Care Quality Commission

Bree Associates Limited

Shandon House

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?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

Shandon House provides accommodation and personal care for up to 25 older people. There were 24 people living at the home at the time of the inspection. People required a range of care and support related to the frailty of old age. Some people lived relatively independent lives, others required support with personal care or mobilising safely, others had a degree of short term memory loss. People were able to live at the home permanently or for periods of respite care. Staff can provide end of life care with support from the community health care professionals but usually care for people who need prompting and minimal personal care support.

Shandon House is a family run home, it is owned by Bree Associates Limited and has one other home within the group. Accommodation was provided over four floors with a passenger lift that provided level access to all parts of the home. People spoke well of the home and visiting relatives confirmed they felt confident leaving their loved ones in the care of staff at Shandon House.

There is a registered manager at the home, who is also the registered manager for the other home, however the majority of her time is spent at Shandon House whilst the provider works at the other home. A registered manager is a person who has registered with the Care Quality

Summary of findings

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.

This was an unannounced inspection which meant the provider and staff did not know we were coming. It took place on 6 and 8 July 2015.

Some people took medicines only if they needed them, for example if they were in pain. There was no guidance in place for staff to ensure these were given appropriately and consistently. Risks to people had not always been clearly identified, or what steps had been taken to minimise the risks.

There was not an effective system in place to assess the quality of the service provided; therefore the registered manager had not identified all of the shortfalls we found.

There were enough staff on duty to meet the needs of people. Appropriate checks where undertaken to ensure suitable staff were employed to work at the service. Staff were provided with a full induction and training programme which supported them to meet the needs of people.

People's needs had been assessed and individual care plans were in place. However, some documentation failed to reflect what actions were required to safely meet the people's needs or reduce the risk of any harm occurring. Despite concerns with documentation, we saw that people received the care they required.

Staff had a clear understanding of the procedures and their responsibilities to safeguard people from abuse. Staff understood their responsibility in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Staff monitored people's nutritional needs. People were complimentary about the food they received. People had access to a varied and extensive menu. If people did not like what was on offer alternatives were available.

People were supported to maintain good health and had access to on-going healthcare support. People were able to see their GP or dentist whenever they needed to.

The registered manager was seen as approachable and supportive and took an active role in the day to day running of the home.

There were a number of breaches of the regulations. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

Not all aspects of Shandon House were safe.

People's medicines were not always managed safely. There was no guidance in place for people who needed 'as required' (PRN) medicines.

Risk management was not always safe. It did not clearly identify risks to people or what steps had been taken to minimise the risks.

There were enough staff on duty, who had been appropriately recruited, to meet the needs of people.

Staff had a clear understanding of the procedures and their responsibilities to safeguard people from abuse.

Is the service effective?

Good

Shandon House was effective.

Staff were trained and supported to meet people's individual needs.

Staff understood their responsibility in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Staff monitored people's nutritional needs and people had access to food and drink that met their needs and preferences.

People were supported to maintain good health and had access to on-going

healthcare support.

Is the service caring?

Good

Shandon House is caring.

Staff knew people well. This enabled them to provide good, person centred care.

People were treated with kindness, compassion and understanding.

People were supported to make decisions about their daily lives.

Is the service responsive?

Requires improvement

Shandon House was not consistently responsive.

People received care and support that was responsive to their needs because staff knew them well. However, some care records contained conflicting information or did not reflect the care and support people received to ensure consistency or demonstrate that people's care needs were being identified and met.

A complaints policy was in place and complaints were handled appropriately.

Summary of findings

Is the service well-led?

Shandon House was not consistently well led.

There was not an effective system in place to assess the quality of the service provided.

People and staff spoke highly of the registered manager. There was a positive, open culture at the home and staff felt well supported.

Requires improvement

Shandon House

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 was an unannounced inspection on 6 and 8 July 2015. It was undertaken 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 the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law.

During the inspection we spoke with eight people who lived at Shandon House. We spoke with two visitors, eight staff including the registered manager, provider and the cook.

We observed care in communal areas to get a full view of care and support provided across all areas. We observed lunch in the dining room. The inspection team spent time sitting observing people in areas throughout the home and were able to see the interaction between people and staff.

