C James and D Burn

Little Hayes Rest Home

Inspection report

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Date of inspection visit:
25 January 2016

Date of publication:
09 March 2016

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

This inspection took place on 25 January 2016 and was unannounced. The home provides accommodation for up to 32 people, including some people living with dementia care needs. There were 28 people living at the home when we visited. The home was based on two floors connected by two passenger lifts; there was a good choice of communal spaces where people were able to socialise; all bedrooms had en-suite facilities.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

People's safety was compromised as the risks to their health and safety were not always managed appropriately and action was not always taken to reduce the level of risk. This included the risks of people falling, choking or developing pressure injuries. People were not protected from the risk of infection as relevant guidance was not being followed in the laundry and care staff did not consistently make sure that people's bedding was kept clean.

Staff did not followed legislation designed to protect people's rights and ensure that decisions are only taken in the best interests of people. However, they did seek consent from people before providing care and understood how to protect people's freedom.

People received personalised care from staff who understood their needs. However, this was not supported by the care planning system, which was disorganised and inconsistent. The registered manager showed us a new care planning system they were planning to introduce to address this.

With the exception of medicines audits, there were no effective systems in place to assess, monitor and improve the service, such as the management of risks to people, infection control arrangements and care planning.

Medicines were managed safely, although procedures to make sure medicines were always available were not robust. We have made a recommendation about this.

People told us they felt safe at the home. Staff knew how to identify, prevent and report abuse, and the provider responded appropriately to allegations of abuse.

The process used to recruit staff helped make sure that only suitable staff were employed. There were enough staff to meet people's needs at all times. Staff were knowledgeable, suitably trained and were supported appropriately in their work.

People were offered varied and nutritious meals, enjoyed the food and received appropriate support to eat

and drink enough. They had access to healthcare services, such as doctors and nurses, when needed.

People were involved in planning the care and support they received, although they were not always involved in reviews of their care. They were treated with kindness and compassion by staff who knew them well. Their privacy and dignity was protected and staff encouraged them to remain as independent as possible.

Staff encouraged people to make choices about all aspects of their lives and were responsive to people's needs. People had access to a range of suitable activities. The provider sought and acted on feedback from people and staff.

There was a clear management structure in place. Staff understood their roles, were motivated, and worked well as a team. There was an open and transparent culture; visitors were welcomed and there were strong links to the local community.

We identified breaches of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have taken 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.

Individual risks to the health and safety of people were not always managed effectively. People were not protected against the risk of infection.

Medicines were managed appropriately in most cases, although procedures to ensure medicines were always available to people were not robust.

People felt safe and staff knew how to identify, prevent and report incidents of abuse. There were sufficient staff to meet people's needs and recruiting procedures were safe.

Suitable procedures were in place to deal with foreseeable emergencies and staff were trained in first aid.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not always follow legislation designed to protect people's rights. However, they did seek verbal consent from people before providing care and support.

Staff were knowledgeable about the needs of people and how to care for them effectively. They received appropriate induction, training, supervision and support.

People enjoyed the food and received appropriate support to eat and drink enough. They had access to healthcare services when needed.

Is the service caring?

Good

The service was caring.

People were involved in planning the care and support they received.

Staff knew people well and treated them with kindness and

compassion. They showed concern for people's well-being.

The privacy and dignity of people were protected. People were supported to remain as independent as possible.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The delivery of personalised care was not supported by care planning records which were disorganised and inconsistent.

Staff were clear about how they provided individualised care and this was confirmed by daily records of the care and support delivered.

People had access to a range of appropriate activities to meet their social needs.

The provider sought and acted on feedback from people.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Effective systems were not in place to monitor the quality of the service, although medicines were audited regularly.

People liked living at the home. Staff understood their roles, were motivated, and worked well as a team.

There was an open and transparent culture at the home. Manager sought feedback from staff and considered their views. There were strong links to the local community.

Little Hayes Rest 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 25 January 2016 and was unannounced. It was conducted by two inspectors and an expert by experience in the care of older people. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed information we held about the service, including previous inspection reports and notifications we had been sent by the provider. A notification is information about important events which the service is required to send us by law.

We spoke with 15 people living at the home and one family member. We also spoke with the registered manager, the deputy manager, six care staff, a member of kitchen staff and two cleaners.

