Michael C S Kainth

Langdale Residential Home

Inspection report

23 Bierley Lane
Bierley
Bradford
West Yorkshire
BD4 6AB

Tel: 01274682164

Date of inspection visit:
05 October 2016

Date of publication:
08 November 2016

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Langdale Residential Home provides personal care for up to 19 older people. The home is situated in the Bierley area of Bradford. The accommodation is provided in mostly single rooms with a small number of double rooms. Some rooms have en-suite facilities. The home has a range of communal areas including lounges, dining room and gardens.

The inspection took place on 5 October 2016 and was unannounced. On the day of the inspection there were 18 people living in the home.

A registered manager was in place. 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.

At this inspection we checked whether improvements had been made to the service since the last inspection in October 2015 where we found a breach of regulation and rated the provider as 'Requires Improvement' overall. We found some improvements had been made but areas remained that required attention. Overall, medicines were managed in a safe way with people receiving their medicines as prescribed. However recording arrangements were not consistently robust.

People and relatives spoke positively about the service and said it provided good quality care in a personalised and friendly way. We observed a positive and inclusive atmosphere within the home with people and staff getting on well.

Risks to people's health and safety were assessed and appropriate plans of care put in place. We found the building to be homely and appropriate for people's individual needs. Safety features were installed in the building to help keep people safe. We identified one concern with regards to fire safety which we referred to the Fire Service.

There were sufficient staff deployed to ensure safe care and treatment. Safe recruitment procedures were in place to help ensure staff were of suitable character to work with vulnerable people.

People told us they felt safe using the service. Safeguarding procedures were in place which were understood by staff and the manager.

The service was acting within the legal framework of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

People said staff had the correct skills and knowledge to provide effective care. Staff received a range of training, supervision and support from the management team.

People praised the food provided by the home. There was sufficient choice and a person centred approach to mealtimes. People's nutritional needs were met by the service.

People's healthcare needs were assessed and met by the service in conjunction with a team of health professionals.

People and relatives said staff were always kind and caring and treated them well. Staff demonstrated a good understanding of the people they were caring for. Information on people's lives had been sought to help staff provide individualised care.

People's care needs were assessed and person centred plans of care put in place which were well understood by staff.

An activities co-ordinator was employed who provided people with a range of group and individualised activities and outings.

A system to log and respond to complaints was in place. People and relatives were highly satisfied with the service provided.

Systems to assess, monitor and improve the service were in place but these were not sufficiently robust, particularly in regards to medicine management and care records. We found some inaccuracies in care plan documentation which should have been identified and rectified through a programme of audit.

Systems to seek feedback from people who used the service were in place. People said they felt listened to and valued by the service.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

There were enough staff deployed who had been recruited in a safe way.

Medicines were generally managed in a safe way, but some improvements were needed to documentation.

Risks to people's health and safety were assessed and appropriate plans of care in place.

Is the service effective?

Good

The service was effective.

Staff received a range of training and support and demonstrated a good understanding of the people and topics we asked them about.

People and relatives spoke positively about the food provided within the home. We saw people had sufficient choice and staff provided individualised support which met people's needs.

The service was acting within the legal framework of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards.

People's healthcare needs were assessed and plans of care put in place. Appropriate contact was made with local health professionals.

Is the service caring?

Good

The service was caring.

People and relatives spoke positively about staff and said they were kind and compassionate. This was confirmed in our observations of care and support where we witnessed a pleasant and inclusive atmosphere.

Staff knew people well and had sought information on their personal histories to help provide personalised care and support.

People were listened to and their opinions valued.

Is the service responsive?

Good

The service was responsive.

People's care needs were assessed and detailed plans of care put in place which were well understood by staff.

People had access to a range of activities and staff took the time to provide care and support which met people's preferences.

A system was in place to log, investigate and respond to complaints. People and relatives told us they were very satisfied with the service.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

We observed a friendly, family atmosphere within the home. People and staff got on well together.

Audits and checks were undertaken in some areas, but medicine audits and care plan audits were not present or sufficiently robust. We identified some aspects of care and support and management activity should have been better documented.

