St. Cloud Care Limited

Chestnut View Care 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?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

This inspection was carried out on the 31 March 2015. Chestnut View Care Home is a service that is registered to provide accommodation and nursing care for 60 older people some of who are living with dementia. They also provide respite care. (Respite care is a service giving carers a break by providing short term care for a person with care needs). The registered provider is St. Cloud Care Limited. Accommodation is provided over three floors. The top floor is primarily for people with nursing needs, the first floor is for people living with dementia and nursing needs and the ground floor is primarily for people living with dementia. On the day of our visit 48 people lived at the service.

There was a registered manager. 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.

Summary of findings

Policies for staff in relation to people's medicines were not always up to date. This meant that staff would not be aware of the most up to date guidance. Peoples' medicine charts were not always completed clearly and accurately. Medicines were stored appropriately and audits of all medicines took place. Staff did not always have the most up to date guidance in relation to their role. Training which the service considered mandatory had not been completed by all of the staff and nurses were not up to date with their clinical knowledge.

One to one meetings were not regularly undertaken with staff and their manager and appraisals had not taken place for all staff. There were mixed reviews about the competencies of staff from health care professionals. One told us that staff did not always have the right knowledge or confidence to deal with clinical concerns.

There were sufficient numbers of staff on duty to meet people's needs. People and relatives said they felt their family members were safe. One person said "I am very comfortable here and would speak to management if I was concerned."

Staff understood what it meant to safeguard people from abuse and how to report any concerns.Risk assessments for people were up to date and detailed. Each risk assessment gave staff information on how to reduce the risk. These included risks of poor nutrition, choking and falls. Staff had a good understanding of people's risks.

There were complete pre-employment checks for all staff. This included full employment history and reasons why they had left previous employment. This meant as far as possible only suitable staff were employed.

Staff had knowledge of their responsibilities under the Mental Capacity Act 2005 (MCA), and the Deprivation of Liberty Safeguards (DoLS). However the registered manager had not always submitted DoLS applications to the local authority where it was appropriate to do so. The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. We saw that where 'Do Not Attempt Resuscitation' (DNAR) forms had been completed for people who lacked capacity there was no evidence that capacity assessments had been completed for this or other decisions that needed to be made.

Staff gave examples of when and why they would ask people for consent in relation to providing personal care. We saw several instances of this happening during the day.

People and relatives said that the food was good. People were encouraged to make their own decisions about the food they wanted. We saw that there was a wide variety of fresh food and drinks available for people. Those people who needed support to eat were given it. One person said " Food is good, there is a lot of choice."

People had access to health care professionals as and when they required it. We saw several examples of visits from health care professionals on the day of our visit.

People and relatives felt that staff were kind and considerate. One person said "Staff are kind - I like the night nurse who puts me to bed and talks kindly." People were treated with kindness and compassion by staff throughout the inspection. Staff acknowledged people warmly and sat talking with people. Where people were anxious staff responded in a caring and reassuring way.

Staff knew what was important to people. We saw that staff knew and understood people's needs. People and relatives had the opportunity to be involved in the running of the service. Residents and relatives meetings were held and the minutes showed discussions about the activities and the refurbishment of the building.

People were treated with dignity and respect. Staff knocked on people's doors and waited for a response before entering and personal care was given in the privacy of people's own rooms or bathrooms.

The provider did not supply any evidence of complaints however there was a complaints policy which people and relatives had knowledge of.

People's personal history, individual preferences, interests and aspirations were all considered in their care planning. Plans provided staff with information so they could respond positively, and provide the person with the support they needed in the way they preferred.

Care plans were reviewed every month to help ensure they were kept up to date and reflected each individual's current needs. We found instances where a change had occurred and care was changed to reflect this. Staff responded to people's needs as and when they needed it.

Summary of findings

There was a programme of activities in place and an activities coordinator who worked part time at the service. Activities included entertainment, trips out to the local café, arts and crafts, and reminiscence sessions.People were also supported to access the outside community.

Audits of systems and practices carried out where not always effective. Where concerns had been identified these were not always addressed. Incidents and accidents were recorded but there was no analysis of these.

Staff said they felt supported or motivated in their jobs. Regular staff meetings took place and staff contributed to how the service ran. Meetings were minuted and made available to all staff. Relatives meetings were organised where discussions took place around events and work being done in the service.

