Prime Life Limited

St Georges

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 6 December 2016, and the visit was unannounced.

St. Georges provides residential care to older people including people recovering from health issues and some who are living with dementia. St. Georges is registered to provide care for up to 36 people. At the time of our inspection there were 33 people living at the home.

St. Georges had a registered manager in post. The registered manager was also the provider, and he was supported by a care manager at the home. 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.

Care plans were personalised and each file contained information about the person's likes, dislikes, preferences and the people who were important to them, however some areas were not covered or planned for appropriately. We found the registered manager had not involved people or their relatives in the review of their care plan. Care plans also included information that enabled the staff to monitor the well-being of people. Staff had access to people's care plans and received regular updates about people's care needs. There were systems in place for staff to share information through detailed records for each person. Risk assessments and management plans covered relevant aspects of people's needs and included finances, health and daily routines.

People felt staff were kind and caring, and their privacy and dignity was respected in the delivery of care and their choice of lifestyle. Relatives we spoke with were also complimentary about the staff and the care offered to their relatives. We observed staff offered people everyday choices and respected their decisions.

The environment of the home was not meeting the needs of people living with dementia. Heating was not available in some bathing areas and staff were not made aware of infection control issues to ensure people are protected.

There were appropriate arrangements for the storing, recording and checking of medicines to ensure people's health and welfare was protected against the risks associated with the handling of medicines.

Staff worked as a team however they were not deployed to provide the appropriate level of assistance at meal times. People had mixed opinions of whether food was satisfactory and the registered manager had arranged a meeting to improve the variety on offer.

The provider had recruitment procedures that ensured staff were of a suitable character to work with people at the home. Most staff had received training in the areas the provider considered essential for meeting the needs of people in a care environment safely and effectively. Training was planned to update the remainder

of the staff to ensure all staffs' knowledge was up to date.

New staff received an induction prior to working with people. This helped them get to know people's needs and establish a relationship with them before working with people on a one to one basis. Staff had been provided with safeguarding training and were aware and had an understanding of their responsibilities to protect people from harm. The registered manager understood their responsibilities to manage any safeguarding concerns raised by staff, and report any instances to the appropriate authorities.

Staff worked within the principles of the Mental Capacity Act 2005 and had a good understanding of their responsibilities in making sure people were supported in accordance with their preferences and wishes. Staff knew people's individual communication skills and abilities and showed concern for people's wellbeing in a caring and meaningful way. However they were observant of peoples dignity at all times.

There was a clear management structure within the home, which meant that the staff were aware who to contact out of hours. The registered manager undertook quality monitoring in the home however this was not wholly effective in revealing recurrent issues. Staff were aware of the reporting procedure for faults and repairs and had access to the maintenance to manage any emergency repairs. The provider had developed opportunities for people to express their views about the service. These included the views and suggestions from people using the service, their relatives and health and social care professionals.

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.

People have not been protected from the risks from infection. Staff have yet to improve the infection control in the home, to a sustainable level. Environmental improvements have yet to be made to assist with this process. Medicines were ordered, administered and stored safely, people were offered as required medicines at appropriate times.

Potential risks to people were not safely managed and concerns about people's safety and lifestyle choices were discussed with them or their relatives to ensure their views were supported. Staff understood their responsibility to report any observed safeguarding.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The food service did not effectively meet people's needs. People had mixed opinions about the food provided in the home, the registered manager had organised a meeting to review the quality and variety of the meals. Some bathing and shower rooms are not adequately heated to ensure people's comfort.

Most staff had completed essential training to meet people's needs safely and to a suitable standard, and the remaining staff had their training planned. Staff had a good understanding of Deprivation of Liberty Safeguards and the requirements of the Mental Capacity Act 2005 and people's consent was sought before care was provided.

Is the service caring?

Good

The service was caring.

Staff understood the importance of caring for people in a dignified way, but failed to consistently demonstrate this in practice. Staff were caring and kind, treated people as individuals and recognised their privacy. People were encouraged to make choices and were involved in decisions

about their care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People received personalised care, however not all of their needs were included in their care plan.

