Care Quality Commission

Continuum Healthcare Limited

Ashcroft Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

The inspection of Ashcroft Nursing Home took place on 9 November 2015 and was unannounced. The previous inspection had taken place on 3 October 2013. The service was not in breach of the health and social care regulations at that time.

Ashcroft Nursing Home is registered to provide accommodation for up to 40 people who require nursing or personal care. There were 40 people living at the home at the time of the inspection. The home was a detached property with accommodation provided over three floors, which were accessible by two passenger lifts. There was an enclosed, well maintained garden.

The service had a registered manager 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they felt safe living at Ashcroft Nursing Home. Staff had received safeguarding training and were able to recognise potential signs of abuse.

Summary of findings

Some safeguarding incidents had not been reported in line with safeguarding procedures. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care and treatment was not always provided in a safe way, in line with the person's needs and care plan.

Some risk assessments had been completed to ensure people could maintain their independence whilst minimising risks. However, risk assessments had not been completed in some situations, for example when oxygen was being used and stored.

The building was maintained and appropriate health and safety checks were completed regularly, in order to help keep people safe.

Staff were recruited safely with appropriate checks being made. Although staff received regular training in areas such as safeguarding, first aid, fire safety and infection control, many staff had not received training in the Mental Capacity Act 2005.

Although some people were asked for consent in relation to some aspects of their care, some people did not receive care and support in accordance with the principles of the Mental Capacity Act 2005. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people were being deprived of their liberty and the registered manager had made applications to the local authority, in order for this to be lawful and for people's rights to be protected.

People received appropriate support to help them maintain a healthy diet.

There were mixed responses from people regarding whether they found staff to be caring. Our observations were that some staff were more caring than others.

People told us they could make their own choices and we saw choice being offered.

People's needs were regularly reviewed and people were involved in their care planning.

Relatives, people and staff told us they felt the registered manager was approachable. We found the registered manager to be open and transparent during the inspection.

Regular audits took place but it was difficult to establish what action had been taken because this was not accurately recorded.

Systems and processes had not been operated and established to ensure the regulations of the Health and Social Care Act 2008 were being met. This was breach of Regulation 17 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.

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

The service was not always safe.

People told us they felt safe.

Safeguarding procedures, intended to protect people and keep people safe, were not always followed.

Medicines were managed and administered safely.

People did not always receive care and support in line with their identified need.

Is the service effective?

Requires improvement

The service was not always effective.

Staff had received some training but most had not received training in the Mental Capacity Act 2005 (MCA).

Some people did not receive care and support in accordance with the principles of the MCA.

People were supported to maintain a healthy diet.

People had access to health care services when they needed them.

Is the service caring?

Requires improvement

The service was not always caring.

There were mixed views regarding whether staff were caring.

We observed some people's privacy not being respected.

End of life wishes were respectfully considered.

Is the service responsive?

Requires improvement

The service was not always responsive.

People told us they felt they had choice and control.

Care plans were reviewed regularly and people, and families where appropriate, were involved in this.

Care plans did not always provide sufficient detail for staff to provide effective care.

Is the service well-led?

Requires improvement

The service was not always well led.

There was an under-reporting of incidents and the registered manager did not always report incidents that they had a duty to report.

Summary of findings

The registered manager was open and transparent and responsive to feedback given at the inspection.

Regular audits took place although it was not always possible to identify the actions taken.

Ashcroft Nursing 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 check whether the provider was 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.

The inspection took place on 9 November 2015 and was unannounced. The inspection was carried out by two adult social care inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Before the inspection, we reviewed the information we held about the home and contacted the local authority.

We had not sent the provider a 'Provider Information Return' (PIR) form prior to the inspection. This form enables the provider to submit, in advance, information about their service to inform the inspection.

We used a number of different methods to help us to understand the experiences of people who lived at the home. We spoke with ten people who lived at the home, five family members of people who lived at the home, two care staff, a cook, the activities coordinator, a registered nurse and the registered manager.