We looked at care plans and associated records for five people and records relating to the management of the service. These included staff duty records, staff training and recruitment files, records of complaints, accidents and incidents, and quality assurance records.

We observed care and support being delivered in communal areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

The home was last inspected on 1 July 2014, when we identified no concerns.

Requires Improvement

Is the service safe?

Our findings

Risks were not always assessed and managed safely. Risk assessments had been completed for some but not all areas of individual risk. For example, there was no risk assessment in place for a person who had a history of falls prior to moving to the home. Staff told us this was because the person had not fallen at the home; however, an accident record showed, and the person confirmed, that they had fallen shortly after arriving at the home. A staff member told us they "just keep an eye on [the person] and do half-hourly obs[ervations]. I'm not saying everyone does it, but I do." The person also had difficulty swallowing and staff told us the person was given a soft diet as they were at risk of choking; however, there was no risk assessment in place for this to help make sure the risks were managed appropriately and consistently. A risk assessment had been completed for another person who was at risk of falling. However, they had had 11 falls in the previous seven months and their risk assessment had not been reviewed to consider whether additional measures were needed to keep the person safe.

Other individual risk assessments did not provide clear guidance for staff as to how the identified risk should be managed. For example, a risk assessment had been completed for a person at risk of developing pressure injuries, but this had not been updated since September 2015. Since that time the person's needs had changed and they were being cared for in bed at all times, which had increased their risk of pressure injuries. A risk assessment for the use of an electric profiling bed and pressure relieving mattress for another person stated staff should 'ensure bed working correctly'. However, no further guidance was provided and staff were not clear about how to check the mattress settings. We found this person's mattress and one other person's mattress were not set correctly, so they may not have protected people effectively against the risk of developing pressure injuries.

Environmental risks were not always assessed and managed appropriately. For example, there was no risk assessment, or information available, to show how risks posed by Legionella in the water systems were being managed. Not all first floor windows had opening restrictors in place to prevent falls and the registered manager was unable to provide risk assessments to show why these were not required.

People were not protected from the risk of infection. Providers are required to take account of the Department of Health's publication, 'Code of Practice on the prevention and control of infections'. This provides guidance about measures that need to be taken to reduce the risk of infection. The code of practice requires providers to complete an annual statement detailing what policies and infection control risk assessments were in place, and any staff training or outbreaks of infection that had occurred. The provider had not conducted any infection control risk assessments or completed an annual statement of infection. The code also requires providers to conduct regular infection control audits. These had not been completed.

Most areas of the home were visibly clean. Care staff were responsible for cleaning communal areas of the home, such as the lounges, and records showed these were cleaned regularly. However, the seat cover on the stair lift was torn and the inner foam base was crumbling; this created a bacteria trap as the seat could not be cleaned effectively. Two bedrooms smelt of urine; staff told us they regularly cleaned the carpets, but

could not get rid of the odour. Sheets on one person's bed and the pillow on another were not clean. Cleaning records showed that cleaners had had to change dirty bedding on two people's beds after they had been made by care staff. The cleaners told us this was not unusual. Although people's bedding was changed on these occasions, it showed care staff were not consistent in ensuring that people's bedding was kept clean.

Staff used soluble red bags for linen that was heavily soiled and potentially infectious. Guidance issued by the Department of Health (DoH) recommends that these items should be cleaned separately at a minimum of 65 degrees Celsius. However, staff told us they sometimes put other washing, such as towels and flannels, with the soluble red bags and washed them at 60 degrees Celsius. This was not hot enough and posed a risk of cross infection. Clean items, such as sheets and towels were stored in the laundry, contrary to DoH guidance, and there was no process in place to prevent such items being contaminated by dirty washing entering the laundry.

The failure to assess and mitigate risks to the health and safety of people and the failure to assess and prevent the risk of infection were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had received training in infection control. They had access to personal protective equipment in all key areas around the home, such as bathrooms and toilets, and we saw this being used appropriately.

Action had been taken to reduce other risks, such as the risk of people leaving via fire exits and falling on fire escapes. All these doors had been fitted with an audible alarm linked to the call bell system which would alert staff if these doors were opened. Where people needed bed rails, to prevent them falling out of bed, risk assessments had been completed to show whether they could be used safely.