People and their families were involved in planning how they were cared for and supported, and staff understood people's preferences, likes and dislikes and how they wanted to spend their time. People told us they would have no hesitation in raising concerns or making a formal complaint if or when necessary.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Provider audits did not reveal poor safety around infection control, deployment of staff, poor toilet facilities and lack of heating in shower and bathing areas.

The provider used audits to check people were being provided with good care and ensured records were in place to demonstrate this. People using the service, their relatives and visiting professionals had opportunities to share their views and influence the development of the service.

St Georges

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.

The inspection visit took place on 6 December 2016 by one inspector, a specialist advisor and expert by experience. The visit was unannounced. A specialist adviser is a qualified social or healthcare professional. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Both our specialist advisor and our expert by experience's area of expertise was the care of older people, people living with dementia and people mental health needs.

Before the inspection visit we looked at our own systems to see if we had received any concerns or compliments about St. Georges. We analysed information on statutory notifications we had received from the provider. A statutory notification is information about important events, which the provider is required to send us by law. We considered this information when planning our inspection to the home. We spoke with commissioning staff from the local authority who told us they had undertaken a quality monitoring visit, and found the provider was operating effectively.

The provider is required to send us a Provider Information Return (PIR). This allows the provider to provide some key information about the service, what the service does well and improvements they plan to make. We received this prior to the inspection taking place.

During this inspection, we asked the provider to supply us with information that showed how they managed the service, and the improvements regarding management checks and governance of the home following our previous visit. We also asked the provider to forward more information following our visit, as some documents were not available on the day. We received the documents the day following the inspection.

Many of the people living at the home were not able to tell us, in detail, about how they were cared for and supported. We used the short observational framework tool (SOFI) to help assess whether people's needs were appropriately met and they experienced good standards of care. SOFI is a specific way of observing

care to help us understand the experiences of people who could not talk with us.

To gain people's experiences of living at St. Georges, we spoke with seven people and six visiting relatives. We also spoke with an associate director, the registered manager, the deputy manager and four care staff. We looked at four people's care records to see how they were cared for and supported. We looked at other records related to people's care such as medicine records, daily logs, risk assessments and care plans. We also looked at quality audits, records of complaints, incidents and accidents at the home and health and safety records.

Requires Improvement

Is the service safe?

Our findings

People were positive about the cleanliness of the service. One person said, "I like to clean my own room but sometimes the cleaner will come in and do it with the vacuum cleaner." Another person said, "I like my room. It is kept clean."

A visiting relative said, "This is a clean place. Sometimes when you go into a care home there's a funny smell. There's never a smell of urine here."

However, at this inspection we found people were not being protected against the risk of infection. We found a number of recurrent infection control issues, which detracted from peoples' protection from cross infection or cross contamination in the home. A ground floor 'wet room' had a build-up of dirt around the drain. A bathroom hoist that was bolted to the floor was rusty around the base, and the safety straps on the hoist seat were dirty and sticky. We also found a ground floor toilet where the hot water tap was loose and the water did not get hot even after being run for three minutes. We also found badly stained furniture in the activity room.

In one bedroom a dado rail was damaged and there was also damage to the wall around the sink. There were a number of different displays on the corridor walls, which were designed to provide sensory stimulation to people. However, many of the items were permanently fixed to the wall and not suitable for cleaning or disinfection.

There were cleaning schedules in place, and the provider employed external cleaners to ensure all areas were cleaned and disinfected. At other times care staff took care of cleaning and disinfection where unplanned spillages had occurred. Both the cleaners from the external company and staff were aware of the colour coding scheme for mops and buckets to reduce the potential for cross infection.

People told us that they felt safe and staff cared for them safely. One person told us, "When I am in my room I leave the door open but when I'm asleep or go out I shut the door. I have my own key to let myself in."

A visiting relative said, "The carers here are very good. I think that there are enough of them to make sure that mum is safe." Another said, "We do feel that mum is safe here."

Staff were able to tell us about people's individual needs, and the support they required to stay safe. People's care records included risk assessments, which were reviewed regularly and covered areas related to people's health, safety, care and welfare. Care plans and associated risk assessments identified any changes in risks to people's health and wellbeing. The care plans provided guidance to staff in respect of minimising risk.