We looked at four people's care records, four staff files and training data, as well as records relating to the management of the service. We looked around the building and saw people's bedrooms, with their permission, bathrooms and other communal areas.

Requires improvement

Is the service safe?

Our findings

People told us they felt safe. One person said, "I feel safe. They come into the bedroom at night about twice to see if I'm alright." Another person told us, "I always feel safe here."

One person told us, "I understand my medicines. I get them breakfast, dinner and bed time. I feel safe. I have my walking frame and I can do things for myself."

People told us they were responded to quickly if they needed help. The people and relatives we spoke with told us they felt there were enough staff, although they felt staff were very busy. One person told us, "There are lots of staff but I don't need much help." A family member said, "They have quite a few staff at the moment." However, one family member did share they felt that staff were stretched and another told us they felt more qualified nurses were needed.

The registered manager told us that a dependency tool was used in order to determine the number of staff required. We saw this tool took into account people's needs such as how many staff were required to support each person. We saw that the number of staff identified as being required were deployed and we observed people's needs being met. We noted there was only one member of staff permanently allocated to the dementia unit. This member of staff was a senior and they told us they buzzed for assistance from other members of staff, when required, and they felt this worked well. However, we noted there was only one set of keys in order to access medication. We observed the staff member leave the unit in order to find the keys, without buzzing for assistance; leaving the unit unstaffed. We advised the registered manager of our observation, who agreed to address this.

When we asked a staff member whether they felt there were enough staff, they told us, "Some days staffing is okay. We have good and bad days. We normally manage." The registered nurse told us they felt there were enough staff. Furthermore, we were advised that consideration was given to the skills mix of staff to ensure that people were supported by staff that had the knowledge they required to perform their role.

The registered manager had an understanding of safeguarding vulnerable adults and was able to identify potential signs of abuse. The registered manager outlined the procedures they would follow if they suspected anyone was being abused or was at risk of harm. The registered manager was able to facilitate training to staff because they had attended a 'train the trainer' course. The staff we spoke with were also able to describe different types of abuse and tell us how they would recognise signs of abuse. Staff told us they would report any incidents to their senior and to the registered manager.

There is a requirement to report any allegations of abuse to the local authority safeguarding team and to the Care Quality Commission (CQC). However, we found the registered manager had not always done this. For example, a person had alleged that some money had gone missing from their personal wallet. This was not reported and the registered manager was unable to locate the outcome of an investigation into the incident. A further incident, which resulted in a skin tear on a person's hand, should have been reported to the safeguarding team and to CQC and this was also unreported. We discussed our concerns with the registered manager and advised them to refresh their knowledge in relation to their obligations to report specific incidents. The registered manager contacted us following the inspection to show us they had amended their processes to ensure that future reporting took place. It is important to have robust safeguarding reporting procedures so that people are protected from abuse and improper treatment.

This demonstrated a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because systems and processes were not established and operated effectively in line with safeguarding reporting procedures.

We found that accidents and incidents were recorded and analysed monthly. There was evidence that this had resulted in actions being taken, such as falls sensor mats being used and referrals to other professionals. This showed the home analysed accidents that may result in harm to people and made changes to their care and treatment where necessary.

Risk assessments were in place and were evaluated monthly. The registered manager was clear they wanted to empower people to be as independent as possible but recognised that risks needed to be minimised. The registered manager explained they had worked together with a person who lived at the home in order to develop a risk assessment and minimise risks of the person going into

Requires improvement

Is the service safe?

town. We saw people's care plans contained risk assessments relating to the individual, for example in relation to bed rails, falls and nutrition. This helped to ensure people could maintain their independence whilst minimising the associated risks.