Annual surveys were sent to the relatives and responses had been received which were very complimentary of the service.

You can see what action we told the provider to take at the back of the full version of the report.

We found breaches 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 were at risk because their medicines were not being managed appropriately in relation to medicines prescribed to be administered 'as and 'when'.

Medicines were stored and disposed of safely.

There were enough qualified and skilled staff to meet people's needs.

Risks were assessed and managed well, with care plans and risk assessments providing clear information and guidance to staff.

Staff understood and recognised what abuse was and knew how to report it if this was required.

All staff underwent complete recruitment checks to make sure that they were suitable before they started work.

Is the service effective?

Requires improvement

The service was not always effective. Staff had not received appropriate up to date clinical and service mandatory training. They had not had regular supervision meetings with their manager.

Mental Capacity Assessments had not been completed for people where they lacked capacity and not all appropriate forms had been submitted to the local authority where people who were unable to consent were being deprived of their liberty.

People had been effectively assessed or care delivered appropriately to meet their individual needs.

Staff understood people's nutritional needs and provided them with appropriate assistance. People's weight, food and fluid intakes had been monitored and effectively managed.

People's health needs were monitored.

Is the service caring?

Good

People were treated with care, dignity and respect and had their privacy protected.

Staff interacted with people in a respectful or positive way.

People told us staff were caring and we observed that people were consulted and involved in their care and the daily life in the service.

Is the service responsive?

Requires improvement

The service was not always responsive. Complaints were not recorded and logged. Staff did not always respond appropriately to meet people's needs.

Summary of findings

Staff we spoke with knew people they were supporting. We saw there were activities and events which people took part in.

Is the service well-led?

The service was not well-led. There were not effective procedures in place to monitor the quality of the service. Where issues were identified and actions plans were in place these had not always been addressed.

Staff said that they felt supported, listened to and valued in the service.

Requires improvement

Chestnut View Care 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 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 which took place on the 31 March 2015. The inspection team consisted of two inspectors, a nursing specialist and an expert by experience in dementia care. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we reviewed the information we had about the service. This included information sent to us by the provider, about the staff and the people who used the 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.

During the visit, we spoke with 18 people who used the service, nine visitors, 11 members of staff, one GP, one physiotherapist, one hairdresser, two visiting nurses and the registered manager. We spent time observing care and support in communal areas. Some people could not let us know what they thought about the home because they could not always communicate with us verbally. Because of this we spent time observing interaction between people and the staff who were supporting them. We wanted to check that the way staff spoke and interacted with people had a positive effect on their well-being.

We looked at a sample of seven care records of people who used the service, medicine administration records, four recruitment files for staff, supervision and one to one records for staff, and mental capacity assessments for people who used the service. We looked at records that related to the management of the service. This included minutes of staff meetings and audits of the service.

The last inspection of this home was in 26 September 2014 where we found our standards were being met and no concerns were identified.

Requires improvement

Is the service safe?

Our findings

People and relatives said that they felt their family members were safe with the staff that looked after them. One relative said "I don't have a sense that my mother would not be safe (with staff) when I go home."

Some of the guidance for use of medicines was not clear. Medicines to be used "As required", had different records relating to their administration. Those medications prescribed by the GP, had full information regarding their use and dosage, however those prescribed by the hospital had little guidance for staff to follow. Some of the hand written Medicines Administrations Records (MARs) MAR charts were untidy and not easy to read. In addition, when the medicine was a variable dose, for example one or two tablets could be given; the amount given was not always recorded. This meant it was not always clear exactly what people had been given. There was a risk that people may not have received their medicines when they needed them. This is a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were stored appropriately and audits of all medicines took place. The medicine rooms were kept locked and only appropriate people were able to access the rooms. Each room was tidy and contained sharps disposal bin and a yellow collection container for unused medications. The medicines cabinet was secured to the walls and locked. We looked at the MARs charts for people and found that administered medicine had been signed for. All medicine was stored and disposed of safely. There was information and an incident form for reporting medication errors .The medication policy covered the principals of medications and referred to NMC guidance and the Royal Pharmaceutical Society guidance. The policy covered receipt and administration of medications, as well as covert medications . (Covert medication is the administration of any medical treatment in a disguised form. This usually involves disguising medicine by administering it in food and drink. As a result, the person is unknowingly taking medicine.)The overall medicines policy was dated 2011, and should be reviewed as changes in good practice may have occurred.