Systems were in place to seek and act on people's feedback.

Langdale Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. We checked to see if improvements had been made to the service following the October 2015 inspection when we issued a requirement action and the service was rated as 'Requires Improvement.'

The inspection took place on 5 October 2016 and was unannounced. The inspection team consisted of two adult social care inspectors.

We used a number of different methods to help us understand the experiences of people who used the service. We spoke with six people who used the service, five relatives, three care workers, the cook, activities co-ordinator, registered manager and deputy manager.

We looked at six people's care records and other records which related to the management of the service such as training records and policies and procedures.

As part of our inspection planning we reviewed the information we held about the home. This included information from the provider, notifications and contacting the local authority safeguarding and commissioning team.

Requires Improvement

Is the service safe?

Our findings

At the last inspection in October 2015 we identified the service was not consistently safe. This was because medicines were not managed in a in a safe way. At this inspection we found some improvements had been made and medicines were generally managed in a safe way, however there were still further areas that required attention such as consistent recording of information.

Medicines were administered by senior care workers who had received training in the safe administration of medicines. We observed the morning medication round and found staff supported people with their medicines in a kind and patient manner. Staff took the time to ensure people had taken their medicines and provided them with appropriate support and fluids to take their medicines in a comfortable way. Staff understood the medicines they were administering and took precautions to ensure they were administered in a safe way. For example, one person was prescribed Digoxin. Staff understood it was a requirement to take the persons' pulse before administering the medicine and knew under which circumstances they were not to administer the medicine and seek medical advice.

Most medicines were provided from the pharmacy in monitored dosage systems. Medicine administration records (MARs) were generally well completed, demonstrating people received their medicines as prescribed. Any refusals were clearly documented within medicine records. Following the last inspection, the home had introduced a stock balance sheet for boxed medicines which ensured a continuous record of the number of tablets in stock. In nearly all cases, the stocks recorded on the balance sheet matched with the number of tablets we found in stock and the audit trail provided evidence people had consistently received their medicines consistently as prescribed. However we identified one medicine did not have a stock balance sheet attached and we were unable to reconcile the number of tablets in stock with the number which should be present. In another case, we found a medicine had a stock balance sheet showing it had been administered, but a MAR chart was not in place, demonstrating an inconsistent approach to recording. We raised these issues with the registered manager who agreed to immediately address them.

Although we were assured people were receiving their topical medicines such as creams, two different sets of records were kept regarding their administration, one on the MAR chart and one in people's rooms. These records provided different information on administration times which made it difficult to establish exactly when these medicines had been administered.

Medicines were stored securely within a locked cabinet or the locked treatment room. There were no controlled medicines present in the home at the time of the inspection, but suitable storage arrangements were in place should they be prescribed. A locked fridge was in place to store refrigerated medicines. However we found although the temperatures were recorded daily, the maximum and minimum temperatures were not recorded to provide assurance that the fridge was within safe temperature limits 24 hours a day.

Medication profiles were in place within care plans instructing staff to as the medicines people were prescribed and the reasons. In most cases, protocols on when to give 'as required' medicines were in place.

However this was not universally the case, with some people's 'as required' medicines not accompanied by protocols. However the staff we spoke with understood when they were required to give these kinds of medicines. We saw one person was receiving their medicines covertly. Although the person's GP was in agreement, there was a lack of evidence the pharmacy had confirmed that this was a safe way to administer medicines.

People living at Langdale Residential Home told us they felt safe living there. One person said, "It's wonderful here, I feel safe." Another person told us, "Yes I feel safe here." Four visitors told us they felt their relatives were in 'safe hands' and had no concerns about their welfare. Staff demonstrated a good understanding of how to identify and act on allegations of abuse. They said they were confident people were safe and did not raise any concerns with us. Safeguarding procedures were in place and we saw evidence they were followed. Following incidents, appropriate liaison had taken place with the local authority and notification made to the Care Quality Commission. A low number of safeguarding incidents had occurred within the service with two in 2016, both relating to the distressed behaviour of one resident who had since been re-assessed and moved to another home.