We reviewed a variety of documents which included five care plans and risk assessments along with other relevant documentation to support our findings. We 'pathway tracked' people living at the home. This is when we looked at their care documentation in depth and obtained their views on their life at the home. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

During the inspection we reviewed the records of the home. These included policies and procedures, audits, along with information in regards to the upkeep of the premises. We looked at three recruitment files and records of staff training and supervision. We read medicine records and looked at complaint records, accidents and incidents and quality assurance records.

Requires improvement

Is the service safe?

Our findings

When asked, people told us they felt safe living at Shandon House. Comments included, "Yes, I definitely feel safe here," and "I feel very safe here." They told us there were enough staff. One person said, "There seems to be enough staff about and they help out immediately." Another person told us, "There seems to be enough staff, even at night." They told us they were able to have their medicines when they needed them. One person said, "I get my medication when I expect it." Although people felt safe at the home there were aspects where we found people were not always safe.

People had not been protected against the risks associated with the unsafe management of medicines. Some of these medicines were 'as required' (PRN) medicines. People took these medicines only if they needed them, for example if they were experiencing pain. Where people received PRN medicines there were no individual protocols to document why the medicine had been prescribed. There was no information about when it may be given, whether it would affect the workings of any other medicines, or what to do if the medicine was not effective. Staff knew people and their needs well so understood when these medicines were required. However, there was no guidance in place to ensure consistency and did not protect people from the unnecessary or inappropriate use of medicines. Information on the medicine administration record (MAR) chart informed staff of the maximum daily doses so staff were aware how much medicine people could have safely each day.

The home had a policy about administering 'homely' remedies. Homely remedies are non-prescription medicines or other over-the-counter-products for treating minor ailments such as coughs or minor aches and pains. There was no individual guidance in place to ensure these were safe to give with other medicines or to identify people who should not receive homely remedies. Not all staff were clear about the correct process for administering homely remedies. This could leave people at risk of harm from inappropriate treatment.

We found that not all cream application charts had been fully completed to show each occasion when prescribed creams were used and there were no diagrams (known as body maps) in place to illustrate which areas creams should be applied to. Information in one person's care plan stated that their prescribed cream was to be applied by staff, but we were told by staff that this person applies their own cream. There was no assessment in place to demonstrate that the risks of self- administration had been considered or discussed with the person. Some bottled medicines and eye drops had not been marked with the date they were first opened; making it difficult to determine when they should be discarded. However, following the inspection the registered manager told us no bottled medicines or eye drops were kept beyond the 28 day cycle. All such medicines were returned to the pharmacy. This meant that no out of date medication was kept at the home.

People were not protected against the risks associated with the unsafe use and management of medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A review of medicine administration records showed that these had been appropriately completed with signatures to denote each occasion when medicines had been given. Our observations of a medicines administration saw staff sought verbal consent from people before giving them their medicines; they also explained which tablets they were being given. Staff watched to ensure that medicines were swallowed before signing the administration record. Medicines were stored securely and the temperature of a fridge used for certain medicines was recorded on a daily basis; so that they were kept in a suitably cool environment. Staff had received training about medicines management and had also had regular competency checks to ensure that their knowledge and practice was of a suitable standard. Routine medicines audits had been carried out and staff made aware of any improvements or changes required as a result of the findings.

Risk management at Shandon House was not robust, it did not clearly identify risks to people or what steps had been taken to mitigate the risks. Although risk assessments were in place to help keep people safe, support them to take positive risks and remain as independent as possible these were not all accurate and lacked sufficient guidance to keep people safe. In addition it appeared not all staff who undertook risk assessments understood the tools they were using to assess risks appropriately. The registered manager had identified this in the PIR as an area for improvement and was planning for staff to attend risk assessment training during 2015.

Requires improvement

Is the service safe?

Some people had been identified at risk of malnutrition, these people were weighed regularly. One person had lost 1stone 2lbs and another had lost 13lbs since December 2014. Nutritional assessments included information about whether people had visibly lost weight for example did their clothes appear lose and had there had been any unintentional weight loss in the past three to six months. Staff had recorded that there had been no unintentional weight loss despite people clearly having lost weight. This meant the risk assessment did not correctly identify the risks to people's health and well-being or include guidance for staff to manage the risks. We identified this with the registered manager as an area that requires improvement. The registered manager told us she was aware some people had lost weight and this had been attributed to the use of new weighing scales, one person's weight had remained within normal range for their height and the GP was involved with the care for the second person.

