Methodist Homes

Greenways

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?	Good
Is the service well-led?	Good

Overall summary

The inspection took place on 12 and 13 October 2015 and was unannounced.

Greenways provides care and accommodation for up to 44 people and there were 39 people living at the home when we inspected. These people were all aged over 65 years and had needs associated with old age and frailty as well as dementia.

The home is purpose built. All bedrooms are single and have an en- suite toilet. The accommodation is divided into five units over three floors. Each unit has its own lounge-dining room with a small kitchen. There is a main lounge area and accessible gardens with tables and chairs for people to use. A passenger lift is provided so people can access all floors.

The service did not have a registered manager, but did have a manager who had applied to the Commission for registration. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered

Summary of findings

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.

Procedures for the handling and administration of medicines were generally safe with the exception of a lack of care plan instructions when people needed to take 'as required' medicines. When topical creams were administered staff did not always record this in the medicines administration records.

The CQC monitors the operation of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Staff were trained in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). Staff were trained in the Mental Capacity Act 2005 (MCA) but appropriate assessments of capacity were not always carried out. People had been referred to have their liberty restricted under the Deprivation of Liberty Safeguards (DoLS) without their capacity to consent to care and treatment being assessed. These would only be required if a person did not have capacity to consent to their care and treatment.

Staff were trained in adult safeguarding procedures and knew what to do if they considered people were at risk of harm or if they needed to report any suspected abuse. People said they felt safe at the home.

Care records showed risks to people were assessed and there was guidance of how those risks should be managed to prevent any risk of harm.

There were sufficient numbers of staff to meet people's needs. Staff recruitment procedures were adequate to ensure only suitable staff were employed.

Whilst staff said they felt supported in their work individual staff supervision and appraisals had not always taken place. This had been identified and action taken to address this shortfall.

There was a choice of food and people were complimentary about the meals. People's nutritional needs were assessed and arrangements made so those at risk of malnutrition or dehydration were adequately supported.

People's health care needs were assessed, monitored and recorded. Referrals for assessment and treatment were made when needed.

Staff were observed to treat people with kindness and respect. People were able to exercise choice in how they spent their time. Staff demonstrated concern for people's well- being and supported them when they were in discomfort.

People said they were consulted about their care and care plans were individualised to reflect people's choices and preferences. Each person's needs were assessed and this included obtaining a background history of people. Care plans showed how people's needs were to be met and how staff should support people.

There were a range of activities for people and a schedule of activities for the week was displayed in the entrance hall. People's individual social and recreational needs were assessed.

The complaints procedure was available and displayed in the entrance hall. People said they had opportunities to express their views or concerns. There were records to show how complaints were looked into and any actions taken as a result of the complaint. A relative, however, did not feel their complaint was looked into properly.

Staff demonstrated values of treating people with dignity, respect and as individuals. Staff views were also sought and staff were able to contribute to decision making in the home.

A number of audits and checks were used to check on the effectiveness, safety and quality of the service which were generally effective in assessing and ensuring quality but some issues noted at this inspection had not been identified by the provider.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not always safe.

The service did not have appropriate arrangements in place to protect people against the risks associated with the unsafe use and management of medicines.

The service had policies and procedures on safeguarding people from possible abuse. Staff knew what to do if they suspected any abuse had occurred.

Risks to people were assessed and guidance recorded so staff knew how to reduce risks to people.

Sufficient numbers of staff were provided to meet people's needs.

Is the service effective?

Requires improvement

The service was not always effective.

Staff were aware of the principles and procedures as set out in the Mental Capacity Act 2005 Code of Practice, but people's capacity to consent to care and treatment was not adequately assessed.

Whilst staff were trained in a number of relevant areas, supervision and appraisal of staff was inconsistent. This was being addressed by the manager.

People were supported to have a balanced and nutritious diet. Arrangements were made to assess and support those at risk of malnutrition or dehydration. Health care needs were monitored. Staff liaised with health care services so people's health was assessed and treatment arranged where needed.

Is the service caring?