The provider had a safeguarding policy and procedure in place that informed staff of the action to take if they suspected abuse. Staff we spoke with had received training in protecting people from harm and had a good understanding of what abuse was and their responsibilities to act on any concerns they had about

people's safety. Staff knew the different types of abuse and how to identify them.

All the staff we spoke with stated that they had attended safeguarding training and gave examples of what they understood as potential safeguarding concerns. They had also attended whistle blowing training. One member of staff said, "I'm confident that I the manager would report on appropriately, but if not I know where I can go [to report safeguarding]."

Staff were aware of the whistle blowing policy and told us how they could use it if their concerns were not acted on. Staff were aware of other relevant authorities outside the service to report any concerns to if required, which would support and protect people. The provider was aware of their responsibilities and ensured safeguarding situations were reported to the Care Quality Commission if required.

We spoke with the staff about what they would do if they suspected someone was being abused at the service. The staff told us they were aware of the external bodies they could report safeguarding to, or whistle blow if any issues had not been taken up by the homes' management. They also told us about the Prime Life internal whistleblowing phone number, which was displayed throughout the home.

We looked at the people's personal evacuation plans (PEEPs). These tell staff how to safely assist people to leave the premises in an emergency. Copies of the PEEPs were also kept in each person's care file and reviewed periodically. Staff told us, and records we viewed confirmed they took part in regular fire drills so they knew what action to take in the event of an emergency, and were aware of the location of the PEEPs and emergency equipment.

We found staff were employed in numbers sufficient to ensure people's safety. Our observations confirmed there was a senior carer and five care staff in a morning, afternoon and evening, and three waking care staff at night. In addition to this there were domestic and catering staff. We viewed the staff rota which also confirmed this. Staff told us they believed staff were employed in sufficient numbers to ensure people were cared for safely.

However though there were enough staff to provide safe care, the deployment of staff at lunch time did not support people's needs. We found of the six staff serving lunch five were in the kitchen leaving one member of staff serving people. That resulted in people becoming frustrated, one person attempted to self-propel their wheelchair out of the dining room by shuffling their feet. Another person attempted to stand and walk out unaided. Both people required assistance. Their attempts to leave the dining area did not ensure their safety. We spoke to the associate director and registered manager who then organised the staff group, and made sure people were given appropriate assistance that speeded up the dining process.

People's safety was supported by the provider's recruitment practices. We looked at recruitment records for three staff. We found that the relevant background checks had been completed before staff commenced work at the service.

People told us they received their medicines when the needed them. One person said, "They give me my medication, I take my medication in the morning and the evening. It is done properly."

We looked at the medication administration records (MARs) for 6 people, which were signed by a member of staff when they were administered. The MARs had people's photographs in place to reduce the risks of medicines being given to the wrong person. Information about identified allergies and people's preference on how their medicine was offered was also included. This helped to ensure that people received their medicines safely.

People in receipt of 'as required' or PRN medicines had instructions added to the MARs to detail the circumstances where these should be given and included the maximum dose the person was prescribed in any 24 hour period. We observed the lunch time medication round and heard people being offered pain relief, which was prescribed on an 'as required' basis. This demonstrated that staff understood when and how these medicines should be offered.

We found that medicines were stored securely in a temperature controlled room. A record of storage temperatures for the medicines room and medicines fridge had been kept by staff to ensure the effectiveness of medicines. Staff we spoke with knew the storage temperature limits and what to do if these exceeded or fell below the recommended maximum and minimum.

Requires Improvement

Is the service effective?

Our findings

People told us they were happy with the staff that supported them and felt they understood their needs and how they preferred to be cared for. One person said, "The staff look after me quite well. They are very well trained." Another person added, "The staff are well trained, they are nice people."

People told us the service was effective and staff said there was enough training and they did not feel they had any gaps in their knowledge. We saw evidence that staff had received induction training after they began their employment. This was followed by training in safeguarding, moving and handling, food and hygiene, fire safety, the mental capacity act, Deprivation of Liberty Safeguards (DoLS) and health and safety. The senior care staff had training in the administration of medicines.

Staff that administer medicines are audited regularly to ensure their competence. One member of staff commented, "These checks are not planned [in advance with us] they just take place which I prefer." We spoke with the registered manager who confirmed these took place regularly and were documented as part of the staff group on-going training.