Two people had stated they would like to lose weight and had agreed to a suggested diet plan where staff would inform them of healthier food choices. They had gained one stone each since December 2014.The registered manager told us people had chosen to put themselves on diets and although they were supported and encouraged they were able to make their own choices about whether they followed the diets.

It had been identified that a number of people were at risk of falling. Falls risk assessments were in place, this included a risk assessment tool. This was a tick box scoring assessment and a score of below 13 indicated people were at risk of falling. We noted that everybody scored higher than this which meant they were not at risk. The registered manager told us she had identified the tool was not effective and was in the process of finding another tool which would better meet the needs of people and be clear for staff to follow. Individual risk assessments were personalised and recorded if the person or staff had identified the concern as a risk. For example staff had identified one person was at risk of falls when they were anxious. There was guidance for staff to reassure and support this person at these times. Some people were at risk of developing pressure sores there were risk assessments in place which provided guidance for staff on how to look after people and minimise their risks.

Systems were in place for the monitoring of health and safety to ensure the safety of people, visitors and staff. The home was clean and tidy throughout, regular environmental and health and safety risk assessments and checks had been completed, for example a fire safety inspection and call bell tests. There were regular servicing contracts in place for example gas, the stair and passenger lift and hoists. There was a maintenance plan in place which identified areas of the home which required maintenance and redecoration.

There were systems in place to deal with an emergency which meant people would be protected. There was guidance for staff on what action to take and there were personal evacuation and emergency plans in place. The home was staffed 24 hours a day with an on-call system. Staff were aware who to contact in case of an emergency.

Staff had received safeguarding training and understood their responsibilities in relation to safeguarding people in order to protect them from the risk of abuse. They were able to recognise different types of abuse and told us what actions they would take if they believed someone was at risk and how they would report their concerns. Staff told us they would report any concerns to the registered manager or most senior person on duty at the time. If this was not appropriate they would report to the relevant external organisations. They told us they would always report concerns to make sure people were safe. One staff member told us, "I can't tell you exactly where I would report it to (outside of the home) but I know where I can find the information and I know I would do it. We need to protect people."

There were adequate staffing levels in place. The rotas showed there were three care staff, the registered manager or senior carer a housekeeper on duty during the day. There was a cook in the morning and care staff were responsible for preparing people's evening meals. There were two staff working at night. People told us, and we saw, staff were available to help them people when they needed it and call bells were responded to in a timely way. The registered manager told us staffing levels were based on people's assessed needs. She told us that it had been identified a number of people who currently lived at the home liked to get up early. Therefore staffing levels and working times had been adjusted to reflect this. Staff told us they were busy in the mornings but had enough time to provide the care people required.

Requires improvement

Is the service safe?

Staff files contained appropriate information for safe recruitment. This included an application form with full employment history, references and the completion of a Disclosure and Barring Service (DBS) checks. This ensured as far as possible only suitable people worked at the home.

Good

Is the service effective?

Our findings

Staff knew people well and had the knowledge and skills to look after them. One person told us, “They (staff) are very capable, they are very friendly.” Another person said, “The people who work here do things which are useful and as they should.” People also told us, “I get the care I need,” and “They have got my panic attacks under control.” People told us the food was good and they had choices of what they ate and drank. One person said, “If there’s something on the menu, which you don’t like, there’s always a choice.” People told us they had access to regular healthcare. We were told, “The carer will get the doctor, if I need him,” and “If I go to the dentist, they provide transport and someone to go with me.”

When they started work at the home staff completed a period of induction. This included the day to day running of the home, health and safety and people’s care records. They then spent time shadowing other staff before they worked on their own. Staff told us induction provided them with the knowledge and skills to look after people. They said they were well supported by the registered manager and colleagues and could always approach them for help.

There was a training programme in place which showed staff received regular training and updates, this included moving and handling, food hygiene, first aid and mental capacity. Staff received ongoing training and further development such as the diploma in health and social care. A number of staff were also undertaking distance learning training in relation to end of life and dementia care. Staff told us the training they received helped them understand and provide appropriate care and support for people. They told us if they identified areas where they required further training, knowledge or skills to look after people this would be provided. Staff demonstrated a good understanding about how they cared for people in relation to their nutrition, pressure area care and mental capacity. The registered manager had identified further training was required for staff in relation to completing risk assessment documentation.