There were safe medicine management procedures in place and people received most of their medicines when required, from staff who were suitably trained. However, four medicines, including eye drops, had run out in the previous month and had been unavailable to people for up to 10 days. Staff told us this was due to difficulties between the prescribing doctors and the pharmacy.

We recommend the provider reviews their medicine ordering procedures to help ensure prescribed medicines are always available for people.

An effective system was in place to monitor and account for all medicines received into the home through clear stock control processes. This included clear processes to help ensure topical creams were not used beyond their safe 'use-by' date. There was also an effective system in place to dispose of medicines safely. Staff were proactive in identifying when people were having difficulty swallowing tablets and contacted GPs to request alternative forms of medicine that were easier for the person to receive. Staff gave people time to take their medicines and explained what they were for.

People felt safe living at the home. One person told us, "Oh, yes, I'm safe here." Staff knew how to identify safeguarding concerns and acted on these to keep people safe. They had received appropriate training and were aware of people who were at particular risk of abuse. Where people found it difficult to manage their money independently, the management looked after small amounts of money for them. Suitable measures were in place to keep this secure and to record its use. This helped protect people from the risk of financial abuse. The registered manager responded appropriately to allegations of abuse by conducting thorough investigations in liaison with the local safeguarding authority. Following one investigation, it was identified that the person needed to be referred to a specialist and we saw this was done the following day.

People were supported by sufficient staff with the right skills and knowledge to meet their individual needs. One person said of the staff, "They always give me the bell and tell me to ring if I want anything; and always come quickly." The registered manager described how staffing levels had been calculated following their own observations and feedback received from people and staff. They had identified that people would benefit from additional staff in the evenings, to enable people to have a bath before going to bed, for example, and were in the process of recruiting staff to work these shifts.

Clear recruitment procedures were in place to help ensure staff were suitable to work at the home. These included reference checks from previous employers and a criminal record check with the Disclosure and Barring Service (DBS). The DBS helps employers to make safer recruitment decisions. Staff confirmed this process was followed before they started working at the home. Part of the recruitment process involved introducing potential staff to people living at the home. The registered manager then sought feedback from people to assess the suitability of applicants.

Suitable emergency procedures were in place. Staff knew what action to take if the fire alarm sounded and completed regular fire drills; they had been trained in fire safety and the use of evacuation equipment. Records showed fire detection and firefighting equipment was regularly checked. Staff were also aware of how to respond to other emergencies. For example, staff described how they would respond to a medical emergency and were aware of the correct action they should take if a person suffered an injury. This included monitoring the person and seeking medical advice. Senior staff told us they had completed first aid training and we saw first aid equipment was available for a variety of emergencies.

Requires Improvement

Is the service effective?

Our findings

Staff showed an understanding of the need for consent. Before providing care, they sought consent from people using simple questions and gave them time to respond. One person said, "[Staff] always ask what I want and what help I need." A staff member told us, "If a person says they don't want care at that time then we leave them and go back later or get another staff member to try".

Most people living at the home were able to make day to day decisions about the care and support they received. Most people who had capacity had signed consent forms indicating their agreement to the care and support they received. However, where they lacked the capacity to make this decision, staff did not always follow the Mental Capacity Act, 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Staff told us one person was not able to make decisions about the care and support they received, but this had not been assessed and best interest decisions had not been made for this person. Another person's relative had signed to agree to a person's care, including the use of bed rails. The person's care record stated the relative had the legal authority to make these decisions. However, the registered manager had not sought confirmation of this.

We discussed this with the registered manager, who showed us new forms they were introducing to enable them to assess people's capacity. These would help ensure the MCA and its code of practice were followed and people's rights were protected.

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). We checked whether the service was working within the principles of the MCA. Nobody at the home was subject to a DoLS application or authorisation. The registered manager was aware of the circumstances when they may need to consider this and how they might obtain guidance if required. Staff were aware of Deprivation of Liberty Safeguards and how these might affect people in their care. They described the correct action they would take if a person left the home and they thought it may be unsafe for them to do so.