Good

The service was caring.

Staff treated people with kindness, respect and with dignity.

People were consulted about their care but this was not always recorded.

Staff promoted people's privacy and people were supported to exercise choice in how they spent their time.

Is the service responsive?

Good

The service was responsive.

People's needs were comprehensively assessed and reviewed. Care plans were individualised and reflected people's preferences.

There was a daily activities programme for people.

Summary of findings

People were aware of the complaints procedure and knew what to do if they were dissatisfied. Records showed complaints were looked into, although one relative felt this was not always the case.

Is the service well-led?

Good

The service was well-led.

The provider sought the views of people and staff regarding the quality of the service and to check if improvements needed to be made.

The service had a set of values it promoted of treating people as individuals and with respect, which staff demonstrated during the inspection.

There were a number of systems for checking and auditing the safety and quality of the service.

Greenways

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. The inspection checked 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 took place on 12 and 13 October 2015 and was unannounced.

The inspection team consisted of an inspector, a pharmacy inspector and an Expert by Experience, who had experience of services for older people. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

We reviewed information we held about the service, including previous inspection reports and notifications of significant events the provider sent to us. A notification is information about important events which the provider is required to tell the Care Quality Commission about by law.

During the inspection we spoke with 12 people who lived at the home and to four relatives. We also spoke with seven care staff, deputy manager, the chef, a housekeeper and the provider's service manager.

We spent time observing the care and support people received in communal areas of the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us.

We looked at the care plans and associated records for five people. We reviewed other records, including the provider's internal checks and audits, staff training records, staff rotas, accidents, incidents and complaints. Staff records were reviewed, which included checks on newly appointed staff and staff supervision records.

We spoke with a community nurse who treated people at the home. This professional gave their permission for their comments to be included in this report.

This service was last inspected on 15 October 2013 and there were no concerns.

Requires improvement

Is the service safe?

Our findings

Most medicines were stored securely and the temperature records for the medicines rooms provided assurance that these medicines were kept within their recommended temperature ranges. However, the medicines refrigerator records indicated that one of the two refrigerators had been outside of the recommended temperature range. The storage of controlled drugs was not in line with current legislation.

The administration of medicines was recorded via Medicine Administration Records (MAR). A care worker explained how they applied creams to the people living in the home as part of their personal care. The care workers showed us where these creams were kept. The care worker also showed us the records they completed. The creaming plans described in detail where to apply the creams and the frequency of creaming. However the description provided by staff suggested not all applications were recorded to ensure they we being applied appropriately.

Information available to support the administration of medicines was variable under heading such as, allergy, "how I take my medicines", "if required" and "variable dose." One person's MAR indicated some medicines could be administered covertly whilst the care plan indicated; "the GP should be informed if medicines were refused for more than three days". There was insufficient detail to show how what procedures should be followed to ensure this person received their medicines as prescribed.

Whilst the effectiveness of medicines were appropriately monitored, there was a lack of care plan guidance regarding medicines which needed to be administered on an 'as required' basis for psychological needs.

People living at the home were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place for the proper and safe management of medicines. This is in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe at the home and that they received safe care. For example, one person said, "Staff check on me to see if I'm OK." Another person told us staff responded promptly when they used the call point in their room to request assistance. We spoke to four relatives of people who lived at the home who gave mixed feedback about the safety of the service. One relative felt that appropriate action was not always taken when people fell and that staff were not always available to safely support people. Two other relatives, however, considered the staff provided safe care to people. Other people who we spoke to said there were enough staff. One person, however, said, "It's really lovely. It's completely understaffed, and the staff are underpaid and over worked. They work their socks of."

Staff were trained in procedures for reporting any suspected abuse or concerns. The provider told us this training was included in the induction training for new staff as well as taking place every 12 months. The training was provided to all staff including care staff, housekeepers and kitchen staff. Staff were aware of the different types of abuse which might occur such as physical, psychological and financial. Staff said they would report any concerns to their line manager and knew they could access safeguarding procedures in the home. Staff were aware they could reports any safeguarding concerns to the local authority safeguarding team. The service had policies and procedures regarding the safeguarding of adults.