There was an ongoing programme of supervision. Staff confirmed they received this regularly and it was an opportunity for them and the registered manager to identify areas where they may require more support or training. Staff did not currently receive formal appraisals we read in the PIR the registered manager had identified this and they were planned to be introduced in the next 12 months. Staff said they were well supported by the registered manager, provider and their colleagues and could talk to the registered manager about concerns at any time. One staff member told us how their understanding of dementia had increased following their distance learning course.

Staff understood the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and what may constitute a deprivation of liberty. The MCA aims to protect people who lack capacity, and maximise their ability to make decisions or participate in decision-making. The Deprivation of Liberty Safeguards concern decisions about depriving people of their liberty, so that they get the care and treatment they need, where there is no less restrictive way of achieving this. The Care Quality Commission has a legal duty to monitor activity under DoLS. This legislation protects people who lack capacity and ensures decisions taken on their behalf are made in the person’s best interests and with the least restrictive option to the person's rights and freedoms. Providers must make an application to the local authority when it is in a person's best interests to deprive them of their liberty in order to keep them safe from harm. The registered manager understood the principles of DoLS, how to keep people safe from being restricted unlawfully and how to make an application for consideration to deprive a person of their liberty.

At the time of the inspection there was one DoLS authorisation in place and further applications had been made. Information about people’s mental capacity assessments was recorded in their care plans. One care plan informed staff a DoLS application for the person had been made. Another person’s care plan reminded staff the person was able to make their own day to day decisions but may need support with larger decisions, for example where to live.

Staff had an understanding of consent and caring for people without imposing any restrictions. Before offering any care or support they asked people for their consent to ensure they were happy with what was offered. We saw within the care plans consent had been sought and signed for a variety of areas such as sharing care plan information, allowing visitors and the use of photographs.

People were positive about the food they received. They told us they enjoyed it and were given choices at each

Good

Is the service effective?

meal. One person chose to have a small breakfast in their bedroom on waking and a later, larger breakfast in the dining room with other people. Breakfast was served in the dining room from 8.30am and people were able to come and go as they chose throughout the morning. At lunchtime most people chose to eat in the dining room, a few remained in their rooms. One person told us they preferred to eat alone; another person usually ate in the dining room but stayed in their room because they felt unwell.

Nutritional assessments were in place and the cook and staff had a good understanding of people's nutritional needs, dietary preferences and choices. There was information displayed in the kitchen about people's specific dietary needs for example those who were diabetics, those who had allergies, their particular likes and dislikes. There was a four week menu on display and meals were varied and extensive. If people did not like what was offered there were always alternatives available.

The dining tables were attractively presented with cloth tablecloths and napkins and a selection of condiments. Meals were covered and taken on a tray to people who remained in their rooms. People were able to sit where they chose however people had developed their own friendship groups and tended to remain in these. People were chatting to each other prior to the meal being served, however the mealtimes themselves were quiet. Meals were well presented and appeared appetising and most people ate well. One person who did not eat much of their meal told us they had little appetite. They said, "The food is lovely, nothing wrong with it, it's just me I don't feel like eating today." Most people did not require support with their meals but some required prompting and encouraging. We saw this was done appropriately and discreetly. Staff reminded people to eat and asked if they needed help for example with cutting up their food. Cold drinks were served at lunchtime, and the meal was finished with a cup of tea or coffee.

People were offered a range of hot and cold drinks and snacks throughout the day. Water and juice was apparent in the lounges during the day and in people's rooms. One person said, "I have a jug of water and they come and top up my glass." Nutrition charts were in place and formed a record of how much, and what, people had had to eat and drink. These were not always fully completed. The registered manager was aware of this and there was an action plan in place to address it. Staff were regularly reminded of their responsibilities and a reminder notice was on display in the staff room.

Communication was seen as essential in ensuring staff were kept up to date with changes in people's needs. Daily handovers allowed all staff to discuss concerns about people's health or well-being, their mood or any other relevant information. Where appropriate referrals were made to healthcare professionals.