We saw people being given their medicines in a safe way and with an explanation from staff.

Staff had knowledge of safeguarding adult's procedures and what to do if they suspected any type of abuse. Staff said that they would feel comfortable referring any concerns they had to the manager or the local authority if needed. One staff member said "People are safe here; I would be comfortable referring any safeguarding concerns if I needed to." Another told us "We can speak openly to our manager about any concerns." There was a Safeguarding Adults policy and staff had received training regarding this which we confirmed from the training records. There were flowcharts in the offices on each floor to guide staff and people about what they needed to do if they suspected abuse.

Risk assessments for people were detailed and informative and included measures that had been introduced to reduce the risk of harm based on pre admission needs assessments. This included management of manual handling, nutrition, skin care, personal care, communication needs, medication management, continence management, and provision of activities, Risk assessments were also in place for identified risks which included malnutrition and choking and action to be followed. One person was at risk of falling. We saw that staff always supported this person when they walked around the service. There was clear guidance to staff on the risks and what they needed to do to support this person. Risk assessments were assessed monthly and sooner if this was needed.

The environment was set up to keep people safe. The building was secured with key codes to internal doors and external doors. Window restrictors were in place to prevent people falling out of windows. Equipment was available for people including specialist beds, pressure relieving mattresses and specialised baths and hoists on every floor. People were able to move around the home if they wanted to. In the event of an emergency, such as the building being flooded or a fire, there was a service contingency plan which detailed what staff needed to do to protect people and make them safe. There were personal evacuation plans for each person that were updated regularly. There were sufficient members of staff on duty. The registered manager told us that each person's needs were

assessed to identify how many staff were needed to care for them. They said that two nurses and seven carers were

Requires improvement

Is the service safe?

needed to safely meet people's needs. We saw from their rotas that the assessed numbers of staff were always on duty. Where there was a gap in staffing levels the registered manager would call upon agency staff. On the day of the inspection we saw that there were enough staff and three staff that we spoke with felt that this was the case. One member of staff said that they would like to have more staff in order to spend more "Quality time" with people however another member of staff said "We rarely have less staff than is needed." The registered manager told us that there was a service dependency tool however on the day of the inspection this had not been completed and there were no records of when this tool had ever been used.

Staff recruitment files contained a check list of documents that had been obtained before each person started work. We saw that the documents included records of any cautions or conviction, two references, evidence of the person's identity and full employment history. This gave assurances to the registered manager that only suitably qualified staff were recruited.

Requires improvement

Is the service effective?

Our findings

People and relatives said that staff understood their needs. One relative said "On the whole they (staff) know what mum needs; they contact the GP if she has any problems at all." One person said "We couldn't be anywhere better." We saw staff interact with people and it was clear they knew and understood them.

Staff were not kept up to date with the required service mandatory or clinical training. Records showed that out of 51 staff 43 had not had dementia training, 36 had not had fire safety training and 49 had not had first aid training. Nursing staff had not had up to date clinical training. We asked for details of what clinical training had been provided but the registered manager did not provide this. One clinical member of staff said that some of the nurses needed more training and updating in blood taking and updated knowledge with syringe drivers. This meant that not all staff had the appropriate and up to date guidance in relation to their role. Staff commenced training during their induction, and had a probationary period to assess their overall performance.

Staff were not always supported to provide the most appropriate care to people. We asked the registered manager for evidence of staff supervision and appraisals. No evidence was provided and staff confirmed that these did not always take place. Nursing staff's competencies should be assessed regularly to ensure that they are making decisions in line with the latest clinical guidance. We saw that for staff that had been there more than a year 10 had not had an appraisal. There was a risk that people may not be effectively cared for. These are breaches of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were mixed reviews about the competencies of staff from health care professionals that we spoke with. One health care professional said "The nurses need to be more pro-active with their care; they need to have additional training to build up their confidence." The registered manager told us that they worked closely with health care professionals and sought their advice when needed. Another health care professional told us that they had "No concerns with the care staff."