Staff commenced their employment at the home with an induction. We spoke with three staff who confirmed that their induction covered areas of health and safety. They also attended mandatory training updates and had additional training in dementia care, tissue viability, MCA and DOLs.

We saw from the training matrix that a small number of staff had yet to have some training updates. The registered manager said the dates had been arranged and all staff training would then be updated. This was confirmed by information made available following the inspection.

Staff felt support and communication between the staff team was good. There were daily handover meetings which provided staff with information about people's health and wellbeing. Staff also told us they felt the regular staff meetings with the provider and care manager also provided support. Staff supervision was used to advance staff knowledge, training and development by regular meetings between the management and staff group. Supervision benefited the people using the service as it helped to ensure staff were more knowledgeable and able to care and support people effectively.

A senior carer told us that she had regular supervision and has attended medicines management training, and has had her medicines competency checked approximately every six months. The person added there were regular staff meetings once a month and additional meetings with the senior carers. The staff member added that staff were able to raise issues at other times, and did not have to wait for a staff meeting. That ensured the staff group communicated effectively.

The registered manager and care staff had been trained in the Mental Capacity Act (MCA) 2005. The Mental Capacity Act 2005 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 people lack mental capacity to make 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 are called the Deprivation of Liberty Safeguards (DoLS).

Fifteen people had DoLS authorisations in place with another six awaiting approval. This meant there were restrictions of people's liberty and the provider had applied for the necessary authorisation from the relevant local authority.

When people lack the capacity to give their informed consent, the law requires registered persons to ensure that important decisions are taken in their best interests. A part of this process involves consulting closely with relatives and with health and social care professionals who knew the person and had an interest in their wellbeing. Records showed that all the people's files we viewed had mental capacity assessments in place with regard to making certain choices and decisions.

We were provided with mixed opinions about the food and menu on offer. One person said, "There is a lot of choice for breakfast. There is always something that I can have." Another person said, "You can't fault the food here, there's always a choice." And another person said, "The food is an old fashioned dinner – it is food that I like."

However some people were not as enthusiastic. One person commented, "Sometimes the food is cold and sometimes it is undercooked." Another person said, "Our meal today was OK – better than some days." We spoke with the registered manager who said he had organised a meeting with the catering services manager to see how the quality of meals could be improved.

A visiting relative said, "The staff always come round with tea, coffee and biscuits when we're here."

People were provided with a dining experience that did not effectively meet their needs. People had the choice of eating in the dining room, lounge or their bedroom. Though people had the choice of these venues, staff started bringing people into the dining room from 10.30am. Some of those people were undertaking activities and one person was playing 'connect four' with a member of staff. However there were other people who came into the dining room and sat alone at tables until lunch was served.

The lunch time meal was not well organised, as staff were not deployed to meet people's needs effectively. This was due to poor oversight by the management staff. The food that was offered looked appetising. However, the choice of meals was restricted as both non vegetarian meals consisted of pastry. People could choose from a meat pasty, a meat pie and some were offered a vegetarian choice. Some people chose to have the meat without the pastry. The vegetables were carrots and potatoes and all meals were plated in the kitchen, and gravy added to the meal. We spoke to the registered manager about both meals including pastry, and he said he would take this up with the company's catering services. He showed us evidence of a meeting that had been arranged to discuss these matters. These choices did not provide a well-balanced meal that effectively met people's nutritional needs.

People were given a choice regarding their choice of meals, though staff did not use photo prompts or present a plated meal to assist people to choose a meal to suit their taste. Staff told us, and demonstrated they knew people's preferences and offered meals based on this information, where they were unable to choose a meal to suit their preference.

Drinks such as water and cordial were available at all times in we were inspecting the home, and additional

drinks were served with people's main meal. Staff appeared to know what drinks people preferred.

We looked at the service's meal provision and how staff ensured that people maintained a healthy weight. We saw people's dietary needs had been assessed and where a need had been identified, people were referred to their GP, speech and language therapist (SALT) or dietician. This ensured any changes to people's dietary needs was managed in line with professional guidelines. People identified as having a poor appetite were monitored by staff who recorded their food and fluid intake which ensured they had sufficient to maintain their health. Staff told us, and we saw, people who were prescribed fortified drinks to ensure they remained healthy.