Risks to people's health and safety were assessed. Care records for people using the service contained identified areas of risk. Risk assessments were in place for falls, nutrition and tissue viability. We saw where risks had been identified action had been taken to mitigate the risk. For example, people who had been assessed as being at risk of falling had 'falls mats' in place. These mats trigger an alarm if the person starts to get out of bed so staff can offer assistance. Another person had a necklace pendant in place to call for assistance rather than trying to mobilise. This meant staff were identifying risks to individuals and taking action to reduce those risks. Where incidents such as falls had occurred these were documented and control measures put in place to prevent a re-occurrence.

We looked around the premises to ensure it was safely managed. Due to recent falls within the home the service had installed several new keypads through the premises to prevent access to the home's staircases. Although these were effective in reducing the risk of falls, we had some concerns these compromised the safe evacuation of people in an emergency situation. The fire risk assessment had not been updated to reflect these changes made to the building, therefore we were not assured that these risks were appropriately assessed and controlled. We referred our concerns to the Fire Service to look into these matters further.

Door alarms were active during the day and night on upstairs doors to alert staff to residents' movement to help reduce the risk of falls. Staff understood how to respond to these and we saw these were responded to promptly during the inspection. Window restrictors were installed on windows to reduce the risk of falls and valves were in place to restrict the temperature of water outlets to reduce the risk of burns. Checks on fire, water, gas and electric systems took place. The premises was suitable for its purpose with adequate amounts of communal space such as lounges, dining area and a garden. Since the last inspection improvements had been made to the environment, with new carpets and décor particularly in people's bedrooms. Further work was needed in some areas, for example to ensure the heavily patterned carpets in the lounge areas were replaced with something more suitable for people living with dementia.

People who used the service and relatives told us the home was kept clean and tidy. One person told us, "Everywhere is kept clean and they wash the tablecloths after every meal." We found the home to be clean and tidy. Staff wore appropriate personal protective equipment, for example whilst handling food and medicines.

Overall, we concluded there were sufficient staff to ensure safe care. People and relatives told us there were

enough staff deployed. For example, one person told us, "Always staff around, who are happy to help." The registered manager told us the service was fully recruited in terms of care staff. Three care workers were on duty during the day and two at night. This was supplemented by the activities co-ordinator who worked 10am to 3pm, five days a week, the deputy and registered manager who also helped out with care and support when required. Staff we spoke with told us there were generally enough staff and shifts got covered. We observed staff and found people were responded to within an appropriate timescale, although we found staff were very busy during the early morning period before the activities co-ordinator arrived. We asked the registered manager to review staffing levels during this period.

Safe recruitment procedures were in place to ensure only staff suitable to work in the caring profession were employed. These included ensuring a Disclosure and Barring Service (DBS) check was made and two written references were obtained before new employees started work.

Good

Is the service effective?

Our findings

People and relatives spoke very positively about the effectiveness of the care. They said the service had been effective in ensuring good outcomes for people. For example, one relative told us how their relatives condition had much improved during the time they had been in the home , with their weight increasing due to attentive and skilled staff. We asked people using the service if they thought staff had received enough training. One person said, "I think the staff have had enough training, they know what they are doing."

We looked at the training matrix and saw staff training was mostly up to date and where training needed to be updated, training had been arranged and booked for 26 and 27 October 2016. The deputy manager explained all of the staff had completed the Care Certificate, even if they had already achieved a qualification in care. This had been done so staff all had the same broad care knowledge and any new care workers would also be expected to undertake this. The Care Certificate is a set of standards for social care and health workers. It was launched in March 2015 to equip health and social care support workers with the knowledge and skills they need to provide safe and compassionate care. It is aimed primarily at staff who do not have existing qualifications in care such as an NVQ (National Vocational Qualification).

