Donnelly Care Homes Ltd

Kirkella Mansions Residential Home

Inspection report

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Kirkella
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Tel: 01482659403

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27 June 2017

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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?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

The inspection of Kirkella Mansions took place on 26 and 27 June 2017 and was unannounced. At the last inspection on 28 April 2015, the service met all of the regulations under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Kirkella Mansions Residential Home provides accommodation and personal cares for up to 25 older people, some of whom may be living with dementia. It is situated in Kirkella, a village in the East Riding of Yorkshire and is on two floors with single and shared accommodation, three lounge areas, a dining room and accessible gardens. The service does not provide nursing care. There is a small car park to the rear of the building. At the time of our visit, 21 people were living at the service, including one person who was having respite care with a view to permanency.

The registered provider was required to have a registered manager in post. 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. The home had a registered manager who had been in post for five and a half years. They will be referred to as 'the manager' throughout the report.

The provider had systems in place to identify, monitor and report potential or actual safeguarding concerns. However, we found that the policies and procedures in place were not reviewed and did not always contain up to date information. Staff training was not refreshed on a regular basis and as a result, one member of staff was unsure of the process to refer safeguarding concerns to external agencies if needed.

Recruitment policies and procedures were in place. However, the providers recruitment checks were not robust. We found that references had not been recorded or sufficient checks made to employ suitable persons of good character.

We identified areas of infection control that needed attention - two bedrooms had damp patches on the walls and one of those showed signs of mould which could potentially affect the health and wellbeing of people using the service. We saw that the laundry room had no guidance for staff to identify the clean and dirty working areas, which increased the risks of infection by cross contamination of clean and soiled items.

An induction training programme was in place and this included a checklist of policies and procedures that were made available to staff. However, new staff had not always completed the induction training.

There was a training matrix in place, although we could not see clear systems to identify when refresher training was due.

We also found that competency checks had not been carried out regularly, supervisions were not up to date

and appraisals had not been completed in line with the provider's policies and procedures.

We observed positive interactions between people who lived at the home and staff. People told us that staff were kind and caring and that they respected their privacy and dignity.

People's nutritional needs had been assessed and were being met by staff. People told us they were happy with the meals provided by the home although one person said the menu was a little repetitive.

People were happy with the activities on offer at the home; these included trips out to local places of interest.

We were told that the culture of the service was 'open and transparent'. People were given various opportunities to give feedback about the service they received.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Staff had good knowledge of potential types and signs of abuse. However, the systems and processes in place to report safeguarding concerns had not been regularly reviewed and were out of date. Some staff had not received safeguarding training.

We identified some issues around infection control within the environment which the manager made plans to prioritise during our visit.

We observed safe moving and handling techniques. Some documentation such as risk assessments required updating.

People's medicines were safely managed and they received them as prescribed.

There were sufficient numbers of staff on duty to meet people's needs but recruitment was not always robust.

Is the service effective?

Requires Improvement

The service was not always effective.

The induction programme in place was not used for all new staff. There was no clear system in place to monitor when staff training had expired, and supervisions and appraisals had not been regularly completed in line with the provider's policy.

The provider was working within the principles of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLs) had been requested where appropriate.

Improvements had been made since our last inspection to make the environment more user friendly for those living with dementia and we recommended further improvements be made in this area

Is the service caring?

Good

The service was caring.

We saw that staff respected people's privacy and dignity and promoted their independence by encouraging them to do things for themselves.

Staff had a good knowledge of people's needs and took the time to engage people in stimulating conversation.

We could see that staff gave people choices and respected their preferences.

Management and staff created a warm and friendly atmosphere where people felt content and happy.

Is the service responsive?

Good

The service was responsive.

Activities were organised with plenty of choice for both indoor and outdoor activities. People's comments were taken into consideration when planning new events.

People were encouraged to maintain relationships with family and friends.

The home provided person centred care and managed people's needs well.

Relatives felt involved with peoples care, and were invited to meetings to discuss best interest decisions and care planning.

Is the service well-led?

Requires Improvement

The service is not consistently well led.

The service had a clear management structure in place. People felt supported and told us that management were approachable.

The culture of the service was open, honest and transparent. Staff and management welcomed visitors and created a warm and welcoming atmosphere.

Although there were management systems in place these were not always successful in identifying areas for improvement.

