed and a little help with zips and fasteners.' However, although it contained some information, it did not give instructions for frequency of interventions and what staff needed to do to deliver the care in the way the person wanted. They did not detail what the person was able to do to take part in their care and to maintain some independence.

Most people's records contained information about people's history, likes, dislikes and preferred routines. For example, 'I like music and dancing' and '[Name] has a sweet tooth and prefers sweet rather than savoury food.' Some people also had a 'This is Me' profile but it was not available for everyone. The information had been collected with the person and their family and gave details about the person's preferences, interests and previous lifestyle. It is important information to help ensure people receive person centred care and necessary for when a person can no longer tell staff themselves about their preferences.

We recommend that staff receive training about person centred care and personhood to ensure that all people receive care in the way they want and need when they are unable to tell staff themselves.

Staff completed a daily diary for each person and recorded their daily routine and progress in order to monitor their health and well-being. This information was then transferred to people's support plans which

were up-dated monthly. Charts were also completed to record any staff intervention with a person. For example, for recording the food and fluid intake of some people and when personal hygiene was attended to and other interventions to ensure peoples' daily routines were met. These records were used to make sure staff had information that was accurate so people could be supported in line with their up-to-date needs and preferences.

People and relatives confirmed there was a choice of activities available. A new activities organiser was employed and an activities programme advertised pamper sessions, aromatherapy, bingo, reminiscence, singing, music therapy, movie afternoons and armchair exercises. Entertainment and concerts also took place. The hairdresser visited weekly and two local members of the clergy visit weekly. People had a variety of opportunities to go out on trips and individually into the local community. Some people were supported to go out daily to the shops, to tea dances and the local pub. Several people attended a local luncheon club and the home had developed very good links and contacts with the local community to benefit people's socialisation.

Regular meetings were advertised with people who used the service and their relatives. The registered manager told us relative meetings were not very well attended but their "door was always open." Minutes were available from meetings that had taken place.

People knew how to complain. People we spoke with said they had no complaints. The complaints procedure was on display in the entrance to the home. A record of complaints was maintained and a complaints procedure was in place to ensure they were appropriately investigated. We saw several compliments had been received from relatives of people who used the service thanking staff for the care provided.

Requires Improvement

Is the service well-led?

Our findings

The home had a registered manager who had registered as manager with the Care Quality Commission (CQC) in February 2016. They were fully aware of their registration requirements and had ensured that the Care Quality Commission was notified of any events which affected the service.

We had concerns audits were not all effective to ensure the well-being at all times of people who used the service.

Auditing and governance processes were in place to check the quality of care provided and to keep people safe. A quality assurance programme included daily, weekly, monthly and quarterly audits. Monthly audits included checks on care documentation, staff training, medicines management, home presentation, complaints management, health and safety and accidents and incidents. Other audits included for health and safety and infection control. All audits showed the action that had been taken as a result of previous audits. However, the audit and governance processes had failed to identify deficits we found in care plans, staffing levels, the environment and people's dining experience.

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

Other quality assurance processes included a weekly risk monitoring report that included areas of care such as safeguarding, complaints, infection control, pressure area care and serious changes in a person's health status was completed by the registered manager and submitted to head office for analysis.

Records showed regular analysis of incidents and accidents took place. Learning took place from this and when any trends and patterns were identified, action was taken to reduce the likelihood of them recurring. For example, with regard to distressed behaviour and people who may be at risk of falls. Records showed people were referred to the relevant professional for advice and guidance when a certain amount of incidents were recorded.

Monthly visits were carried out by the area manager who would speak to people and the staff regarding the standards in the home. Reports showed they also audited a sample of records, such as care plans, complaints, accidents and incidents, risk assessments, social activities, safeguarding and staff files. These audits were carried out to ensure the care and safety of people who used the service and to check appropriate action was taken as required. Action plans were produced from monthly visits with timescales for action where deficits were identified. Reports showed the improvements that had been made to help ensure the service was run for the benefit of people who lived and to ensure they were safe and comfortable.

The registered manager told us the registered provider monitored the quality of service provision through information collected from comments, compliments, complaints and survey questionnaires that were sent out to people who used the service. Survey results were available from the provider's quality assurance

surveys from February 2017 which showed people responded positively.

The registered manager was enthusiastic and had introduced many ideas to promote the well-being of people who used the service. One relative told us, "I think the home has improved a lot." Staff were positive about the management of the home and had respect for them. All staff members told us the registered manager was approachable." People and relatives told us they were listened to by the registered manager.

The atmosphere in the home was lively and friendly. Relatives said they were always made welcome. Staff, people and relatives said they felt well-supported. Several staff members told us they had worked at the home for several years. Staff were positive about other staff in the home and had respect for them. One staff member commented, "Staff morale is good, we all work as part of a team." Another staff member said, "The registered manager is really approachable."

People and relatives were all positive about the home and the changes that had taken place or were planned. They said they would recommend the home to other people. One relative told us, "It's very homely, [Name] has settled well." Another relative commented, "I wish I'd known about this home sooner." A third relative said "This is a good home."

The registered manager assisted us with the inspection, together with the area manager. Records we requested were produced promptly and we were able to access the care records we required. The registered manager was able to highlight their priorities for the future of the service and were open to working with us in a co-operative and transparent way.

Staff told us monthly general staff meetings and head of department meetings took place and minutes of meetings were available for staff who were unable to attend. One staff member commented, "Staff meetings happen monthly." Staff meeting minutes showed topics discussed included health and safety, medicines, staff performance, activities and documentation. Staff meetings kept staff updated with any changes in the service and to discuss any issues.

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 17 HSCA RA Regulations 2014 Good governance The registered person had not ensured systems and processes were established and operated to ensure compliance with the registered persons need to assess, monitor and improve the quality and safety of the service. Regulation 17 2(a)

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 had not ensured staffing levels were sufficient to provide safe, effective and person centred care to people at all times. Regulation 18 (1)