A person living at the home was receiving oxygen treatment. We noted there was no risk assessment in place in relation to this. Wherever oxygen is administered, there is an increased risk of fire. To minimise risk, it is therefore good practice to display a notice indicating that oxygen is in use in a particular area. We highlighted this to the registered manager, who immediately arranged for a sign to be displayed.

We found some actions that had been identified as being required, in order to ensure people's safety, had not been recorded so it was unclear whether actions had been taken. For example, one person was identified as being at risk of developing pressure sores, so they needed assistance to turn on a regular basis. The care plan stated the person required assistance to turn every four hours. A staff member told us the person was required to turn every two hours. The records on the night turning chart documented that, during the night prior to the inspection, the person had not been assisted to turn between 18.00 and 11.25 hours. Due to the records being difficult to read and interpret, it was difficult to determine whether care and treatment had been provided according to the care plan in this instance. We highlighted this to the registered manager.

On the day of our inspection, it was raining heavily and the home had experienced some leaks in the conservatory which resulted in a slippery floor. This had been reported and appropriate yellow warning signs, indicating that the floor was wet, had been placed in the area. This showed that consideration had been given to minimising the risk of people falling.

We found that safety checks such as water temperatures, lift servicing, gas safety and legionella water tests had been completed. Equipment, such as hoists for example, had been recently serviced. This meant steps had been taken to ensure the safety of premises and equipment.

We looked at policies and procedures and found these to be in place for emergencies and for safeguarding and infection control for example. The emergency procedure contained relevant contact telephone numbers in the event of different emergencies such as a lift breaking down, gas or electrical emergency and fire. There was an emergency evacuation plan and a designated place of safety nearby. There was a 'grab and go' pack available so that, in the event of an emergency, all relevant information could easily be obtained, in order to evacuate people as safely as possible.

We looked at four staff files and found that safe recruitment practices had been followed. For example, the registered manager ensured that Disclosure and Barring Service (DBS) checks had been carried out. The DBS has replaced the Criminal Records Bureau (CRB) and Independent Safeguarding Authority (ISA) checks. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups.

There was a disciplinary procedure in place and the registered manager was able to outline the policy to us. Staff were given the policy in their employee handbook, so staff were clear of the expectations from them and what would happen if their performance or conduct fell below that which was expected.

We found medicines were administered and managed safely. Staff who administered medicines had been trained to do so. There were photographs of each individual so that staff could identify the person correctly. The medication administration records (MARs) were clear and the registered nurse responsible for administering medication told us night staff checked signatures against stock to ensure these were correct. Any errors or discrepancies would be reported and investigated. We checked a random sample of the MARs and found there to be no missing information and the number of medicines remaining tallied with the records we looked at. This demonstrated that medicines were administered and managed in a safe manner.

Some people were receiving medication through a patch placed on the body. Where appropriate, body maps were used to indicate the location of the patch on the body so staff knew where to find the patch and where to put a new one. This helped to minimise the risk of errors in administration occurring.

We checked the medicine room and refrigerator temperatures and found these were appropriate for the medicines stored. We checked the controlled drugs, which

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Is the service safe?

are prescription medicines that are controlled under Misuse of Drugs legislation. We saw there was a book which clearly showed medicines received, administered and medicines remaining. Two people signed to show they had checked this. This showed that medicines were being properly controlled.

Hand gel was available for visitors to use. We observed staff using hand gel and wearing personal protective equipment (PPE) during our inspection. We also saw there were notices displaying effective hand washing procedures in bathrooms. There was an 'infection control lead' at the home. This was a member of staff who had received additional training in this area and they attended link meetings with the local authority. This helped to prevent and control the spread of infection.

Requires improvement

Is the service effective?

Our findings

The family members we spoke with told us that staff understood their relatives well. One family member told us, "[name] is deaf and the staff know about that when they interact with [name]."

We spoke to a visiting professional who told us they had no concerns and said, "They're very good here."