Kirkella Mansions Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to 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 inspection took place on 26 and 27 June 2017. The inspection was unannounced.

The inspection team consisted of 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.

In preparation for this inspection, we reviewed information we held about the home, such as information we had received from the local authority and notifications that the registered provider submitted to us. Notifications are documents that the registered provider submits to the Care Quality Commission (CQC) to inform us of important events that happen in the service. The registered provider was asked to submit a provider information return (PIR) before this inspection. The PIR is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. The PIR was submitted within the required timescale.

On the day of the inspection, we spoke with 10 people who lived at the home, seven visitors, two health care professionals, seven staff, the assistant manager and the manager. We looked around communal areas within the home and some bedrooms, with people's permission. We looked at records, which included the care records for four people who lived at the home, the recruitment records for two members of staff and other records relating to the management of the home, such as quality audits, staff interviews, maintenance records for the premises and medication.

Requires Improvement

Is the service safe?

Our findings

Relatives spoke positively about the service and felt that their loved ones were safe. Health professionals told us they had confidence in the manager's ability to provide safe care and had no concerns about safety.

We spoke to 10 members of staff, who told us they felt confident that managers would be proactive in dealing with any safeguarding concerns they brought to their attention. Safeguarding notifications had been submitted to CQC and the appropriate local authorities had been informed. However, we found the systems and processes in place to report safeguarding concerns had not been regularly reviewed and were out of date, referring to the incorrect regulations of the Health and Social Care Act 2008. There were no clear procedures in place for staff to follow should they need to report any concerns to an external agency.

Staff knowledge regarding the different types of abuse was good, but not all staff had received safeguarding training. The providers training matrix showed that 11 out of 27 staff had received this training within the last 3 year period. One member of staff was unclear as to the procedures to follow should they need to report concerns to an outside agency.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a whistle blowing procedure in place and staff told us they would report concerns to the manager.

We saw there was a disciplinary procedure in place and this was included in the staff handbook, which also included a statement in relation to bullying and harassment being strictly forbidden, a brief outline of resident's human rights and information about discrimination.

We observed that most communal and private areas of the home were clean and free from unpleasant odours. However, during our walk around the premises, we noted that two rooms had damp patches and one of those showed signs of mould; the NHS Choices Website states, 'If you have damp and mould you are more likely to have respiratory problems, respiratory infections, allergies or asthma.'

We also noted that some toilets had soap and toilet rolls missing. When asked about this, the manager told us that one person living at the home sometimes removed the toilet rolls in one toilet as part of their routine. Staff were aware of this and inspected the area more regularly. An enclosed dispenser has been fitted and the original holder kept to allow this person to continue with their routine, which is important to them. This meant that staff may not always have the facilities to wash their hands in between providing care and support.

The laundry room had no clear clean and dirty working areas. There was no signage to guide members of staff as to where items should be placed. The registered manager told us that this area was due to be refurbished in August or September of 2017 and would address the need for clear separate working areas.

We discussed our findings with the manager who told us that maintenance works were on going and any rooms that had not been redecorated were being completed as they were vacated. The refurbishment to date had included redecoration, the fitting of more suitable carpets, non-slip flooring and new stainless steel units in the kitchen. We observed that some works needed to be prioritised, such as the damp and mould in peoples rooms. Although there was no clear refurbishment plan in place to address these issues, the manager was confident they would deal with these concerns immediately and took measures whilst we were there to identify the cause of the leak on the roof so that maintenance works could be carried out.

We found ineffective systems in place to ensure the environment was regularly monitored for safety. The written policies and procedures for fire safety had not been updated since March 2010. The provider's policy stated, 'All staff should receive Fire Awareness training every six months,' but the training record showed that only six of the 27 staff had received training in line with the company policy.

This is a breach of regulation 12 (2) (d) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the recruitment files of four members of staff, which included application forms with a full history of employment, identification documents and Disclosure and Barring Service (DBS) checks. References for the four staff whose files we reviewed showed that three staff had one reference and one member of staff had no reference recorded. One of those references only confirmed basic dates of employment, no details to confirm that the person was of good character and no further attempts had been recorded by the provider to obtain any additional references. The manager advised that sometimes references were taken verbally but not recorded. Part of the providers recruitment and selection procedure states that prior to confirmation of employment they require 'two suitable references'. This showed us that recruitment procedures and the systems in place to record information were not robust and effective.