We saw staff had completed additional training to ensure they could meet the specific needs of people who used the service, for example, insulin administration, diabetes, epilepsy and palliative care. On the day of our inspection training was being delivered in pressure area care by an external trainer. All of the staff we spoke with and observed demonstrated they had the necessary knowledge and skills to meet the needs of the people using the service. They were able to describe people as individuals and knew about people's likes, dislikes and preferences. This showed us staff worked in a person centred way. Where people had equipment such as catheters, staff demonstrated a good knowledge of the care they were require to give, and told us knowledge had been disseminated throughout the staff team to help ensure consistent and effective care.

The registered manager and deputy manager told us staff received supervision every two months and an annual appraisal which was reviewed after six months. We saw from supervision records staff had the opportunity to discuss their professional and personal development. For example, we saw one person had asked for their 'Train the trainer, safer people handling' qualification to be updated. This had then been completed before their next supervision. Staff we spoke with told us they felt supported in their roles.

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

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 procedures for this in care homes and hospitals are

called the Deprivation of Liberty Safeguards (DoLS).

Since the last inspection, we found improvements had been made to the service's approach to DoLS. People's capacity to make decisions for themselves had been assessed. DoLS applications had been made where people had been assessed as lacking capacity and requiring a high level of supervision or control over their lives. Where people were judged to have capacity, we saw the service had correctly made the decision not to make applications. A large number of applications were currently awaiting assessment by the local authority. Two authorisations had been approved by the local authority and we saw the conditions attached to the authorisations were being adhered to.

Our observations of care and support lead us to conclude care and support was being delivered in the least restrictive way possible. For example, people who expressed a desire to go out were taken out on 1-1 trips by the activities co-ordinator.

We found the service was working within the principles of the MCA and staff had an understanding of how these principals applied to their role and the care they provided. Staff demonstrated to us they followed a best interest process where people lacked capacity. However we identified some instances where best interest decisions were not robustly documented, for example for one person who was receiving their medicines covertly.

We saw there was a culture of gaining consent from people before assisting with care and support tasks. Staff waited patiently for their responses and listened to them. Since the last inspection some of the signage around the home had been improved to aid decision making, such as the larger notice boards informing people of the activities and food on offer. We found there was a lack of pictorial displays throughout the home. However the manager told us they were in the process of sourcing this to aid the understanding of people with dementia.

People told us meals at the home were good. One person told us how they usually had cereal for breakfast but wanted an egg sandwich that morning which staff provided for them. Another person told us (pointing at the chef), "He's a good chef, you just tell him what you want for breakfast and he gets it." Another person said, "At lunchtime you can have soup, sandwiches or a hot meal. At tea time we have a cooked main meal. Last night it was stew and dumplings." A third person said, "The food is lovely, proper home cooked food like stew and dumplings."

We observed the mealtimes within the home. At breakfast time the chef took people's orders as they came into the dining room and then prepared the breakfast they had chosen. We saw people eating cereal, porridge, toast and jam, bacon and egg sandwiches, scrambled eggs/baked beans on toast, bacon/egg/tomatoes and bread and butter. People were also given a choice of hot drinks. Mid-morning and mid-afternoon drinks, biscuits and/or cakes were served.

At lunchtime most people came to the dining room where the tables had been set with tablecloths, placemats, cutlery, drinking glasses, serviettes and condiments. Staff served each person with the meal they had chosen earlier in the morning. People were served table by table so no one was left waiting for food whilst others were eating. The desserts were not served until the whole table had finished. This encouraged people to eat their main meal before being 'tempted' by the pudding. We saw people who required plate guards, and special drinking cups were provided with these so they could eat and drink independently. One person told us, "I am a diabetic and staff keep an eye on me." We saw at lunchtime this person asked for extra cake. The care worker who was serving them gently reminded them about their diabetes and the second slice of cake was then declined by the person.

At lunchtime one person did not want to go for lunch in the dining room. Staff went to them frequently to ask if they wanted to have some lunch, which they agreed to mid-afternoon. Staff assisted them to the dining room and their choice of soup and bread was made for them. Another person came to the dining room during the afternoon and wanted cornflakes and hot milk, which was then provided. This showed the service provided an individualised and person centred approach to mealtimes.