Staff were informed about their responsibilities under the Mental Capacity Act 2005 (MCA), and the Deprivation of Liberty Safeguards (DoLS). The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. No records of MCA assessment were available to us. The registered manager was not sure whether these assessments had taken place. There were no records of any decision around why it was in someone's best interest to restrict them of their liberty. We found examples where people (who lacked capacity) had rails placed on their beds to prevent them from falling. There was no record of any best interest decision around this.

The front door and doors to each corridor had a coded door entry system. Not all of the care plans we looked at contained MCA assessments or DoLS applications in relation to people not being able to access the code. The registered manager said that they had made all the applications they needed to Surrey County Council in relation to people that lacked capacity where they felt their liberty may be restricted in relation to the doors. However they were not sure whether DoLs applications had been submitted for people who lacked capacity and had bed rails on their beds. We saw that where 'Do Not Attempt Resuscitation' (DNAR) forms had been completed for people who lacked capacity (as stated on the forms) but there was no evidence that capacity assessments had been completed. These are breaches of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 11 and 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff gave examples of where they would ask people for consent in relation to providing personal care. We saw several instances of this happening during the day including staff asking people if they wanted support with their drink or whether they could enter people's rooms. Staff told us that if people refused care and the person became agitated they would leave the person and then ask them again later.

All of the people we spoke with said that they enjoyed the food at the service. People said that the food was good and

Requires improvement

Is the service effective?

that there was plenty of it. One person said "If I don't like what is on offer the chef will cook me a baked potato or make me a sandwich which is most kind." Another said "They feed you well, I eat most things, and I enjoy fish and chips and curries."

People had a choice of where to have their meals, either in the dining room or their own room. A menu was displayed in the dining room for people. Where people were unable to read the menu staff showed people both meals and asked them what they preferred. We observed lunch being served, we saw that staff engaged with people, offered choices and provided support to eat their meal if needed. One person told us that the meal that day was delicious. The dining room was bright and airy and the tables were nicely laid. People had their special places where they liked to sit and there was a relaxed and sociable atmosphere in the room. People who ate in their rooms were supported by staff in a timely way.

Where people needed to have their food and drinks recorded this was being done appropriately by staff. Peoples' food and fluid was recorded on the computer by the night nurse from the information recorded on the charts. Those people who were drinking little had entries such as "Sips" or "Refused", recorded. Those who were drinking had good intakes recorded. This meant that staff had recorded that people had had a drink. However it was noted during the inspection that some people's drinks were out of reach for people that were in bed. We raised this with the registered manager on the day who said that they would address this immediately and did they ?.

The chef had records of people's individuals requirements in relation to their allergies, likes and dislikes and if people required softer food that was easier to swallow. For those people that needed it equipment was provided to help them eat and drink independently, such as plate guards and adapted drinking cups. Nutritional assessments were carried out as part of the initial assessments when people moved into the home. These showed if people had specialist dietary needs. People's weights were recorded and where needed advice was sought from the relevant health care professional.

People had access to a range of health care professionals, such as Macmillan nurses, the GP, opticians, community dentist and physiotherapist. The GP visited regularly and people were referred when there were concerns with their health. On the day of the inspection we saw that people were being seen by the GP and the Physiotherapist. One health care professional said that they worked well with the staff at the service.

Good

Is the service caring?

Our findings

People and relatives said that staff were kind and caring. One person said "I love it here; staff are kind and do their best to make me comfortable". Whilst another said "The staff are willing and very very nice, they (staff) have a sense of humour." One relative said "Everyone is so kind – it is a very hard time, but the staff have helped them (family member) enormously."

There was one occasion where staff did not treat people with respect. One person was assisted to go to the bathroom, they told us that they were left on the toilet for around 40 minutes alone before a member of staff came back to assist them back to their chair. They said that they used the call bell continuously for a period of 40 minutes and we confirmed that this was the case from the call bell records. We spoke to the manager about this who said that this should not have happened and would address this with the staff.

Staff treated people with dignity and respect. Staff shut doors to people's rooms and the bathrooms when giving personal care. Everyone said that staff were polite and respectful. We saw one person being moved in their bed and staff were careful to ensure that their clothing was in place and that they were covered with a sheet to maintain their dignity.

We saw caring and kind interactions with staff and people during our visit. Staff knocked and waited before entering bedrooms. There were two people in bed who looked comfortable and were visited by staff throughout the day. We saw staff interacted with people and taking their time to explain things. People were treated with dignity and respect and gentle conversation going on throughout the day. One member of staff said "I love my job and I love the residents here."