We saw that some people had been provided with adapted cutlery and crockery to enable them to eat their meals independently. Others required prompting and some required one-to-one assistance to eat their meal. This was done at a pace to suit the person, and staff were positioned to enable good eye contact to provide effective support. The size of the plates used caused people some concern. Where a person had a larger appetite, a larger meal was offered, though some people were unable to stop their meal spilling off onto the table. This did not effectively meet people's dietary needs.

We heard and observed staff seek peoples' consent prior to support with personal care. We heard staff ask, "Can I help you with that?"

People's health needs were met effectively. People told us their health and medical needs were met, and they were happy for the staff to arrange GP and health appointments for them. People's care records showed that they received health care support from a range of health care professionals and when necessary were accompanied to external medical appointments by relatives and staff. The records we viewed confirmed people had regular health checks by their GPs, specialist health professionals' and hospital consultants.

The corridors were wide and well-lit which allowed the easy movement of equipment along the corridor and into public rooms and bedroom areas as they had wide doors. There were some pictorial and written signs to the bathrooms and toilets, and the lounge has pictorial and written signs. However there was a lack of signs directing people to communal areas, toilets, lift or bedrooms and the corridors were painted in very similar in colour. Clear sign posting is important to promote peoples' awareness where they are in the building and assist to promote people's independence. Not all people had indicators that would orientate them to their personal space.

The premises were not adequate in meeting people's needs. Toilet seats were a domestic type that pictures of pebbles or fish, and some were broken, which was a potential risk to people's safety. These objects are not appropriate for people living with dementia, who have difficulty understanding their environment and could have additional visual difficulties. National Institute for Health and Care Excellence(NICE) guidance states that care managers should ensure environments are enabling and aid orientation and include attention to lighting, colour schemes, floor coverings, signage, garden design and access to and safe external environments. NICE guidance is information distributed by the NHS to encourage high standards within health and social care settings.

Other areas of the home had no central heating radiator in the first floor shower or bathroom. That does not provide satisfactory or inclusive environment for older people. That meant these areas could not be kept warm enough for people's health and welfare needs.

Good

Is the service caring?

Our findings

People told us the staff were caring and approachable. One person said, "Everyone is lovely. If I need anything the staff will help me." Another person said, "I like it here. Everyone is nice." And another "The staff are kind to me. They will bring me a cup of tea." And another, "The staff talk to me all of the time. They are lovely."

Comments from visiting relatives included, "There was one occasion when Mum was taken to hospital she was able to return to this care home in the middle of the night. When she came back the staff were kind to her and looked after her very well. She was even offered some food." And, "I think that this is one of the better care homes. There are enough staff, they work hard and are kind and caring."

We observed the culture of the home was a caring one and people's needs were catered for by staff who communicated with people in a compassionate and caring way.

Some people were unable to express their views and opinions. Records showed that family members had been involved in care plan reviews and there was information in care plans to ensure people were referred to by their preferred name. Staff said people were asked to take part in care plan reviews but only a few of them chose to do so. Staff confirmed relatives were informed when people's health or wellbeing changed.

We found people and their relatives thought they were treated with dignity and respect.

One person said to us, "They are not nosey. I have times when I can be private. It is good." Another said, "I'm looked after. They leave me on my own but if I need help I've got it. And another "Nothing is too much trouble for the staff here. I only have to ask and the staff will help me. They are kind and well mannered."

A visiting relative said, "My (relative) always looks very clean and presentable. Her clothes are always clean."

Staff understood the importance of caring for people, and they described how they treated people in a dignified way. However, when we saw people being assisted to stand with a mechanical hoist, their clothes rose up exposing their skin. We saw this happen on a number of occasions. We spoke to the registered manager, who said he would speak with the staff, and observe their practice in this area offering support where required.

We saw the staff on duty communicated with people effectively and used different ways of enhancing that communication by touch and ensured they were at eye level with those who were seated. We heard one member of staff reassuring someone and asked, "Would you like some help?" This was said in a compassionate way.

We heard other staff speaking with people throughout the inspection. One staff member asked a person, "Hello (named) have you had your hair done? It looks lovely. Where would you like to sit for dinner?"