Risks to people were assessed and recorded. These included assessments of the risk of pressure areas developing on people's skin. There were corresponding care plans which set out actions the staff were taking to minimise the risks such as how often people needed to be turned or moved when they were seated or in bed. Staff completed charts to record how often this occurred, which were in line with the care plan instructions. Details were also recorded regarding the use of equipment to alleviate pressure areas such air flow mattresses and pressure relieving cushions, which we observed in use. These assessments were reviewed on a monthly basis.

There were also risk assessments regarding falls and for the moving and handling of people. Relatives and a health care professional told us how specialist equipment was used to help prevent falls, such as pressure mats which alerted staff when those at risk of falling got up in the night. There were care plans regarding mobility and dexterity for individual people, which gave detailed guidance for staff on how to safely support people. We observed staff assisting people with their moving and handling needs; the staff were careful to support people safely and explained to people what they were doing. Where people had experienced a fall an accident report was completed, which included a review of the incident and action to prevent a reoccurrence. A

Requires improvement

Is the service safe?

relative expressed the view that people were not always adequately supervised so falls were prevented but also acknowledged people enjoyed the freedom to be able to walk around the home. A health care professional said they were working with the manager and staff regarding the management of the risks of falls to people.

Sufficient numbers of staff were provided to meet people's needs. The provider assessed each person's needs every month using a dependency tool which gave an indicative level of staffing to meet people's needs. The provider's service manager said he checked the staffing levels each week. The service manager also said the total numbers of staff in the home were 10% in excess of the levels assessed as being needed, so changes in staffing levels could be accommodated. Staffing was organised on a staff rota over two week periods. At the time of the inspection two senior care staff were on duty from 8am to 8pm with eight care staff. The manager and deputy manager's hours were in addition to this. The service also had kitchen and housekeeping staff. The staffing levels calculated and deployed ensured that there were enough staff to safely meet the needs of people.

When we asked staff if there were enough staff to meet people's needs, one replied, "Absolutely," and another said, "Yes, there's enough." One staff member said there times when there weren't enough staff which meant people might have to wait "a little longer." People gave mixed feedback about their views on staffing levels. One person told us there were occasions when staff were not always prompt when they used their call bell and attributed this to staff. Other people told us staff responded promptly when they used the call points in their room. We observed staff were available to respond to people in the communal areas and during the lunch time meal. A health care professional said they were sufficient staff to look after people and added that staff were always available when they visited the home.

We looked at the staff recruitment procedures. References were obtained from previous employers and checks with the Disclosure and Barring Service (DBS) were made regarding the suitability of individual staff to work with people in a care setting. There was a record of staff being interviewed to assess their suitability for the post. Each staff member completed a 'probationary' period when they started work when their abilities and suitability to continue their employment were formally assessed.

The home was found to be generally clean and housekeeping staff were observed cleaning and using carpet cleaners in corridors. Two relatives commented on the home not always being clean. Both these relatives referred to table surfaces not always being wiped clean. One relative said food debris fell down the sides of cushioning on the dining room seats. We checked this and saw some staining from spilt food and some small items of food debris on seating in dining areas, which we raised with the manager after the inspection. The manager agreed to look into this.

Requires improvement

Is the service effective?

Our findings

The service had policies and procedures regarding the Mental Capacity Act 2005 (MCA) and the associated Code of Practice. This legislation and guidance protects those who do not have capacity to consent to their care and treatment. Staff were trained in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). DoLS authorisations are made by the local authority for those who do not have capacity to agree to their care and treatment and have their liberty restricted for their own safety. The service had made applications for 12 people to have a DoLS authorisation for their liberty restricted for their own safety. We found these were not always preceded by an adequate assessment of people's capacity to consent to care and treatment. A DoLS would only be made for someone who did not have capacity to consent to care and treatment.