We saw that newer staff completed an induction programme. We spoke to a member of staff who told us they had shadowed more experienced members of staff before they were expected to carry out their duties. They told us they had received training in mandatory areas such as first aid, fire safety, moving and handling, safeguarding and food hygiene and we saw that other staff had also received this training. Staff told us they had the opportunity to view care plans before providing care to people. This meant that staff had received essential information, prior to commencing their role.

Although we saw evidence the registered manager had held group supervisions with staff and staff had told us they felt supported, we found there was a lack of regular supervision for individual staff. Furthermore, records of individual supervision meetings were very brief, with only training and development and care practice being recorded as discussed. We discussed this with the registered manager who told us they were responsible for the supervision of all staff and it was therefore difficult to conduct regular one-to-one supervision sessions. The registered manager told us they would give consideration to better planning of supervision meetings and to delegating some of the responsibility.

We looked at the staff training matrix and could see that staff training in areas such as safeguarding, health and safety, fire training and moving and handling were up to date. Furthermore staff had received additional training specifically in relation to different aspects of dementia care. However, we saw that many staff had not received Mental Capacity Act training. For example, of the 22 care assistants listed on the matrix, the record showed that six had completed this training. One of the staff we spoke with told us they had not undertaken any specific mental capacity training and another told us they were about to commence a learning package on-line in relation to mental capacity. Although the registered manager was aware that not all staff had received training in this area and told us this was ongoing, this meant that staff lacked the necessary skills and knowledge to ensure people received care in line with current legislation.

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

We found that people's consent was sought in relation to some aspects of their care and support, for example in relation to photographs being taken. People were asked for their views on whether they would like a key to their own room and whether they would prefer their room to be kept locked. However we found that some people, who were having decisions made on their behalf because staff felt they lacked capacity, did not have the necessary mental capacity assessments in their care plan. We discussed this with the registered manager during our inspection. This demonstrated a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered person did not act in accordance with the Mental Capacity Act 2005.

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). We checked whether the service was working within the principles of the MCA. The registered manager recognised that some people were being deprived of their liberty and applications had been submitted to the local authority, requesting this to be authorised.

We discussed restraint with the registered manager, who told us that restraint was never used. Staff were also clear they would not restrain people. The staff we spoke with told us they used distraction techniques and would leave people and return to them later if people were becoming distressed at care being offered. Staff had received training in 'de-escalation and challenging behaviour.' This demonstrated the home did not use unnecessary restraint.

Requires improvement

Is the service effective?

People told us they liked the food and they made positive comments about the standard and quality of food. Comments included, "The food is marvellous," "The food is very good. I enjoy it," and, "I enjoy a good breakfast. By the time it gets to lunchtime I'm not particularly hungry. But later on at about five o'clock we have dinner. We can have another meal or sandwiches." People also told us they were offered additional snacks and drinks throughout the day and we observed this.

We observed the lunchtime experience and a member of the inspection team ate lunch with people who lived at the home. The tables had been set with cutlery, glasses and napkins. Flowers were on the tables and the dining area looked appealing. The food was served hot and it looked and smelled appetising. Fresh vegetables were served. People were offered extra gravy if they so wished. A range of hot and cold drinks were offered. People were asked if they needed assistance, for example with cutting food, and this was provided where required.

On the dementia unit we observed that a person had their lunch placed in front of them on a plate which had a plate guard. The plate guard is designed to stop any food dropping from the plate onto the table. However, it was poorly positioned so it did not work, and food dropped onto the table and onto the floor. This meant it was difficult for the person to eat a full meal. Furthermore, on the dementia unit, we saw some people were not offered a choice of drinks and were given orange juice without being asked their preference.

The registered manager told us that people's dietary needs were considered and discussed upon admission and reviewed every month. This information was shared with the cook. We saw that people had been referred to the speech and language therapist (SALT) team where appropriate. We spoke with the cook and found they had a thorough understanding of people's dietary needs and food intolerances and the implications of this in preparing people's food. The home had achieved a gold award from the local authority for 'good standards of food hygiene and healthy food options.' This showed people received the support they needed to enable them to maintain a healthy diet.