People were supported to have access to healthcare services and maintain good health. Care records showed external healthcare professionals were involved in supporting people to maintain their health. This included GP, district nurses, optician and chiropodist. We spoke with three healthcare professionals who told us the staff referred concerns to them appropriately when a need was identified. One healthcare professional told us, the registered manager was very proactive in contacting their team for advice and assessment. Another healthcare professional told us how they had worked with the home to improve communication and provide a more person centred service for people.

Good

Is the service caring?

Our findings

People told us staff were friendly, kind, caring and respectful. One person said, "The staff are friendly and they are kind." Another person told us, "I am so well looked after here and I've been here a long time." People told us Shandon House was a happy place to live. A visitor told us, "Happy staff make residents very happy." Staff demonstrated caring attitudes when they spoke about people. One staff member said, "I like working with people, doing things with them and making it meaningful." Another told us, "I always think, how would I like to be treated and that's how I look after people."

There was a calm atmosphere at the home and it was clear staff had a good knowledge and understanding of the people they cared for. There was information in people's care files about them and their life before they moved into Shandon House. These and had been completed with sensitivity and understanding. Staff treated people as individuals and were able to tell us about people's choices, likes, dislikes, personal histories and interests. For example they knew some people liked to remain in their own bedrooms but join other people for mealtimes and some activities. We observed staff reminding people it was lunchtime and informing them of what activities were taking place and supporting them to attend. End of life care plans were in place, these had been sensitively prepared and contained information needed to act in accordance with people's final wishes.

Each person was treated with kindness and respect and care delivered was observed to be of a kind, sensitive and calm nature. We observed staff spending time with people who were distressed or upset and showing them compassion, offering comfort and practical support. One person who had a degree of memory loss and was waiting for a visitor was gently reminded of what time their visitor would arrive and reassured they had not missed them. One person told us, "Everybody, down to the cleaner, looks after me well."

Throughout the inspection we saw staff talking with people in a caring and professional manner. We observed conversations and interactions that were caring and courteous. It was noticeable that staff and people chatted about all sorts of things not just care related topics.

Staff promoted people's independence and ensured they were able to make choices about all aspects of their daily living. People told us they were able to spend their day as they chose. One person told us they liked their own company, another told us they liked to spend a lot of their time reading and someone else told us they liked to go out every day and others told us they liked to spend time in the lounge with other people. We observed friendship groups had developed between people and they were supported to maintain these. Visitors were welcomed at the home. One visitor told us they were able to visit whenever they chose and always felt welcome.

People's equality and diversity needs were respected. People took pride in their appearance and staff supported them to dress in their preferred way. The hairdresser was at the home on the first day of our inspection. We observed staff reminded people it was 'hairdressing day' and supported them to have their hair done. Staff then complimented people on their hair once it had been done.

People were involved in decisions about their day to day care and support. Staff told us about one person who was on occasion reluctant to maintain their own personal hygiene. They told us how they prompted and encouraged the person, they said they reflected back to the person's younger days and used their knowledge of the person to inspire them. Staff told us although they would encourage people they understood it was up to each individual what they chose to do. They said, "We can encourage people and support them but we would never make someone do something they didn't want to."

Staff supported people and their privacy and dignity was respected. All of the bedrooms were single occupancy and they had been personalised with people's own belongings including furniture, photographs and ornaments. People were able to spend time in private in their rooms as they chose. Bedroom doors were kept closed when people received support from staff and we observed staff knocked at doors prior to entering. People told us, "I get privacy when they (staff) attend to me," and "They knock on my door even though it's always open."

There was a 'residents code of conduct' displayed at the home. This had been developed by people and included information about how they would like to address certain areas of communal living. It reminded people they were able to sit where they chose in the lounge and dining room, it reminded people to knock before they entered other

Good

Is the service caring?

people's bedrooms and it gently reminded people not to discriminate against others who for example may have a degree of memory loss. We observed one person reading this to another. They then said, "Well, I think that's lovely, I don't think we could ask for anything more." The other person agreed.

Requires improvement

Is the service responsive?

Our findings

People told us they received care and support that met their needs and was personalised to their individual choices and preferences. They said they were able to choose how they spent their day. We were told, "I do wish to stay in my room except for meals but I have the choice." They said they were involved in decisions about their day to day care. One person told us, "They involve me with things about my care." Another person said, "They do go through my care plan with me."