Staff were observed to be discreet when people required personal care. We saw staff reassured people who were anxious and distressed and responded promptly, calmly and sensitively. This was observed with a person who became agitated after lunch and a member of staff sat with them. Staff were observed that when doors were closed, they knocked on bedroom doors, waited and identified themselves before entering the room.

One person told us, "They speak to me nicely. When I am in my room they knock before they come in."

Requires Improvement

Is the service responsive?

Our findings

None of the people we spoke with or their visiting relatives were involved in the care planning process. We spoke with the registered manager who confirmed people were involved with their previous life histories, but due to the majority having high dependency needs they involved those family members who wanted to be involved in the planning and review process.

Care planning was linked to people's individual needs which ensured care plans were specific to each person. We saw evidence of information on allergies, likes, dislikes, and where staff updated peoples' life and family histories. We also saw detailed information on relevant issues such as personal care, mobility and dexterity, pressure area care, continence, nutrition and hydration, medical history and pain relief. People's capacity and DoLS status was also recorded. Staff were able to explain, and demonstrated through the care we observed, the specific support that people required.

Staff had access to people's plans of care and received updates about their care needs through daily handover meetings.

People told us they had access to activities both in and out of the home. One person told us, "I like to read a book sometimes and we sometimes go next door for a cup of tea." Another person said, "We had a trip out to Bradgate [park] I enjoyed that." And another, "I do my own drawings and I go shopping once a week, I would like to go out a bit more but there isn't the staff to take me." And another person said, "I would like to go out, I'm not allowed to go out on my own."

We asked the registered manager about these people who stated a number of people were taken out on an individual basis but these additional staff hours were restricted. They added some people were subject to a Deprivation of Liberty Safeguards (DoLS) restriction and had planned time out of the home. We saw evidence of the time people spent out of the home recorded in their daily records, and saw one person who was assisted out to visit a local coffee shop.

A visiting relative said, "I don't think that there is enough for Mum to do but to be fair I'm not sure that she would join in anyway." Another relative said, "We are free to come and visit at any time that we wish, and are always made to feel welcome. Sometimes we have to wait a long time at the front door to get in." We spoke with the registered manager about this who said he would look for alternatives where regular visitors could enter the building, and remind the staff, but at busy times people did sometimes have to wait.

A variety of activities were provided that did not meet all of the people's needs. There were notices around the home about the daily activities. We observed activities taking place where staff assisted people with a game people played Jenga [wooden brick building game] and a person doing a jigsaw. We spoke with the staff who provided activities on a daily basis. Staff were aware what activities people living with dementia could be offered. Staff told us about the range of individual activities offered though we did not see these on the day we inspected.

On the day we inspected there was also hairdressing and beauty treatments taking place. Not all the people could engage with this activity, and one person had requested not to take part in group activities, due to lifelong complications with their mental health and joining in group activities. That meant some people did not have activities that responded to their needs.

We looked at the minutes of the meetings which included discussions around the menu, activities and staffing suggestions, people said they wanted more bingo evenings and visits to the shops. We spoke with staff about what activities people preferred to do. They told us that some people just enjoyed speaking with the staff and playing games. They added that though an activities plan was in place, if people didn't want to do the allocated activity, then staff would provide alternatives.

One person said, "There isn't anything that I'm not happy about." Another person said, "I have no complaints at all. If I did, I would feel comfortable telling someone. The people (staff) here are very easy to talk to. And another, "I don't think that they answer the alarm bell quickly enough. It took about 5 minutes for someone to come." We spoke to the registered manager about this who again said, he would speak to staff about timely answering of call bells.

The provider had systems in place to record complaints. One relative said, "We would be happy to speak to the staff if we had a complaint. They do listen to what we have to say." Another said, "When the buzzer is rung it doesn't take the staff long to answer them. We think that this is a very good care home."

People we spoke with said they knew how to make a complaint, and indicated they could rely on the registered manager, the deputy manager and staff to deal with any issues. Records showed the service had received three written complaints in the last 12 months. An outcome had been provided, and changes were made to the service. One person had been compensated for lost clothes. Analysis of the complaints revealed there were no themes. Information from complaints was fed back to staff through staff meetings or individual supervision sessions.

Requires Improvement

Is the service well-led?