We saw capacity assessments had been carried out for some people but these were not in sufficient detail. In two cases, where people did not have capacity to consent to care and treatment, the records showed family members had agreed to decisions on people's behalf, rather than making reference to any best interest decision-making processes or people's legal representatives. These assessments were carried out in 2013 and the provider had introduced a more up to date mental capacity assessment tool which had not yet been used. We saw records that staff were trained in the MCA. One staff member we spoke to was aware of what the MCA was used for and another knew of it, but said they had not received training in the MCA. The provider's service manager acknowledged staff needed to have more up to date training in this so they were aware of how the Supreme Court decision impacted on the procedures for making DoLS applications.

The provider was not effectively assessing the capacity of people to consent to care and treatment and in line with the Mental Capacity Act 2005 and the associated Code of Practice so the appropriate procedures for best interests decisions and the need for DOLs applications were followed to protect people's rights. This was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People considered staff were skilled in providing care. One person, for instance, said the staff were "Very good, marvellous" and another person said, "The staff are all in the upper echelons of my praise." A relative said the skill levels of staff was variable and added that they considered four staff were outstanding carers but that others did not have this skill level. Two other relatives describe staff as skilled in caring for people. A health care professional said staff provided a good standard of care and were receptive to learning.

Newly appointed staff received an induction to prepare them for their role. A recently appointed staff member said the induction was sufficient to give them the knowledge of how to look after people as well as the policies and procedures. The service used an induction workbook to plan and deliver induction training to staff. These were comprehensive and there was a separate induction booklet for senior carers, care staff and housekeepers. We saw induction workbooks where staff had recorded the completion of parts of their induction.

Staff had access to a range of training courses which they described as "good" and "very good." The provider monitored staff training on a spreadsheet matrix which gave details of when individual staff had completed training considered essential to their role. This included dates of when the training needed to be updated. These included first aid at work, infection control, food hygiene, fire safety, the values of care, challenging behaviours, dementia awareness, care planning and moving and handling. Fifty three per cent of staff had completed a National Vocational Qualification (NVQ) at levels 2, 3 or 4 or an equivalent level of training. These are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard.

The competency of staff was assessed regarding practical skills, such as personal care including nail care, eye care, oral care and bed making. A manager entered their signature on the training record to acknowledge the staff had completed this. Staff competency skills were also assessed regarding medicines procedures. This involved an observation that staff were competent in medicines procedures which was recorded. The manager told us this assessment this would be repeated if staff had made an error in handling medicines. Therefore any skills or competency issues could be addressed and improved.

Whilst staff said they felt supported in their work and could ask for advice when they needed it, they also said there was

Is the service effective?

a lack of supervision. We found staff supervision and appraisal was inconsistent. The manager was already aware of this and had devised a plan for the supervision of staff. One staff member said they received supervision every six to eight weeks but supervision records showed only two had taken place in the previous 18 months. Two other staff said they had not had supervision. Staff supervision records showed one supervision in 14 months for one staff member and for another staff member the last supervision was recorded as taking place over two years ago. There were also no records of staff appraisals. The provider maintained a spreadsheet to monitor when staff had supervision. This showed 19 of a staff group of 47 had a one to one supervision in 2015. This had the potential that staff skills may not have been adequately checked and action taken to address areas where improvements were needed. We recommend that the provider continue to review their frequency of staff supervision and appraisal to ensure staff are enabled to carry out their role effectively.

People had a choice of food and were asked in advance what they would like to eat. The provider was responsive and flexible regarding meal routines to help ensure people had adequate food. For instance, people were asked what they would like to eat 24 hours in advance of the lunch. The provider had changed this as people had forgotten what they had chosen and now asked people in the morning a few hours before lunch. The main meal of the day was provided at just after midday. This was being reviewed as some people had commented they preferred the main meal in the early evening. A sample trial of providing meals in the early evening showed people ate more food at this time so consideration was being given to introducing this. The manager and service manager said if people preferred their main meal at lunch time this would be continued.