People told us they didn't have any complaints. One person said, "I've never complained but if I was unhappy about something, I'd tell them," and "I've never complained, but I would." Visitors we spoke with told us they were updated about any changes to their relative's needs.

Staff knew people really well and understood the individual care and support they needed. Care plans were very detailed and included personal information and guidance about how best to support the people in a way they wanted to be looked after. However, there were some areas where the information was conflicting or did not reflect the care and support people received. Specific forms were not completed consistently for example one person was at risk of falls had a pressure mat in place to alert staff when they got out of bed. A mobility care plan informed staff the mat was in place but the information was not included in the risk assessment.

Information about people's health related conditions was not always clear or easy to identify, for example guidance for one person's seizures was contained within their mobility care plan. Staff were aware of this and supported the person appropriately. Another person had a pressure wound. The care plan had highlighted the person was at increased risk from pressure areas when they were incontinent of urine and therefore their skin must be kept clean and dry. A detailed pressure area plan had not been fully completed and this did not record anything related to pad changes. Staff told us this person was now able to use the toilet independently and only wore a pad for reassurance. This person required an air relieving pressure mattress and cushion and these were in place. Staff knew the correct settings to ensure optimum benefit for the person however these had not been recorded within the care documentation. Where people had diabetes staff knew how to support this person to maintain good health, however there was no written guidance in place.

Other daily charts for example topical medicines (creams and lotions for skin) to tell staff where to apply the medicine and records of when it had been applied had not been completed. However, care plans and daily care sheets showed the medicine had been applied.

We were told care plan reviews and key worker evaluations took place monthly. One person's care plan had not been reviewed since April 2015, however keyworker reviews had taken place and a manager's review was carried out in May 2015. Another person's care plan informed staff if the person continued to lose weight for two months they required a referral to the GP. This person had continued to lose weight, staff told us what actions had been taken and we saw from other documentation the GP was involved with this person's care. There was guidance in the care plan to support this person maintain a nutritious diet but this did not fully reflect the care that staff provided for this person.

Person centred care summaries were in the front of the daily notes. These gave an overview of the person and the care they needed and were useful when delivering care as they gave 'at a glance' information. However, they did not include any information about people's emotional health or mental capacity.

Although staff knew people well the issues above meant staff did not have easily accessible recorded information about people's needs. It was not always easy to retrieve the information they needed to identify the risks or the actions needed to balance them. There was no guidance for staff to ensure consistency or demonstrate evidence that people's care needs were met.

Personal records were not accurate and complete.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.Before people moved into the home the registered manager undertook an assessment to make sure they would be able to provide the person with the care and support they required. People, and where appropriate their representative were involved with the development and review of their care plans. There was clear evidence in the care plans that people's choice and independence was

Requires improvement

Is the service responsive?

encouraged. They contained information about what the person could do and where they may require prompting or supporting. Information was available on people's life history, their daily routine and important facts about the person. This included their likes and dislikes and what remained important to them. For one person, this included spending time alone as they were not used to the company of other people. The care plan reminded staff this person, 'likes their own space.'

Staff had a daily handover which included up to date written information about people, any changes to their needs or individual reminders. For example, one person needed to take their tablets after meals and another had exercises to do each day. Staff used this information to support the care they provided to people.

People were supported to follow their interests, take part in social activities and maintain relationships with family and friends. One person told us they often went out into the town whenever they wished and visitors to the home told us they were always welcome and were able to visit when they chose. An activities timetable was displayed on a noticeboard and we saw staff supporting people with activities. People were observed enjoying themselves during the inspection. People told us they were able to join in when they wished to. One person who remained in their room told us, "They tell me what's going on (activity) and come and take me if I fancy it." People who remained in their rooms told us they were not bored and they had enough to do.

People were encouraged to share their views on the service during daily discussions with the registered manager and staff. The registered manager said she maintained regular contact with people and their relatives to facilitate communication and feedback. Recent compliments cards sent by relatives were available for staff to read. This ensured staff were aware when positive feedback from people using the service was received.

There was a complaints policy at the home. People said they did not have any complaints at the time but they were able to speak to the registered manager or staff if they did. They told us they were listened to and any worries were taken seriously and addressed. Visitors told us they had never had to make any complaints but when they had raised issues they had been listened to and their concerns addressed. This prevents concerns escalating into formal complaints.