This is a breach of regulation 19 (2) (a) (3) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People living with dementia responded positively to staff prompts and distraction techniques were used effectively. Health professionals advised us that they felt risks were well managed by the home and staff were proactive in making appropriate referrals such as those to the falls team or speech and language therapists (SALT). However, some risk assessments we saw in people's care plans required updating to include details of any changes. This was fed back to the manager on the day of the inspection.

Throughout the visit, we observed friendly interactions between staff, health professionals, relatives and people using the services. The atmosphere was warm and homely, and staff had a good knowledge of people's personal history and their needs.

We observed safe moving and handling techniques being used by staff and the provider had systems in place to ensure equipment was safe. Maintenance certificates and some safety checks had been completed within the last 12 month period and records showed us that the staff completed quality assurance checks once a year in different areas each month on a rotational basis. We noted that a fire audit had been completed since our last inspection and that fire extinguishers had been checked, the last checks were dated April 2017.

We saw people had a personal emergency evacuation plan (PEEP) in place. This contained sufficient information about the support people would need to evacuate the premises. PEEPs were kept in the reception area for ease of access in the event of an emergency. Contingency plans were in place to advise

staff of how they should deal with unexpected emergencies. This promoted people's safety and ensured evacuation procedures were clear.

We observed staffing levels throughout the visit as being sufficient to meet people's needs. We were told that of the 21 people that currently used the service, one person was having respite care and eight people were living with dementia. We spoke with 10 people that used the services, they told us they felt safe, happy and that there was always plenty of staff on duty. One person said, 'There's plenty of staff around and I feel safe.' Relatives told us they felt there were enough staff to meet people's needs and that staffing levels were never a concern. Additional staff were employed to support with administrative duties, cooking, maintenance and housekeeping. This meant care staff were able to concentrate on supporting the people who lived at the home.

There was a clear accidents and incidents policy, which included the nature of accident, description, and any immediate action or treatment completed. These were summarised monthly and a record kept of any actions taken.

We saw that medicines were stored safely, obtained in a timely way so that the person did not run out of them, administered on time, recorded correctly and disposed of appropriately; this included the management of controlled drugs (CDs) CDs are medicines that require specific storage and recording arrangements.

Relatives told us, 'Staff administer tablets and record it on a chart.'

The temperatures of the medicines fridge and medicines room were checked on a daily basis to ensure medicines were stored at the correct temperature. Expiry dates for medicines such as eye drops were monitored effectively and dates opened recorded on packaging. However, we noted that one bottle of eye drops stored in the fridge was out of date. The deputy manager immediately disposed of this item, confirming that it was not in use. Some people's medicine records did not contain a photograph for ease of identification. Medicines that were taken as 'as and when required' (PRN) had no instructions or guidance available for them.

The deputy manager advised they would ensure guidance for PRN medicines was available for staff to refer to, and that photographs were placed in all peoples medicine records.

Requires Improvement

Is the service effective?

Our findings

There was an induction training programme in place and this included a checklist for policies and procedures that staff were expected to be made aware of. For example, the whistle blowing policy stated that staff were made aware of the procedures during the induction programme. However, of the four staff files we reviewed only one made reference to an induction and it had not been fully completed. In addition to this, the provider's policy on induction training had not been updated since 2010.

We discussed this with the registered manager who advised us that new staff trained to National Vocational Qualification (NVQ) level 2 or above attended the company's induction programme, but did not complete the Care Certificate. The Care Certificate is a set of standards that social care and health workers observe. It is the minimum standards that should be covered as part of induction training of new care workers.

We saw that one of the staff had obtained their NVQ in 2012 and had only received fire training since the start of their employment. In addition, no competency checks had been completed to check their level of knowledge, competency and skills in order to carry out their role. This appeared to be an isolated case.

We discussed with the manager how they should consider a more robust induction programme for all new staff in line with the 'Skills for Care – Care Certificate.'

The deputy manager advised us that the training co-ordinator was currently on leave and normally managed staff training. Although there was a training record in place, we could not see clear systems to identify expiry dates for when refresher training was due, although it was clear that some staff required refresher training.

We also found that competency checks had not been regularly completed, supervisions were not up to date and appraisals had not been completed in line with the provider's policy; this stated that supervision meetings should take place 'every 6-8 weeks.'