People's dietary and nutritional needs were assessed when they were admitted to the home as well as their preferences. Each person's risk of malnutrition was assessed using a recognised assessment called a malnutrition universal screening tool (MUST). The chef was aware of people's preferences for food and any special diets, such as desserts for those with diabetes. The chef also said how full fat milk, cream and milk powder were used to increase the calorific value of food so people had adequate nutrition. The chef said fresh produce such as fruit and vegetables were used.

Nutritional assessments were completed and people's weight monitored so action could be taken if people's weight changed. Referrals were made to the dietician where people had lost weight or were at risk of malnutrition. Where needed food and fluid charts were completed to ensure checks were made that people ate and drank enough.

We observed the lunch in two of the units where people ate. The days' menu plan was displayed at each dining table so people could read what was available. In both units the meal time was unhurried and people were supported by staff who took time to assist people to eat. People were asked what and how much they would like to eat. People were offered alternatives. Staff noticed if people were not eating and took action by asking people if they wanted something else. Staff offered people a choice of drinks and tea and coffee were available afterwards. Staff were patient in supporting people with their meals. We saw how one person had fallen asleep at the dining table and did not want to eat when roused. The meal was given to them later on in the afternoon when they were awake. Staff were aware of the need to offer people snacks when people were reluctant to eat main meals. We observed people who were at risk of malnutrition eating snacks outside of meal times. Drinks and biscuits were provided to people in the morning and afternoon. People said they liked the food. Comments included the following, "I'm a vegetarian, but they do their utmost to be helpful," "The food's ok. I can't eat any seafood, I'm allergic, so choices can be limiting. I have to make sure the sandwiches aren't fish," and, "The food is very good." A relative also made positive comments about the food, "The food is wonderful," and added that staff supported people to eat.

People's health care needs were monitored and each person had a support plan regarding their health care, which was reviewed each month. Records showed staff referred people for medical assistance when it was identified people needed medical input. This included contacting community nursing services and people's GP. We noted two care plans did not give sufficient detail and guidance for staff when they needed to contact medical services regarding specific needs. We discussed this with the manager who agreed to look into this. Records of any appointments people had with health care services were recorded. There were also care plans and assessments regarding people's mental health. There was a care plan regarding the management of diabetes for one person. This

Requires improvement

Is the service effective?

included the signs and symptoms to assist staff in identifying when someone was experiencing hyperglycaemia but this did not include guidance of when medical assistance or advice was needed. A health care professional said the staff contacted them appropriately regarding people's health care needs and that any guidance given was implemented. This professional said they provided support and guidance to staff regarding health care needs such as the management of diabetes.

Relatives said the purpose built environment promoted people's needs being met. Reference was made to the home being sub divided into units which helped create a homely atmosphere. The manager told us of improvements taking place or planned to take place regarding redecoration and refurbishment. One relative told us how much people liked the garden and another relative said the garden needed to be maintained better. We noted the garden was in need of maintenance which could discourage people from using it. The manager told us that improvements to the garden were planned.

Good

Is the service caring?

Our findings

People said they were supported by staff who listened to them and who were also kind and caring. For example, one person said, "The staff are lovely. They are fine, no complaints." Another person said, "I don't feel I could be in a better place." "I'm quite happy and content here. Everyone is so kind." People said they were able to spend their time as the wished and that their preferred routines were acknowledged by staff. Comments from people about choice included the following, "I get up when I choose. There's no set time to go to bed. I ask for help to get undressed." A health care professional described the staff as caring and responsive to people. Relatives described the staff as caring and "very committed to the care of the residents."

The provider commissioned a survey in 2014 of people, and relative's views of the service provided. The responses showed 100% of those who completed the survey felt staff treated people with kindness, dignity and respect; 67% said staff took time to talk to people.

One person said they were able to choose whether they received care from male or female staff whereas another person said they did not have a choice. We discussed this with the manager and service manager who said staff were aware of this and asked people whether they preferred a male or female carer. However this preference was not included in people's care plans for reference.