Requires improvement

Is the service well-led?

Our findings

People told us the home was well run. Comments included, "The Home is run well," and "The Home is very good." People also said the registered manager was approachable and available. We were told, "The manager pops around to see me," and "The manager is very nice." Visitors told us they were always able to speak with her if they had any concerns. One visitor said, "The manager is a very sweet lady and knows the residents. She is apparent around the home."

The provider had systems in place for monitoring the management and quality of the home but these were not always effective. Care plan audits took place three monthly. The last audit in June had identified some areas where improvements were needed for example falls and nutritional screening assessments required updating for some people. However they had not identified that information related to people's health conditions had not been accurately reflected in their care plans, for example management of seizures, diabetes and continence. The medicines audit had not identified there were no PRN protocols in place. There was no policy for the administration of covert medicines although these were not being administered at the time of the inspection.

There was individual falls analysis in place, when people fell actions taken following the fall did not include any measures taken to prevent a reoccurrence. There was some information about what may have caused the fall but it did not take into account all possible factors for example medicines people were taking. There was no overall analysis to identify themes and trends across the home.

These issues above meant that the people had not been protected against risks associated with unsafe treatment by the quality assurance systems in place. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Provider audits had previously taken place by an external consultant however these had ceased at the beginning of 2015 and no audits had taken place by the provider. We read in the PIR the registered manager had identified this as an area for improvement. She told us she planned to re-introduce provider audits through an external consultant.

The registered manager had identified the MAR charts were not always fully completed. Through the audit system she had identified which staff member had been responsible. Staff were reminded of their responsibilities and then completed a reflective practice report. Reflective practice is, thinking about what you did, what happened and decide from that what you would do differently next time. This enabled staff to learn and develop their skills to improve the care and support for people.

The registered manager worked at the home most days and had a good knowledge and understanding of people, their needs and choices. She promoted an open inclusive culture with her priority being the well-being and happiness of people who lived there. Staff confirmed there was an open culture at the home. They told us it was a good place to work. One said, "It really is a family business, we're all part of it."

Staff told us the registered manager and the provider were approachable, they said they were able to discuss any concerns with them. One staff member said the registered manager encouraged all staff to speak to her and discuss any concerns or issues and we saw evidence of this during our inspection. We were told concerns would be addressed appropriately and confidentiality would be maintained. Staff told us although they worked for a family business the registered manager and provider were professional and they dealt with any concerns about staff members appropriately.

The registered manager received regular supervision from an external consultant, she told us this enabled her to discuss issues and concerns with someone who was independent of the home and the provider. She told us this was useful and enabled her to manage the home with increased skill and confidence.

Staff had a clear understanding of their roles and responsibilities and who they would report concerns to in the absence of the registered manager. Staff had a handover which included written information about people, any changes to their needs or individual reminders. It also informed staff about their allocated duties for each day, for example being responsible for activities or preparing people's tea. We were told these were worked out with staff and as far as possible staff preferences were taken into account, for example some staff enjoyed working in the kitchen more than others. Staff told us it was clear at the start of each shift what was required of them.

Requires improvement

Is the service well-led?

People and staff were involved in the day to day running of the home. There were regular resident meetings and we read minutes of these. The minutes from the most recent meeting was displayed on the residents' noticeboard. There were discussions about food, laundry and activities. We saw issues raised were addressed. People had raised an issue about not liking the prunes, minutes from the latest meeting showed these were now being obtained from a different supplier and people were happier. At the latest meeting people had said the lift was not clean, there were finger prints and dust. We saw this had been raised as an area for improvement on the cleaning schedule. There was a residents and staff 'code of conduct' on display in the entrance hall. We were told this had been developed following feedback from people and was used to remind people of their rights and responsibilities at the home.

Feedback surveys were sent out to people, relatives and professionals regularly. Surveys were being sent out at the time of the inspection. There was a comments box next to the sign in book which people and visitors could use to provide written feedback if they chose to. People told us they were happy to discuss concerns with staff.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People were not protected against the risks associated with the unsafe use and management of medicines. Regulation 12(1)(2) g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance People's personal records were not accurate and up to date. The provider did not have an effective system to regularly assess and monitor the quality of service that people receive. Regulation 17(1)(2)(a)(b)(c)(f)