This was a breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). The 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. People had been assessed for their capacity to make specific decisions, and DoLS authorisations put in place when appropriate. Relatives had been invited to best interest meetings when people had needed support to make decisions and records of these were kept in care files.

We saw that the majority of staff received training in MCA and DoLS authorisations. Staff were aware of people's rights under the MCA and were clear about gaining peoples consent prior to delivering care. One member of staff told us "We always ask people first and support them to make every day decisions. If they are unable to consent we involve family and health professionals to arrange best interest meetings and when needed put DoLS in place."

One relative told us there loved one could not communicate easily, they said, 'staff take the time to communicate using different methods and are brilliant.' We observed staff taking time to speak with people, getting down to their level and using touch to communicate with people.

We spoke with people about the choice and quality of meals provided. People told us, "What I do like is their puddings and the elevenses are always freshly baked buns." We spoke to the cook who was aware of people's dietary requirements such as pureed and diabetic diets. The cook was aware of people who required plate guards or coloured plates to help them with co-ordination and identifying the meal on their plate. We saw a list in the kitchen of people's needs and preferences, and that any changes to these were noted daily on a whiteboard so the cook was aware. One person commented that the food was monotonous and they would like to see more variety of fresh (not frozen) vegetables.

The dining area had plenty of space to accommodate mobility aids such as wheelchairs. We spoke to people about the meals provided and they told us "The food is really nice and the cook is very good." People had the choice of two main meals at lunchtimes and could have a lighter hot or cold meal at teatimes. During mealtimes, we observed people being supported appropriately and dietary requirements being met. Everyone had plenty of hot or cold drinks and snacks were offered at regular intervals throughout the day.

People's daily electronic records included details of personal cares completed and reflected a person centred approach. They included social activities undertaken and people's needs were clearly documented.

People's weight had been checked weekly or monthly depending on their needs. Where people were identified to be at risk in regards to hydration and nutrition, their food and fluid was monitored and if needed the relevant input from professionals sought. Staff had an awareness of people's specific dietary needs such as pureed, diabetic and soft diets, and this information was recorded in their care plans.

Health summaries had been completed to give staff a brief overview of each person. We saw evidence in people's care records that staff supported people to access community health care services such as district nurses, opticians, GPs and the speech and language therapy (SALT team). A health professional told us, "All staff are good at communicating with us. Staff take appropriate action straight away." They continued, "Residents always appear happy and cared for, we have no concerns."

Since our last inspection on 28 April 2015, the home had made improvements to the signage and use of colours to help guide those living with dementia. There was an enclosed garden space available for people to use, and the manager told us that this was in the process of being made more user friendly. We discussed with the manager that the design of the environment could still be further improved in line with current research, for example, the King's Fund 'Enhancing the Healing Environment', or research undertaken by Stirling University and Bradford University.

The provider told us they were a member of the following associations; Social Care Institute for Excellence (SCIE), Skills for Care and National Activity Providers Association (NAPA). They advised us that they attended regular provider meetings with the Local Authority, where they were briefed on any local issues.

Good

Is the service caring?

Our findings

We received positive feedback from relatives, health professionals and people using the service about the care and support delivered by staff. People using the service told us, "The staff are all very kind and caring, the girls are superb" and "They are very good here they are friendly and nice they have a laugh with you." We spoke with seven relatives and they all commented on how lovely the staff were. One relative told us, "They can't do enough for you." And another said, "The staff are brilliant. One of the things that impressed us was how naturally caring they are." We saw the cook had made a birthday cake for one of the people who lived at the home and staff asked people to join them to sing happy birthday.

We observed interactions between staff and people using the service. We saw that staff asked people how they were feeling, if they wanted a bath running and had time to stop and provide stimulating conversations. People looked happy and were not afraid to ask for additional refreshments or something alternative to the menu provided, staff accommodated individual preferences.

When asked about privacy and dignity we received positive feedback that staff carried out their roles in a respectful way and promoted dignity in all aspects of care provided. One of the staff told us, 'We talk to people to make sure they are comfortable and keep them covered whilst we do personal cares.'

People were able to move freely around their home, some required assistance from staff and the use of mobility aids and others were able to mobilise independently. One relative told us the staff encouraged people to be as independent as they could be and that they were encouraged to do things for themselves.