Staff were observed to treat people with kindness and compassion as well as being patient with people. We spent time observing staff with people in two of the dining areas and during an activities session in the main lounge. Staff were aware of people's needs and preferences and spoke to people calmly. Staff were observed paying attention to people who were either unsettled or agitated. The staff were aware of these people's needs and recognised they needed additional time to find out if they could be helped in any way or if they were in discomfort. People were engaged with activities and staff involved people in discussions about the activity.

People said they were consulted about their care and copies of people's care plans were held in their rooms so people could see them. However, the records did not always reflect this practice. There was a record in care plans to show people's relatives had agreed to people's care but there was no evidence people themselves were consulted even when they had capacity to do so. There was information in people's care plans about their background and preferences in their daily lives so staff had information about people's individual lifestyles. There were other mechanisms for people to be involved in making decisions and having their views considered, such as through residents' meetings and meetings with their keyworker.

The service had policies and a statement of commitment to treating people as individuals and with respect. These were incorporated into one of the staff training courses called 'Living the Values.' Staff told us their own values were of treating people with respect and dignity and to promote people's independence and privacy. For example, one staff member commented, "I treat people how I would want to be treated or how I would want one of my family treated." Staff also said it was important to allow people to maintain their independence and for people's spiritual needs to be met. Religious services were provided for people who wished to attend these and we observed one taking place during the inspection. Care plans included details of the personal care tasks people could do themselves and what support staff needed to provide.

People's privacy was promoted by the staff. We observed staff knocking and waiting before entering people's bedrooms. Staff asked people if they were willing to give their agreement to the inspector looking at their care plan documents. It was not clear from discussion with the manager and service manager if people were offered a key to their bedroom door so they could exercise privacy and security. There was no record of this being offered in people's care plans.

Good

Is the service responsive?

Our findings

Relatives gave mixed views about people receiving personalised care which met people's needs. One relative said they were not satisfied that changing care needs were always met. Two relatives referred to lapses in the delivery of care which included bathing of people and staff failing to set up people's hearing aids properly. One of these relatives commented that they felt this was being addressed by the new manager. However, another relative said the staff maintained good standards of personal hygiene for people and when people refused to have a bath the staff were skilled in encouraging people to do so. This relative said people were always clean and well- dressed which was also noted during the inspection.

People said they were satisfied with the way they were supported. For example, one person said they got the right help with their personal care and another said, "I have help to get undressed. I don't feel I could be in a better place. I'm quite happy and content here."

Each person's needs had been assessed and these were used to devise a personalised care plan which reflected people's needs and preferences. This included an assessment of the person before they were admitted to the home so a decision could be made about whether the person's needs could be met. Care records also included copies of social services' assessments completed by referring social workers. This provided the staff with information so care needs could be ascertained. Care records included details of who and when assessments were carried out with one exception where the document was not dated.

A personal profile was completed for each person, which included details of the person's background and preferences, such as sleeping routines so staff knew how to plan and delver care. Care plans also included information on people's preferences for food, how they wished to be supported with personal care and daily routines such as sleeping. There were care plans for personal care which were well recorded and included specific details of how staff should support people. These also incorporated tasks which people could do for themselves regarding their personal care and what staff needed to help people with.

Mental health needs were assessed and care records included areas of mental health which people needed support with. Assessments and care plans were reviewed and updated on a regular basis.

People's social and recreational needs were assessed and activities planned to meet these needs. An activities coordinator was employed and there was a notice board of activities for people. People had a printed copy of the activities programme. We observed people engaged with two staff in the main lounge in a flower arranging session. The staff were observed to be skilled in engaging and supporting people in the activity and people had one to one discussions with staff about the type of flowers and how to arrange them. Relatives told us they considered the provision of activities was good. People were observed with visitors such as family members. There were no restrictions on when people could receive visitors.

Relatives told us they were able to raise any issues or concerns at the relatives' meetings. The complaints procedure was displayed in the hall and people said they knew what to do if they had a concern by speaking to the manager, although one person was not sure what they would do if this happened. The provider had a complaints policy. Where a complaint was made a decision was made about whether it should be dealt with by the manager which the provider, called a Stage One complaint, or, by the provider; this was called a Stage Two complaint.