We saw people's weights were closely monitored and speech and language therapists and/or dieticians had been involved for advice when staff had been concerned. We looked at the care plan for one person who had been assessed as being nutritionally at risk. This gave staff important information about the way the person's food should be prepared and about their preferences. For example, they had a particular liking for sweet puddings and if they did not eat their main meal the care plan stated staff should offer them extra pudding. We saw staff were recording their food and fluid intake and checking they had received enough to eat and drink. We saw this was effective as the person was maintaining their body mass index (BMI).

We spoke with the chef who showed us the four week cycle of menus. They were aware of people's individual preferences and their dietary needs. They explained how they fortified people's diets to make sure they were getting additional calories to help them maintain or put on weight. We saw one person had only weighed 6st 12lbs on admission but had put on weight and was currently 8st 1lb, which was a more healthy weight for them. We concluded people's nutritional needs were being met.

People's healthcare needs were assessed by the service and plans of care put in place. There were no pressure sores within the home and a low historic rate of issues demonstrating that people achieved good health outcomes in the area of skin integrity. We asked people who used the service what happened if they were not feeling well. One person told us, "Last week I wasn't feeling so well and they (staff) kept coming to check on me. They (staff) will get the doctor or nurse in if you need them. The chiropodist comes regularly to do my feet." Visitors we spoke with told us staff kept them fully informed about their relatives' health and well-being. We saw from the care records staff were quick to involve health care professionals if they thought, for example, someone may have a chest or urinary tract infection. We also saw they checked any action district nurses had agreed to take. For example, the district nurses had told staff they would upgrade one person's pressure relieving cushion. When no new cushion was delivered they followed this up to ensure the person received the right equipment. This showed us people's health care needs were being met.

Good

Is the service caring?

Our findings

People we spoke with told us they liked the staff and found them kind, caring and helpful. One person told us, "The staff are very, very good; if we want anything they get it for us." Another person said, "Everyone who looks after me is very nice. I'm treated very well; the staff are kind and helpful." One relative said, "All of the staff are very nice and can't do enough for you." Another relative told us, "Staff are very approachable, friendly, kind and patient." Relatives praised the personalised and friendly atmosphere within the home. For example, one relative told us the home was, "Run like a house, like a family." They said they knew all the staff and manager and felt listened to by the service. Another relative told us staff were kind and caring and they always got a good welcome to the home.

We saw people who used the service were nice to each other and had clearly developed friendships with the people they lived with. For example, at breakfast time there were four people eating their breakfast in the dining room. A fifth person came in and greeted each one of them with a kiss on the cheek. At lunchtime one person was concerned the person they usually sat next to had not come for their lunch. They were reassured by staff, on more than one occasion, that the person was fine and did not want to come for lunch yet, but would have something later on. One person who used the service said, "I've got friends here, we all get on."

It was clear strong positive relationships had developed between staff and people. We heard one care worker talking with one person about the famous people they had met and their working life. During the conversation they were gently encouraging the person to drink more of their tea. This showed us staff knew about people's lives and experiences and used this knowledge to engage people in conversation. Information on people's life history had been sought and was retained on file to aid staff to understand the people they were caring for better.

Relatives told us people's birthdays were always celebrated with a party and whoever's birthday it was would choose what food they wanted to be served. The activities co-ordinator told us when people had a special birthday they booked entertainment to come into the home.

We observed care and support. All roles of staff including the management and ancillary staff took the time to engage with people which resulted in a pleasant and inclusive atmosphere. For example, we observed the cleaner took a break from cleaning duties and sat in the lounge engaging in friendly conversation with one person. Staff meeting minutes showed they were instructed to provide social interaction between care and support tasks, demonstrating the service recognised the importance of providing people with companionship and interaction.

We saw people's privacy, dignity and human rights were respected. For example, staff asked people's permission and provided clear explanations before and when assisting them with medicines and personal care. This showed people were treated with respect and provided with the opportunity to refuse or consent to their care and/or treatment. Staff knocked on doors before entering and ensured people's dignity was maintained during moving and handling tasks such as hoisting. We saw people's bedrooms were neat and tidy and personal effects such as photographs and ornaments were on display and had been looked after.