Our findings

People told us they felt supported by the registered manager, their deputy and staff team, and there appeared to be an open and friendly culture in the home. A visiting relative said, "There is a nice atmosphere here. They do listen to what we have to say." Another said, "The staff here are very easy to talk to." And another, "They are very open to suggestions here."

The provider's procedures for monitoring and assessing the quality of the service was not consistently effective. The registered manager or deputy undertook a 'daily walk round'. This was an environmental check, which had revealed the rusty base of the bath hoist, but staff had failed to act on this information. The registered manager said that any repairs and maintenance of equipment was due to take place following our inspection. The 'daily walk round' had also failed to reveal a missing a buckle from a bath hoist safety strap. There was also no record of the lack of heating in some shower and bathrooms, and there were no plans in place to upgrade the heating.

We saw there was no structure to the deployment of staff to aid the meals being served at lunch time. There were some quality assurance checks in place. We saw records of the checks that had been undertaken which included the medicines system, care plans, accidents and incidents and people's weight loss or gain and their nutritional and dietary requirements. However the lack of a consistent monitoring system of staff deployment and their effectiveness did not point to a well led home.

We saw there was a way to ensure people's personal allowances were administered safely and securely. The administrator had developed a system that was checked regularly by one of the management team and at least twice a year by auditor from the company head office. We checked four people's individual monetary transactions and receipts of items purchased which were all correct.

The registered manager told us the provider issued annual questionnaires to people using the service and their relatives and these had just been sent out. The registered manager and deputy worked flexible hours to ensure they had an overview of how the service ran on different days and at different times. They also supported staff by providing on-call contact telephone numbers, so staff could contact them for support at any time.

There was a system in place for the maintenance of the building and equipment, with an on-going record of when items had been repaired or replaced, though this was not fully effective. Staff were aware of the process for reporting faults and repairs but had not picked up all issues. Records showed that essential services such as gas and electrical systems, appliances, fire systems and equipment such as hoists were serviced and regularly maintained. The management team also had access to external contractors for maintenance and any emergency repairs.

We looked at the record of safety tests undertaken in the home. These were completed by the Prime Life's 'estates team' from the head office. The periodic testing of gas appliances and electricity supply were up to date and were performed by appropriately qualified engineers. There was a business continuity plan

produced by the provider. This had information for staff in the event of a significant failure of part of the building, water, gas or electrical services. That meant staff had essential information they could use in the event of an emergency to immediately arrange any remedial action.

Staff were aware of the process for reporting faults and repairs, and had access to a list of contact telephone numbers if there was an interruption in the provision of service. Other information included instructions where gas and water isolation points were located and emergency contact numbers if any appliances required repair. Records showed that essential services such as gas and electrical systems, appliances, fire systems and equipment such as hoists were serviced and regularly maintained.

We saw evidence that people who used the service, their relatives and visiting professionals were asked to contribute to the quality assurance process. They were sent questionnaires, so were enabled to comment about the quality of service offered by the home. Staff confirmed people at the home participated in the process and if necessary they or their relatives assisted them in completing questionnaires. We saw some of the feedback had been adopted by the provider. A meeting had been set up to look at the meal choices form the central kitchen, and some changes to the evening meal choices had been made.

People who lived at the home and their relatives were also invited to meetings with the registered manager and their deputy. We looked at the minutes of these meetings, and saw people had made reference to poor care mentioning the laundry and damage to people's clothing and the lack of variety of trips out of the home. We saw where these concerns had been acted on and changes made to improve the service. That meant the provider had acted on these issues and provided evidence of a culture which was empowering.

The provider understood their responsibilities and ensured that we were notified of events that affected the people, staff and the building. The provider had a clear understanding of what they wanted to achieve for the service and they were supported by the registered manager and staff group. There was a clear management structure in the home and staff were aware who they could contact out of hours if needed.

Staff had detailed job descriptions and had regular staff and supervision meetings. These were used to support staff to maintain and improve their performance. Staff confirmed they could see the provider's policies and procedures if they needed to. They understood their roles and this ensured that staff were provided with the same information. This was used to provide a consistent level of care throughout the home. Staff were aware of their accountability and responsibilities to care for and protect people and knew how to access management support when required.