Records were maintained of any complaints made along with details of any investigation, the outcome of this and any meetings with complainant. There were records of any learning and action plans to address any identified areas of improvement.

Relatives told us they felt able to raise any concerns they had, but we received mixed responses when we asked relatives if these were dealt with to their satisfaction. One relative said how any concerns or issues raised were always dealt with and that they received a response to say what action was taken. Another relative told us they did not consider the staff had fully responded to the changing care needs of their relative who lived at the home, particularly where the risk of falls had increased. The relative said they had made a complaint about an incident and did not feel their complaint was properly addressed. At the time of the inspection the manager could not locate an incident report about his but confirmed after the inspection that it was completed at the time of the incident. We saw a record of a

Good

Is the service responsive?

complaint where action was taken to look into a complaint. There was an initial response to the complaint, which included an apology from the manager as well as a record of an investigation meeting. There was no record of the conclusion of the findings of the investigation nor a final outcome letter or response to the complainant, which would have made clear to the complainant that the issue was addressed and the outcome concluded.

Good

Is the service well-led?

Our findings

People said they had opportunities to give their views on the service and the provider actively sought people's views in order to improve the service so that it met people's needs and wishes. Relatives also said they felt able to raise concerns. One relative said there had been three managers of the home in three years which they felt had a negative impact on how the service ran. Staff and a health care professional commented on how the newly appointed manager was more proactive in implementing improvements.

Residents' and relatives' meetings were held so the manager and staff could communicate with people about any developments to the service and to ask people if there were any issues they wished to raise. Records of these meetings were made and relatives said they were a useful way of expressing their views. The provider also commissioned an independent survey of the views of people, their relatives and staff about the service. The results of these were compiled so the provider could see percentage rates of satisfaction and where improvements were needed. The survey was last carried out in 2014 and the manager and service manager said it would be carried out again in 2015. Each person had a staff keyworker allocated to be their main contact to discuss and agree care matters. The manager told us this gave opportunities for people to raise any issues or to give feedback on the service provided. The service manager and manager described how staff met with people regarding the provision of food and as a result of this consideration was being given to moving the main meal to early evening rather than lunch time for those who wanted this.

At the time of the inspection the service did not have a registered manager but there was a manager in post who had applied to the Commission for registration. There was a structure of management in the home so staff could seek assistance when needed; this included a deputy manager and senior care staff. Staff said they had access to management support during the day and night.

Staff said staff meetings allowed them to communicate their views about the policies and procedures in the home as well as to discuss arrangements for meeting people's needs. They also said they were consulted about any proposed changes. Staff said they felt valued, that the manager was approachable, and, they felt able to raise anything which was responded to.

The values of the service were set out in the provider's mission statement which included treating with respect, dignity and as individuals, as well as nurturing people's body, mind and spirit so they had a fulfilled life. These values were demonstrated by staff who told us the importance of treating people well and with respect and dignity. We observed these values when staff interacted with people.

The provider used a quality assurance system to check and assess the safety and standard of the service provided to people. These included health safety, fire safety risk assessments, fire safety and legionella checks. Risk assessments were also carried out of the environment and there were personal evacuation plans for each person so staff knew how to support people should the building need to be evacuated. Audits were also carried out of care plans and equipment such as first aid kits and mattresses. Specific incidents were recorded collectively such as falls, changing body weight and pressure areas, so any trends could be identified and appropriate action taken. Although the quality monitoring systems did enable the provider and manager to assess and improve many aspects of the quality of the service, they had not identified and addressed the issues identified with lawful consent and safe medicines management.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The management of medicines was not safe. Regulation 12 (1) (2) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The provider did not always adequately asses the capacity of those who did not have capacity to consent to their care and treatment, including those where the provider had made referrals for a Deprivation of Liberty Safeguards authorisation to restrict their liberty. Regulation 11 (1) (2) (3)