People had access to health care. People and family members we spoke with told us this was arranged quickly and efficiently when necessary. One family member said, "The staff send for a doctor straight away if there are any problems and let me know." We saw referrals had been made to other professionals when necessary, for example district nurses and the optician.

There was a separate dementia unit which accommodated six people. The registered manager told us they had sought advice from a dementia trainer and looked at dementia studies and best practice guidelines when considering the design of the unit. Consideration had been given to pictorial signage and contrasting colours for example. The unit was designed to visually resemble a street, with access to a well maintained, enclosed garden area. Each person's door was personalised and there were pictures of interest on display. This demonstrated the registered manager considered best practice in order to provide an effective care environment.

Requires improvement

Is the service caring?

Our findings

Some people told us they felt staff were caring. One person told us, "The staff are excellent. The staff are pleasant most of them. One or two are reserved and quiet." Another person said, "It's lovely here. I love it. It's like being at home and I wouldn't change anything."

One person told us, "Some carers are better than others. Some are a bit rough and make you wait if you want to go to bed, especially on a Friday, when [registered manager] is not here." We shared this information with the registered manager.

The family members we spoke with on the day of our inspection also told us they felt staff were caring. Comments included, "This place feels like family," and, "[name] receives unbelievably good care."

A member of staff told us they felt the care offered at the home was person centred and said, "Everyone is different. People get up when they want. We offer people a choice."

Following our inspection we were contacted by a family member who told us they felt that some staff were not as caring as others. They felt that, if people were resistive to care, some staff did not withdraw but could sometimes escalate the situation.

We found from our observations that most, but not all, staff treated people with dignity at lunchtime. For example, one member of staff told a person to, "Put this on," whilst handing the person a clothing protector. Another person had a clothing protector placed around them, without being asked or being spoken to. A different member of staff treated people with more dignity and asked a person if they would like to wear one, "To protect your top." This demonstrated to us that some staff were more caring than others.

One member of staff was asked by a person living at the home whether they were okay. The member of staff said, "I will be at two o'clock when I finish here." This was not caring towards the person who was being supported. We shared this information with the registered manager, who agreed to address this.

Following the lunchtime period, we observed a carer assist a person to the lounge area. The carer asked the person where they wanted to sit and ensured that the person had access to their call bell. This was done in a caring manner, enabling the person to be as independent as possible, whilst maintaining their safety by having access to the call bell.

One member of staff told us they respected people's privacy and dignity by closing curtains and doors and by asking for consent from people before providing care. We observed staff knocking on people's doors prior to entering their rooms. However, the staff we observed did not wait for a response before entering the room. One person told us, "The staff give one knock and come in. They don't wait." This meant that some people's privacy was not respected.

People were able to keep their possessions secure and have their privacy in their rooms if they wished. One person told us, "I don't have a key to my room but if I asked they'd give me one. Stuff doesn't go missing here anyway." Another person told us, "I have a key and I lock my room. They come for my key when they want to clean my room."

People had their religious needs met and they received support to enable them to practice their faith. Regular faith services were held at the home.

The registered manager told us that end of life wishes were sensitively discussed with people, and their families where appropriate, as well as Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) choices. We saw that DNACPR information was contained within people's care plans. This showed that respect was given to people's end of life wishes.

Requires improvement

Is the service responsive?

Our findings

One person told us, "I've got my own room. It's nicely furnished and I've got my telly and my own fridge. I've got everything I need." A relative told us, "The bedroom's comfortable and kept clean. [Name] has [name]'s own ornaments, photos and teddies in the room."

People told us they could make their own choices, for example whether they preferred to bathe or have a shower, when they wanted to retire on an evening or rise in a morning. One person told us, "I get up and go to bed whenever I want." Another said, "I do what I want."