Staff spoke with genuine care for people and advised us they tried to support friends and relatives when needed, this included facilitating them to visit at any time of day or evening to ensure people's social and emotional needs were met. Relatives told us, 'We can visit any time of the day or evening, it is never a problem.'

We noted from staff files that online training had been completed in areas such as the Equality Act 2010 and data protection. People told us that staff treated them well and we saw that equality and diversity information such as gender, race, religion, and sexual orientation was recorded in the care files. The home had an equal opportunities policy in place. It stated that discrimination of any kind was unacceptable and would lead to disciplinary investigations. There was a list of people's basic human rights and this had been personalised to a care home setting. The local vicar and congregation provided a weekly service and some people were offered a quiet room to pray and have communion with their visitors.

We noted that some of the rooms were shared and questioned whether people were involved in making decision about sharing a room. One of the people we spoke with that shared a room commented, "I share a room. It's ok as I'm friends with [Name]. I get on alright with her. There's a curtain that divides us which keeps things private so that's ok.' We asked that the provider considered peoples involvement in making decisions regarding sharing rooms or if they lacked capacity that historical preferences were taken into consideration in their best interests.

The provider was aware of local advocacy services and accessed these when appropriate to support people with any difficult decisions. These were well documented within people's files so that staff were aware of anyone that might require this service.

The provider told us no one was in receipt of end of life care at the time of our visit. A health professional advised that previously they had visited people and that the end of life care was, 'Really good here.'

Staff treated people as individuals and supported them to access local facilities outside of the home. Every last Saturday of the month staff told us they ordered in a takeaway depending on peoples choices.

We observed staff interactions with people and saw that they spoke in a softer tone when discussing anything of a personal nature. Staff had a good knowledge and awareness of the importance of keeping peoples personal information confidential at all times and we saw this in practice during our visit. The staff handbook included a short statement about the importance of maintaining people's confidentiality taken from the full policy.

Good

Is the service responsive?

Our findings

Staff told us they were introduced to people during their induction period and given an overview of their general needs. We found that staff had a good awareness of people's medical conditions and made an effort to connect with them on a personal level during one to one contact throughout the day.

People's electronic care files included details of their assessed care needs during the day and night. These included communication, mobility, emotional support, nutrition and weight, falls, health professional involvement, continence, financial support, and religious and cultural needs. Each care plan included key information so that staff could fully support people's needs, offer choice and respect any individual preferences. The majority of care plans were reviewed and updated every 3 months or earlier if changes were identified.

We observed person centred care on both days of our visit and discussions with staff confirmed they were knowledgeable about peoples care needs and individual preferences. However, some of the systems in place such as a bath book with set dates did not promote person centred care. The manager told us people could have a bath whenever they wanted and that they would look to implement an alternative system to monitor when people's personal care been met. Life histories had not always been recorded which meant that new staff would have limited insight into people's background, preferences and interests to meet the needs of those living with dementia.

Relatives told us they felt involved with peoples care and were invited to attend reviews, relatives meetings and activities or events organised by the home. One relative was aware of a singer attending the home and told us they had supported with fundraising events that were held each year. People were happy and advised us, 'I get visitors and can take them to a quiet area near the hairdressers if I want. I'm involved in reviews which are held about once a year.'

We spoke to the activities co-ordinator who advised they worked three days a week, and they left a rota of activities for staff to complete during the days they were not at work. They had been employed by the service for the last 10 years, previously in a caring role. Their knowledge of individual's preferences and needs was good. They told us they met with new people to try to find out their likes, and completed a plan of group and one to one activities people wanted to attend. There was a range of activities on offer such as card making, baking, history talks, reminiscing, watching films, afternoon teas, quizzes and, discussions on subjects such as the most recent one about 'Hull - city of culture.' We were advised that staff took the lead from people during discussions and allowed them to explore areas of interest. This showed us that individual choices were respected and encouraged by the home.

Regular outings into the community were organised and often as a result of requests made at meetings, surveys, the suggestion box and evaluation forms. Recently there had been a trip to the seaside, a local pub or coffee shop in the village and annually people had the choice of attending a Christmas pantomime.

People told us, 'There are no restrictions on me going out as long as long as someone is with me' and

another person said, ' My relatives come and take me out often.'