People who used the service told us the laundry service was good and we saw people looked well dressed. This showed staff respected people and their belongings.

People and relatives reported no restrictions on visiting times. We saw relatives arrived throughout the day and receive a warm welcome from staff. Relatives we spoke with told us staff were friendly and helpful and they were made to feel welcome when they visited.

Throughout the inspection we saw staff supported people to express their views. Staff asked people what they wanted to eat for breakfast and lunch and patiently took the time to listen to their responses. People we spoke with told us they felt listened to and involved in their plans of care. The activities co-ordinator demonstrated flexibility in the activities they provided, asking people want they wanted to do and respected these choices. Discussions with staff demonstrated a culture whereby people's choices were sought and respected in all areas of care and support. People's views were also sought through regular surveys of the food and quality of care and review meetings. There was a culture of involving people and relatives in the home. For example, the home was currently consulting people and relatives about installing CCTV within the home to provide a more secure environment. People's views had been gained through a period of consultation. This demonstrated the home involved people in important decisions being made within the home.

Good

Is the service responsive?

Our findings

People and relatives told us the service provided appropriate care to meet people's individual needs. Relatives told us that people's personal care needs were met and they were always clean and tidy. We saw people looked well cared for, clean and wore appropriate clothing.

We asked people using the service if they received the care and support they wanted. One person told us, "The staff always come quickly if I press my buzzer." Another person told us, "I get help to get a bath or a shower. A relative told us, "If [Name] needs anything [Name of registered manager] will go out and get it for [person]."

We looked at the care files for two people who had recently moved into Langdale Residential Home and saw two members of staff had been to see them prior to admission. At this visit they completed a full assessment of their care needs and social interests. From this assessment we saw detailed care plans were put in place ready for their admission to the service. This showed us staff ensured people's needs were fully assessed prior to admission to aid in the provision of appropriate care. We reviewed six people's care records which were detailed and person-centred. They showed what the person could do for themselves and the support they needed from staff which included any particular preferences, for example around care, support and food.

People and relatives told us they felt involved in their care and support. We saw care plans were reviewed on a monthly basis to check if any changes needed to be made to people's care and support. We saw the reviews gave a good overview of people's well-being for the previous month and identified any new issues.

Daily handovers between care shifts took place which helped the transfer of importance information between staff groups. Staff we spoke with said these were useful and gave examples of how they had used new information received through this channel to make changes to people's plans of care. We asked staff a number of questions about care and support. Answers demonstrated they understood people well and their individual needs.

People we spoke with praised the activities provided by the home. One person told us how they had particularly enjoyed a game of bingo the day previously and they had won a prize. We asked people who used the service how they spent their time. One person told us they liked to watch television and another said, "We have an activities woman who does bingo and that." People also told us they sat outside when the weather was nice and could go for a walk with staff if they wanted. A relative told us, "There are activities every day; last week they did some dancing and took a video." There was an activities co-ordinator who worked five hours each weekday. At weekends the care staff took responsibility for organising movie afternoons.

We saw people's care files contained information about how people liked to spend their time; for example reading the newspaper, doing crosswords, watching television , listening to music and singing. We saw a range of activities were on offer during the week and at weekends. These included baking, bingo, floor

games, chair exercises and pamper sessions. We saw the activities co-ordinator spent time with individuals and small groups. At breakfast time one person asked the activities co-ordinator if they could take them out to get a new pair of shoes. This request was accommodated and they returned later on in the morning and showed us the new shoes they had purchased.

We saw the activities programme was flexible and responded to what people wanted to do on the day. For example, the planned activity on the day of our visit was 'pamper session'. However no one wanted to be pampered so a game of 'Play Your Cards Right' was organised.

Information on how to complain was on display throughout the home and within the service user guide to bring it to the attention of people who used the service. A system was in place to log, investigate and respond to any complaints. We saw no formal complaints had been received about the service since 2014. People and relatives we spoke with said they were very satisfied with the service. We asked people who used the service and relatives what they would do if they had any concerns. They all told us they would speak with the registered manager. One relative told us they had raised a minor issue and the manager had dealt with it straight away.