People told us they received effective care and support. One person said of the staff, "They look after me and nothing is too much trouble." Another person told us, "We love this house; how could you not?" We observed people appeared cared for, in that they were wearing clean, appropriate clothing, attention had been given to hand and mouth care and their hair was styled. One person told us, "The girls [staff] do it, or sometimes the hairdresser does it." People who were less mobile looked comfortable in their beds. Daily care records demonstrated that people were receiving appropriate care and support.

Staff were knowledgeable about the needs of people and how to care for them effectively. New staff received induction training, which followed the Care Certificate. This is awarded to staff who complete a

learning programme designed to enable them to provide safe and compassionate care to people. We spoke with a newer staff member who told us they had completed a formal induction and shadow shifts where they worked alongside staff but were not "counted in the numbers". Staff were up to date with all essential training and this was refreshed regularly. One staff member said "The training is really good; we did safeguarding last week and even though I have covered this before I still learnt something new". Other staff told us they were being supported to undertake nationally recognised care qualifications. Most staff had obtained vocational qualifications relevant to their role or were working towards these. We observed that the training had been effective. For example, we saw staff supporting people to move around the home using appropriate techniques, and staff were able to communicate with people appropriately.

People were cared for by staff who were appropriately supported in their work. Staff told us they felt "very supported" by the registered manager and other senior staff. One staff member said "I have been here 25 years and have always had support; I have no worries about working here". All staff said they felt able to approach the registered manager for support and guidance. One said "Anything, work or not work related, I can ask [the registered manager] for help; they are always available." Another staff member told us, "We have the manager's mobile number and any problems we can call them, they always answer." Staff received one-to-one sessions of supervision with a manager, which included being observed whilst they were providing care to people, to check they were working in a compassionate and effective way. A formal supervision form was used to assess the performance of staff and identify any additional training or support required. Staff also received an annual appraisal. They told us this was a formal process during which they met with the registered manager, talked about their work and identified any training needs.

People were complementary about the meals provided. One person said, "I'm happy with the meals; there's always a choice of two and if you don't like them they do you an alternative. For example, I don't like fish, so they always do me an egg and I'm happy with that." Another person told us the food was "great".

People were offered varied and nutritious meals which were freshly prepared at the home. Choices were provided and the chef visited people each morning to identify which of the main meal options they preferred. Special diets were available for people who required them and people received portion sizes suited to their individual appetites. Drinks were available throughout the day and staff prompted people to drink often. Staff monitored the fluid intake of all people and recorded this when cups were collected. The registered manager told us they had just purchased a set of sit-on weighing scales to enable them to monitor people's weight more accurately.

People received appropriate support to eat and drink enough. One person told us "I want to carry on eating [independently] for as long as I can. [Staff] know to cut my food up and that I don't have [certain foods]." We observed the lunchtime meal in the dining room and the support people received who had chosen, or needed, to remain in their bedrooms. A staff member was present at all times in the dining room and provided encouragement or assistance to people as required. People sat at small tables of up to four and chattered in a relaxed way throughout the meal. The tables looked attractive with tablecloths, place mats and flowers. Food was served to all the people sat at each table at the same time, so people did not have to wait for their meal while watching others eat.

Where people needed full support to eat, this was provided on a one-to-one basis by staff who were attentive and unrushed. They engaged with the person they were supporting and offered them choices. For example, we heard a staff member ask a person: "Which would you like first; shepherd's pie or some vegetables?" A person in bed was made comfortable and assisted to sit at an appropriate angle to eat. The person did not eat very much, so the staff member tempted them with alternatives. They told us "[The person] didn't eat much of the crumble and custard, but she does prefer sweet things, so I thought I'd try

this jelly, so she might get some more eaten."

People were supported to access other healthcare services when needed and they were seen regularly by doctors, nurses, dentists, opticians and chiropodists. For example, one person was supported to visit hospice day services each week. The Registered manager was clear about the level of need and type of care that Little Hayes could provide and only admitted people whose needs they could meet.

Good

Is the service caring?

Our findings

When people moved to the home, they, and their families where appropriate, were usually involved in assessing and planning the care and support they needed. However, some people told us they had not been involved in planning their care and were not always consulted when their care plans were reviewed. We discussed this with the registered manager who showed us a new care planning format that was being introduced which would record people's involvement more effectively.