People were clear about what they would do if they had any concerns or complaints. Comments included, "If I don't like anything I can tell them," and, "I ask questions if I don't understand anything. I'm not scared to share my opinion."

A family member told us they were involved in the care planning and assessment process when their relative moved to the home. We were told, "The staff discussed [name]'s care with me when [name] first came. Another relative told us, "The doctor came when [name] move in as [name] was a new patient."

We looked at four people's care files. They contained important details such as a clear photograph of the person, what the person preferred to be called and a short biography which gave the reader an understanding of the person's background and history. People's care plans provided information regarding individual care needs and essential information pertaining to the level of support people required was documented. The staff we spoke with demonstrated they were aware of people's needs and had read their care plans. For example, one person's care plan highlighted the need for the person to sit on a pressure cushion, to provide protection for their skin. We observed this in practice and staff moved the pressure cushion to the wheelchair when the person was assisted to transfer into their wheelchair. This was an example of care and support being provided in line with a person's care plan.

We found some people's care plans to be lacking in information. For example, one person's care plan stated the person could be resistant to care and therefore distraction techniques were to be used. However, the plan did not state what the distraction techniques were or what staff should do. Another plan stated a person may become repetitive and question their whereabouts. There was no action or guidance, advising care staff of what action to take in these circumstances. Another person's care plan highlighted that the person 'needs assistance' with nutrition, but did not detail what level of assistance and what staff should do. This meant that staff may not have had sufficient information in order to provide effective care to people.

We saw people's care needs and plans were reviewed monthly and people were asked whether they would like to be involved in this. This helped to ensure people's needs were being met appropriately.

The home had an activities coordinator. There was an activities programme and we found there were activities planned for 18 days out the 30 days during the month of our inspection. These included hairdressing, board games, jigsaws, cinema sessions, bingo, light exercises and memory games for example. We observed one of the activity sessions, which we found to be age appropriate and suitable to the group. However, we found the delivery of the session was fast paced and there were missed opportunities for reminiscing or opportunities to reflect. We felt this could have enhanced the activity and experience for people. Having a dedicated activities coordinator meant that staff at the home were able to continue to deliver care whilst people participated in activities.

We spoke with the activities coordinator, who told us they tried to involve everyone in choosing and developing activities. There was a monthly planner on the noticeboard and people could choose what they wanted to do. Some people had assisted to plant herbs as well as flowers. The activities coordinator told us this was so that, if people's sight was limited and they could not visually appreciate the flowers, they could experience the smell of the different herbs. Furthermore, if people were unable to assist with planting due to a physical impairment, they were involved in selecting different coloured flowers and choosing the design and layout of the area. This demonstrated that consideration had been given to people's individual needs.

People chose whether they wanted to participate in activities. One person told us they chose to go to their room after lunchtime. They told us, "I go to my room at 1 o'clock to watch my soaps. I've got lots of channels on my television. I can go to bed and watch TV. I prop myself up with my pillows."

Requires improvement

Is the service responsive?

People and their families were encouraged to attend the next residents' forum, which was a few days after our inspection. This was advertised on the noticeboard. We saw minutes from previous forums and issues discussed included the upkeep and layout of the building, staff, ideas for activities, any complaints and food. The meetings were well attended by families as well as people who lived at the home. There was a recently created hair salon, which the registered manager told us had been designed as a result from feedback from people living at the home. This showed that people living at Ashcroft Nursing Home were involved and consulted in decisions about the home.

We saw, in one person's bedroom, a sign had been placed on their door. It was positioned so the person would see the sign when they left the room. It reminded the person which glasses to wear for what circumstances, for example for seeing into the distance or close up. The sign was pictorial to make it easier to understand. This showed the home provided care in a personalised way and this helped to keep the person safe.

We found the environment to be clean, airy and odour free. The lounge area was large but chairs were arranged in smaller clusters, which provided people the opportunity to socialise. Additionally, there was a quieter area for people who preferred this.