Relatives and friends were invited to events and encouraged to attend the summer barbeque, Christmas party, afternoon teas or stay for lunch with their relatives. Staff supported people to attend family lunches and support groups by providing transport.

The activities co-ordinator told us they had photographs of some of the schools people had attended and old war memorabilia such as 'ration cards,' these were successfully used to distract people living with dementia that had a wish to return home. We noted during activities some people tended to walk away and they were encouraged back into the activity area laughing, singing and dancing. We noticed that rummage boxes were available at the home for people to use. Rummage boxes are filled with items that may help those living with dementia tap into memories from the past. It is about reminiscing and often makes people feel empowered and secure in familiarity. Staff were very proactive in their approach and felt well supported by management.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. The registered manager was supported by a deputy manager and together they supervised all care and ancillary staff.

We saw that there was a clear management structure in place and staff told us they felt supported and that management were approachable. All the relatives that spoke with us knew the manager and deputy manager's names and felt confident that they communicated information to them and did their best to support their loved ones. One relative advised, 'The manager runs this place really well and always someone around to talk to if needed.'

Although audits were carried out and actions identified, we found no evidence that these had been followed up to ensure actions were completed.

During our visit we found that some records were incomplete or required a review and some documents were not completed accurately. We saw one person's file where there was conflicting information on a body map compared to the written details about the anatomical area. Life histories had not been completed in two of the files we audited.

Management systems were in place but they were not always effective at driving improvements as we found breaches in policy and procedures, staff training and supervision and infection control.

This was a breach of Regulation 17 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager was open and honest about the issues raised during this visit and proactive at putting plans in place to address any concerns we raised. Relatives had told us they felt confident in the management structure within the home and were happy to discuss complaints with staff. Everyone we spoke to felt confident that management would address any issues and that improvements would be actioned as a result.

We saw that the manager had attended meetings with people who lived at the home and relatives and taken on board people's views and actioned some changes. One change made was to hold separate meetings for people and their relatives so it was easier for people to have time to voice their opinions.

The home encouraged the 'Mum Test' in that they made their staff consider whether the care and support received in the home was good enough for one of their family members or loved ones. We observed a pleasant atmosphere within the home and identified lots of good practice such as staff meeting people at eye level in a warm and friendly manner to engage them in conversation. Staff told us, 'Relatives like how

nice we are, I love being here.'

The home had a clear statement of purpose, which was included in the staff handbook given to staff at the time they commenced employment at the home. Observations confirmed that the management and staff followed this commitment and provided an environment where people could live their lives with dignity, respect and freedom of choice.

Everyone told us that the culture of the service was open and transparent and that the manager was always available to speak to. Comments included, "Nothing is ever any trouble". Staff told us that the manager was always suggesting new ideas to improve practice and encouraged additional training to meet the needs of those living with dementia.

Staff had made contact with the local school and children visited regularly to speak to people or sing to them. In the past, the children had taught people how to make bracelets and then people who lived at the home had taught the children how to knit and crochet.

The manager sought feedback from people who used the service, relatives and other external stakeholders in an annual satisfaction survey and through a suggestions post box. In addition to this, a book was available for anyone to write concerns or views of the home.

We could see that the quality of care was of a good standard, people looked smart and clean and appeared to be smiling and content. The home had a welcoming atmosphere and health professionals advised us that they were welcomed and never needed to make an appointment to complete reviews. Relatives were encouraged to visit at times that suited their work commitments and were very happy with the leadership in the home.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Ineffective systems were in place to assess potential risks in relation to detecting and controlling the spread of, infections, including those that are health care associated. Regulation 12 (2) (h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes in place to report safeguarding concerns were out of date and not regularly reviewed. Not all staff had received safeguarding training and no clear procedures were in place for staff to follow when recording and reporting safeguarding incidents. Regulation 13 (1) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance and record keeping processes were ineffective in monitoring and improving quality and safety of the service, assessing and mitigating risks to people who used the service and maintaining an accurate, complete and contemporaneous record in respect of each person using the service. Regulation 17 (1) (2)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Fit and proper persons employed. The provider had not made reasonable attempts to obtain satisfactory evidence of conduct in previous employment, such as references. Regulation 19 (2) (a), (3) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not receive appropriate induction training, supervision or appraisal as is necessary to enable them to carry out their duties. Regulation 18 (2) (a)