Requires Improvement

Is the service well-led?

Our findings

Systems to assess, monitor and improve the service were in place but these were not always sufficiently robust. Audits of infection control, the premises and cleaning took place monthly. We saw evidence these had identified some issues and actions taken action to resolve them.

At the last inspection in October 2015 we identified medicine management audits were not sufficiently robust as they focused solely on stock level checks. We identified this was still the case at this inspection, with a lack of audit of other aspects of the medicine management system such as checking people were receiving their medicines as prescribed, storage and safe ordering and disposal arrangements.

At this inspection, we also identified a lack of care plan audits. We identified a number of issues within the care plans we looked at. For example, the information on one personal emergency evacuation plan [PEEPS] was inaccurate as it stated the person was mobile with a zimmer frame when in fact they required the use of a hoist for all transfers. None of the PEEPS were dated. We saw one person's continence needs had changed at the end of September 2016, but their care plan had not been up dated. We asked the deputy manager about their current support needs and they were able to give a good account of their current needs and the plan was updated before we discussed our findings on the day of our visit. Where best interest decisions had taken place, these were not always robustly documented. These discrepancies could have been identified and rectified through a robust system to audit care plan documentation.

We found documentation was not sufficiently robust in other areas. We found the administration of topical creams was recorded in two different places with sometimes conflicting information recorded on when people had received support with these medicines. Although the registered manager had clearly assessed the risks associated with the premises and put several new control measures in place, this was not formalised into a documented risk assessment. The fire risk assessment also needed updating to reflect the new control measures in place. When we looked in the staff files we found although appraisals had been completed many were not dated so it was not clear which ones were the most recent.

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

Incidents and accidents were logged, investigated and action taken to prevent a re-occurrence such as the updating of risk assessments and the installation of physical control measures. The number of incidents and accidents including falls was analysed every month. Falls analysis was detailed and looked at the time, type and severity of incidents in order to try and establish if there were any trends which needed investigating.

Periodic staff meetings were held. The last meeting was held in May 2016, we saw evidence a number of quality issues were discussed about the home to help drive improvement.

People and relatives spoke positively about the overall quality of the service. They said they received a highly personalised service. People identified the registered manager by name and told us they were approachable and they could talk to them. We asked people who used the service if they would recommend

it to others, and they said they would. One person said, "If you want to be comfortable and looked after, this is the place to be." Another person told us, "Two big lounges, TV, it's kept nicely decorated, and the staff are good." We observed a positive and inclusive atmosphere within the home with good friendly interactions between people and staff.

We asked staff about the leadership of the service, they all said it was well led. For example one staff member told us "[Name of registered manager] is always there and has got everyone's back. I couldn't have a better manager." Staff reported morale was good and that staff and people got on very well together.

We saw one of the objectives for the service was, 'To provide a homely comfortable environment where residents receive the care and support they need to maintain their well-being, dignity and optimum independence.' From speaking with people who used the service, relatives, staff and from our own observations we concluded these objectives were being achieved.

An established registered manager was in place. We found the required notifications had been submitted to the Care Quality Commission such as allegations of abuse or notification of any death.

The manager told us the home did not hold residents' meetings as they had found they were not a successful way to gain feedback from people or their relatives. As the home was small and the manager was very visible, feedback was gained on an informal and individual basis. We found the manager had a good understanding of the people they were caring for and their requirements. People also provided feedback on the service through more formal mechanisms such as care reviews and regular surveys. We saw two sets of surveys had been conducted within 2016. These were divided into two sections, one that looked at food and the other the quality of care. Responses were all very positive with people and relatives describing care as good or excellent. We saw where some suggestions had been made such as regarding future meals the registered manager had noted and was in the process of addressing these. They told us they were planning to install a 'You said, we did' board so people could see the actions taken as a result of issues raised.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance (1) (2b) (2c) (2d) Systems to assess, monitor and improve the service were not sufficiently robust. A complete and accurate record in respect of each service user was not always kept. Sufficient records in relation to the management of the regulated activity were not consistently kept.