People were treated with kindness and compassion in their day-to-day care. One person said of the staff, "Oh, they are lovely here. You couldn't ask for better." Another person confirmed this and added, "The staff are all so sweet; all of them." Written feedback from a relative stated: "Everyone is so nice and cheerful and helpful." We observed positive interactions between people, including staff dancing and singing with people. We also heard good-natured banter between them, showing they were relaxed and comfortable in each other's company and knew how to relate to each other in a positive way. Staff used their knowledge of people's backgrounds to strike up meaningful conversations with people and help them to reminisce. During an entertainment sessions, one person had a coughing fit and was attended to quietly and patiently. The person was offered the chance to go to their room, but chose to stay for the remainder of the entertainment, which they were supported to do.

Staff had sought people's views about the use of terms of endearment, such as "love" or "darling", and only used these with people who had agreed to them. In most cases, staff addressed people using their preferred names. They showed concern for people's wellbeing; staff spent quality time with people and did not rush when providing care. They engaged with people at eye level and used touch appropriately to reassure them when they became anxious.

Staff supported people to build positive relationships. Several people had formed close relationships with others living in the home. Staff were aware of this and made arrangements for them to sit together at meal times.

People's privacy was protected. Staff knocked and waited for a response before entering people's rooms and closed their doors when personal care was being delivered. Staff described practical steps they took to maintain people's dignity, such as partially covering them with towels when delivering personal care. A bedroom had been converted into a 'treatment room' for visiting doctors and nurses, so they could examine people in private. The registered manager told us "People love it in there. We're very proud of it."

Confidential information, such as care records, was kept securely and only accessed by staff authorised to view it. When it no longer needed to be retained, it was disposed of confidentially. However, the records of daily care and support given to people was not documented individually, but recorded on forms used for a number of people. This could compromise people's privacy when other people's care records were viewed by professionals.

People were encouraged to remain as independent as possible to the full extent of their abilities. They were

able to move freely around the home. The home was spacious and allowed people to spend time on their own if they wished. Some chose to spend the majority of time on their rooms, but there was a good range of communal spaces where people were able to socialise and take part in activities. People's bedrooms were personalised with items important to them, such as photographs and mementos.

Requires Improvement

Is the service responsive?

Our findings

People said they received personalised care from staff who understood and met their needs well. One person told us "They give me all the help I need. They help me get dressed and undressed on bath days; they help me get undressed for bed. They check with me what I want." Staff were able to describe the way people preferred to receive care and support. Records of the care and support provided by staff on a daily basis were comprehensive and showed that people had received a personalised service.

However, care plans were not always up to date and did not support the delivery of individualised care. They were disorganised, contained inconsistent guidance and were not easy to access. They did not provide comprehensive information about how each person's needs should be met. Consequently, there was a risk people would not receive care in a consistent way. A staff member described the care planning system as "a pain" and told us it was "hard to find information". For example, one person had a history of constipation; they were receiving medicine for this but there was no information about how this should be monitored or when specialists should be contacted. Another person's care plan stated the person was: "capable of attending to all care needs", but elsewhere stated that they "need assistance from one carer for personal care". The care plan did not specify what assistance was needed or when. Other information, such as in relation to people's allergies, was not recorded consistently; different allergies were recorded in varying sections of the care records which meant medical staff may not have had access to accurate information.

We discussed this with the registered manager who showed us a new care planning system they were planning to introduce in the near future. Once rolled out, this would better support the delivery of personalised care to people.

Staff supported people to make choices and were responsive to their needs. One person told us, "Sometimes I go to the dining room, sometimes I stay [in my room]; depends how I feel. [Staff] do come in and chat to me." Another person said, "Sometimes I [go to the dining room], but lately I've had meals brought to me in my room. I'm quite happy being able to choose which I do." A further person told us of action staff had taken when the heating had broken in their room. An alternative form of heating was provided, including a hot water bottle for the person.