Requires improvement

Is the service well-led?

Our findings

The home had a registered manager in post, who had been registered with the Care Quality Commission to manage the home since 2011.

All of the relatives we spoke with and most people knew who the registered manager was. One family member said, "I've been to the relatives' forum. I know who the manager is. She's lovely and really approachable." Another said, "I'd go see the manageress if I had a problem. Everything's been fine."

Staff told us they felt the registered manager was approachable and supportive. One member of staff told us, "I'd tell [registered manager] if there were any issues. It's an open door policy."

We were provided with staff meeting minutes dated March and June 2015. These minutes showed staff had been reminded about good practice, for example to ensure that buzzers were within reach of people. Staff meetings are an important part of the registered manager's responsibility in monitoring the service and coming to an informed view regarding the standard of care and treatment for people living at the home.

We saw the complaints procedure was displayed. The registered manager told us they proactively sought feedback from people and relatives and they saw this as an opportunity to improve the service. We saw there was a complaints and compliments box in the reception area to enable people to leave comments and suggestions.

The registered manager had due regard for the duty of candour, which meant they acted in an open and transparent way. The most recent inspection ratings and infection control report were displayed and shared on the noticeboard for anyone who wished to see it.

Registered managers have a duty to report specific incidents to the Care Quality Commission (CQC). We found there to be an under-reporting and incidents that should have been reported were not. For example, the registered manager had kept a safeguarding consideration log but had not reported incidents appropriately. We reminded the registered manager of their duties in relation to this. The registered manager was responsive to this and took action following the inspection.

There were links with the local community. For example, the home held a summer fayre and invited people from the wider community to attend. This raised money for the residents' fund. Additionally, there were links with a local school and students were invited to a coffee morning.

The registered manager felt supported by the registered provider. They told us the registered provider was regularly involved in providing advice and support, for example with training suggestions and equipment advice.

Regular audits were undertaken in relation to cleanliness, equipment, mattresses and pressure sore prevention for example. We saw in some cases that actions had been taken, such as new mattresses being ordered and provided. However, we found that actions resulting from audits were not always recorded as being completed. For example, an action from a cleanliness audit stated 'bread storage bin to clean'. However, the 'date action implemented,' section of the form was not completed, so it was unclear whether the necessary cleaning had been undertaken.

There was an audit tools file, which contained the tools and timescales of the different audits that were required. The actual audits were then held in different files. We found it difficult to navigate through the information to find relevant details for each audit, because the numbering system had been updated in one file but not in another and therefore they did not correlate. We shared this with the registered manager, who agreed that the system needed simplifying. It is important that registered providers have systems in place for regular audits so they can monitor and improve the safety and quality of service.

The registered manager told us that questionnaires were sent to people living at the home, families and other professionals every six months. We saw 'quality of life' questionnaires had been completed by people during July 2015. There was an action log for these, although the comments were positive and no actual actions were recorded as being required. This demonstrated the registered provider had been proactive in obtaining people's views. It is important to obtain feedback from people because this can be used to drive improvements.

A registered manager has responsibility to ensure that systems and processes are established and operated effectively so that the requirements of health and social care regulations are met. We found an under-reporting of incidents and some regulations were not being met.

Requires improvement

Is the service well-led?

Although the registered manager was responsive and engaging with us at the inspection and agreed to take action, this demonstrated a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because systems and processes had not been operated and established to ensure the regulations were being met.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The registered person did not act in accordance with the Mental Capacity Act 2005 and staff who obtained consent of people who used the service were not familiar with the codes of conduct associated with the Mental Capacity Act 2005. Regulation 11(3).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **Systems and processes were not established and operated effectively to prevent abuse of service users. Regulation 13(2).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Systems and processes were not established and operated effectively to ensure compliance with the requirements of Part 3 of the Health and Social Care Act 2008. Regulation 17(1).**