People were treated with kindness and compassion by staff throughout the inspection. We saw that staff knew and understood people. Staff took the time to acknowledge people either with a smile and there was plenty of laughter between staff and people. People said staff were caring towards them. Where people were anxious we saw staff reassured them and ask them what was upsetting them. We saw instances of people becoming agitated and staff understood what they needed to do to reassure people. One member of staff told us "Staff don't patronise people here, we understand people's behaviours and what they need from us."

Staff told us that they took the time to get to know people to really understand who they were. We saw that staff knew people well and understood them. They knew people's backgrounds and individual preferences. One member of staff said that they were able to encourage one person to have personal care because they understood how to speak to them and how they would respond better to them. Staff had knowledge of what people were interested in so tailored their conversations to each person. One relative said that when their family member was unwell "Staff put (their family members) cuddly toys on the pillow and ensured that ice cream was available as she wasn't eating or drinking much, but did like ice cream."

People's family and friends were able to visit at any time and we saw this happening throughout the visit. Health care professionals said that the staff were caring.

Where possible people were given the opportunity to be involved in the running of the service. The staff actively sought the views of people in a variety of ways. Residents meetings were held and the minutes showed discussions about staff that were new to the service, plans for the refurbishment of the building and activities. People were given an opportunity to make suggestions about things they would like to do more.

Requires improvement

Is the service responsive?

Our findings

People and relatives told us that before they moved in the manager undertook a pre-assessment of their needs. One relative said "I feel very involved in my mum's care plan; I feel they are meeting her needs."

Complaints were not always recorded. There was a complaints procedure in place for people to access. We asked the registered manager to provide us with evidence of complaints received and how these were responded to but they were not provided. We could see evidence of any action plans that had resulted from any complaints made and how these had been resolved. The manager was new to the service and was not able to tell us if there were any outstanding complaints.

However all of the people and relatives we spoke with said that they would make a complaint if they needed to. They said that their when they did have a concern it was responded to promptly by the manager. One relative said "All the information we need to know about how to make a complaint is in the contract." We saw that there was a copy of the complaints procedure available for people in the reception.

We found occasions where staff did not respond to someone's needs in a timely way. One relative said that they asked staff to assist their family member as they were concerned about their wound. The wound concern was not addressed until the next day by another member of staff. This meant that there was a risk that the wound would deteriorate as a result of the concern not being addressed. We spoke to the registered manager about this. They said that this should not have happened and would address this with the member of staff concerned.

On one occasion someone had had an accident, which had resulted in a head injury. An ambulance was called and the person was checked by the ambulance staff. However the person's observations were only checked once by staff at the service on the day of the incident. There were no head injury observations conducted by staff in the home, head injury chart or information, even though the wound was described as "a graze to right eye" and in another record "bruise on right head". The wound required no dressing. The entries in the check sheet for that day did not refer to the head injury at all. A body map was completed noting the location of the injury and next of kin informed. When injuries occur to the head, special precautions and observations should be undertaken in case the person should deteriorate.

Staff were given appropriate information to enable them to respond to people effectively. The service used electronic care plans and risk assessments. Care plans covered activities of daily living with supporting risk assessments. Care plans had relevant information with personal preferences noted, for example whether a resident preferred male or female care staff to assist them with personal care. Care plans also contained information on people's medical history, mobility, communication, and essential care needs including: sleep routines, continence, care in the mornings, and care at night, diet and nutrition, mobility and socialisation. These plans provided staff with information so they could respond positively, and provide the person with the support they needed in the way they preferred.

Where people had an incident that resulted in skin damage for example a pressure ulcer they were provided appropriate care from the staff. There was a description of the wound, a clear photograph and entries regarding how often dressings should be changed. The waterlow score, which is a tool for identifying skin integrity problems, was reviewed monthly and sooner if required. One person was being nursed on a specialised bed and the pressure relieving mattress was set at the correct setting to prevent pressure sores. Other actions to help prevent people developing pressure sores included repositioning of people to ensure they were not in the same position for too long and checks on pressure relieving equipment. that.

In another person's file, the care plan for communication referred to problems with their vision and how that affected communication. The care plan in relation to speech impairment also had specific and individual information to guide staff in delivering care. There was also a care plan to guide staff in dealing with peoples' confusion and anxiety. Staff were encouraged to use verbal prompts during conversations and to refer to the date and time for instance, to help people keep a sense of place and time.