People had access to a range of activities. These included impromptu coffee mornings, one-to-one time with staff and outside entertainers most afternoons. Some people knitted, crocheted or painted and we observed 'sing along' entertainment in the afternoon which nine people took part in. The entertainer engaged people by talking about the songs, their dates, associations, and adverts on the television. This started a reminiscence session alongside the music which people clearly enjoyed. Some people chose not to attend the entertainment and watched television instead. One person told us "I have enough to do." Another person said, "We have plenty to do; sometimes too much choice." Staff were aware of people's individual interests and met these where possible. For example, one person enjoyed watching a particular type of film and had access to a wide range of these. The person told us, "I've got loads of DVDs; I don't mind how often I watch them." People had level access to an enclosed garden. They told us they did not like to go outside in winter, but described events that took place in the garden in summer, which they enjoyed.

The provider sought feedback from people through the use of survey questionnaires. Comments from people were positive, showing they were satisfied with the service. They included: "Very happy here"; "No concerns"; "I am pleased with everything"; "[Staff] are excellent in every way"; and "I am totally satisfied my [relative] is very well looked after."

There was an appropriate complaints policy in place which was prominently displayed in the reception area. People told us they knew how to complain and said any concerns would be taken seriously and acted on. We viewed two complaints that had been dealt with, and responded to, in accordance with the provider's policy. Complaints were used to improve the service; for example, the registered manager told us about changes they had made to fire safety arrangements, after issues had been raised in a complaint.

Requires Improvement

Is the service well-led?

Our findings

With the exception of medicine audits, there were no effective systems in place to monitor, assess or improve the quality of the service provided. Consequently, the provider had not identified or implemented improvements that were needed to ensure people received a safe and effective service. These included the need to review and manage the risk of falls, infection control arrangements, the implementation of the MCA, and reviews of care plans to make sure they remained up to date and reflected people's current needs.

The failure to have effective systems in place to assess, monitor and improve the service was a breach of of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The administration of medicines was audited each month to ensure medicines were properly administered and accounted for. The audits had identified that some medicines were not available for people; action had been taken to address individual cases, although this had not addressed long term issues. A community pharmacist had reviewed the arrangements for managing medicines and confirmed that they were appropriate and effective.

People liked living at the home and felt it was well-led. One person said of the management, "They are excellent in every way." The registered manager told us they had a clear vision to provide a high quality service in a homely setting, so they could maintain a personal, friendly atmosphere. They said, "I want to provide a home-from-home environment that's not clinical; I want them to feel this is their home and their friends and family are part of it." This vision was understood and shared by the staff, who were committed to maintaining a relaxed environment and were attentive to people's needs.

People benefitted from staff who understood their roles, were motivated, and worked well as a team. There was a clear management structure in place. This consisted of the registered manager, a deputy manager and senior care staff. Staff turnover was relatively low, so staff knew people and their needs well. Staff received a formal handover at the start of each shift so any known information about people was passed over to them.

The registered manager told us they and the deputy manager worked alternate weekends so there was always management cover to support and guide staff. All but one member of staff described the managers as "supportive" and said they enjoyed working at the home. One member of staff told us, "I really love it here. I'm left alone to do what I need to do and if I need anything I go and ask one of the managers and they sort it out." Another said, "Any concerns are dealt with and I get on well with management. There's good team work, people are safe and we treat them as individuals." A further staff member told us, "There's always a senior [staff member] on each shift; we have separate lists [of tasks] and are paired up with another person to do them."

The registered manager sought feedback from staff, including through staff meetings. Staff were encouraged to make suggestions about how the service could be improved. One staff member told us, "We

can talk about anything in staff meetings and we are listened to." Minutes of the most recent staff meeting showed staff had been involved in discussions about re-scheduling mealtimes in the future; their ideas had clearly been sought and considered.

There was an open and transparent culture at the home. Communication between management and staff was relaxed and open. The registered manager had an open door policy and their office was located in the centre of the home, which made it easy for people and staff to pop in and discuss concerns. The previous inspection report was displayed in the reception area; the provider notified CQC of all significant events; relatives could visit at any time and were made welcome.

There were strong links to the local community. Some people had lived nearby for many years and were supported to keep in touch with friends and family members. Ministers from local faith organisations visited the home regularly and one person attended weekly services at a local church.

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 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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured that risks to the health and safety of service users, including infection control risks, were being managed effectively. Regulation 12(1) and 12(2)(a), (b) & (h).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems in place to assess, monitor and improve all aspects of the service. Regulation 17(1) and 17(2)(a).