Daily records compiled by staff detailed the support people received throughout the day. Care plans were reviewed every month to help ensure they were kept up to date and reflected each individual's current needs. Where a change to someone's needs had been identified this was updated

Requires improvement

Is the service responsive?

on the care plan as soon as possible and staff were informed of the changes. One person had been more uncomfortable at night and staff were advised to change their medication. This was updated in their care plan.

People enjoyed living at the service. One person said "I love it here, I like all the activities and watching what's going on" whilst another told us "I like my own company and look forward to my paper." People enjoyed taking part in the activities, one person said I loved yesterday we made flower pots and decorated them with Easter Chicks." We saw the activities for the week displayed in the home. This included music groups, coffee morning at the local ice cream shop, outing to a garden centre, hot cross bun morning and an Easter bunny hunt. People also had access to televisions, radios, books and mobile phones in their own rooms. We saw that all people in the service were included in the activities if they wished to. Staff and the activities coordinator had one to one sessions with people who were being nursed in their beds.

Requires improvement

Is the service well-led?

Our findings

People and relatives said that the service was managed well. They all felt that they could approach staff and the management. One person said "The manager is a lovely lady." One relative said "The manager is seen a lot around the home."

There were not robust quality assurance systems in place. Monthly 'Provider visits' took place by the service operations manager. These covered areas of care, staff recruitment, staff training and supervisions, health and safety and the management of the service. It was identified in December 2014 that staff training (both service mandatory and clinical) was out of date, that staff supervisions needed to be completed and that there was a lack mental capacity assessments in people's files. We found that this was still a concern and that these matters had not been addressed when the January 2015 audit took place and on the day of our inspection. This is a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager undertook additional internal audits of the service. For example an infection control audit was undertaken in March 2015. An action plan was produced to look at areas identified and a time limit was set to address the concerns. .

Staff said they felt supported. One told us "If we have missed something in the job we are doing then we are told in a respectful way by the manager, the manager is very approachable." Another told us "I feel valued with the manager and appreciated by the people and relatives I provide care to." They said there was good communication between the care staff, nurses and management within the service. One member of staff said "We are encouraged to do additional training to become senior carers." The registered manager said that they also had informal evenings at the service where both staff and residents could all have meals together. We saw one of these evenings advertised on the notice board.

Staff meetings were regularly held and minutes of the meetings were recorded and made available to all staff. We saw a record of staff meeting minutes. Best practice guidance was discussed during these meetings and any concerns that staff had. For example discussions around making sure the laundry was kept up to date, that staff took appropriate breaks and visitors being asked to sign in for fire safety purposes.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The registered manager of the home had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.

The registered manager carried out relative meetings. Events and work being done in the home were discussed at these meetings. Discussions included the refurbishment of the service, information about the providers and information on audits that had taken place. The minutes of the meetings showed that relatives were asked for their views on the changes and were involved in decisions; relatives were able to ask questions and make suggestions for improvement.

The service 'Mission' was clear to people, visitors and staff. There was a copy of the 'Mission' statement in the reception of the service. Staff understood what it should mean for people who received care and that the highest standards of care should be maintained. One member of staff said that she treated people like they were her own family. One of the aims of the service was whether 'It is good enough for our Mum.' Staff at the service were open and approachable. We found that interactions between staff, people and visitors promoted a sense of well-being.

There was a service business development plan which took into account people's, relatives and staffs views on the improvements they would like to see. We saw that the staff room was going to be updated, team building events (including awards for staff performance) were being introduced and the local community was to be invited to the service.

Relatives were asked to complete an annual survey. We looked at the last one completed in February 2015. The survey results were very complimentary of the service and where any concern had been identified the registered manager said they were looking at addressing this.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment This is because the registered provider failed to protect people against the risks associated with unsafe use and management of medicines

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing This is because the registered provider did not have suitable arrangements in place to ensure that persons employed are appropriately supported in relation to their responsibilities.

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 This is because the registered provider did not have processes in place that assured the improvement of quality and safety of the service.

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 This is because the registered provider did not have suitable arrangements in place for obtaining and acting in accordance with, the consent of services users in relation to their care and treatment provided for them.