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Green Trees Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 1 March 2017 and was unannounced. At our last inspection on 24 February 2015, the service was rated 'Good'.

Green Trees Care Home provides accommodation and personal care for a maximum of 16 people. It is a family owned home for older people, some of whom may have dementia. On the day of the inspection, there were 15 people using the service.

There was 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.

People were not always safeguarded from abuse and avoidable harm as the provider had not notified the local safeguarding authority of safeguarding concerns. The provider did not notify CQC of two known safeguarding concerns.

Although scheduled activities took place on some days, we found that people were sitting in the lounge with little interaction or stimulation. There were sufficient staff on duty to ensure people's needs were met, however, we observed that people were left unsupervised for periods of time. There were a number of occasions during the inspection when staff did not interact with people.

Risks associated with people's care and support needs had been identified and these had been assessed, giving staff instructions and directions on how to safely manage those risks, However, we saw that people's risk assessments were not always followed.

There was a complaints procedure in place and complaints were investigated. However, some people told us that they did not know how to complain.

Safe medicine management systems and process were in place to ensure that people received their medicines safely and as per their needs and requirements.

Care plans were detailed and person centred and updated regularly.

All staff had received training on the Mental Capacity Act (2005) and understood the importance of obtaining consent from people. Where people's liberty was deprived, the appropriate authorisation had been applied for which was recorded on people's care records.

People told us that staff were caring. People told us they could choose their own routines and staff supported them to maintain their privacy and dignity.

Mealtimes were relaxed and people were offered a choice with alternatives offered.

Safe recruitment and selection procedures were in place. Staff were supported with regular training and supervisions. Annual appraisals were not documented.

People were supported to access healthcare.

Quality assurance systems were in place to monitor the safety and quality of care provided. People, relatives and staff were invited to completer an annual satisfaction survey.

Staff and resident/relative meetings did not take place.

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 were knowledgeable about how to safeguard people from abuse; however the registered provider had not alerted the local safeguarding authority to safeguarding concerns.

Robust risk assessments were in place for people, however we found that they were not always being followed to ensure people's safety.

Medicines were managed safely.

Safe recruitment practices were followed ensuring all appropriate checks were completed prior to care staff starting work at the service.

We found staffing levels sufficient; however people were left unsupervised for periods of time

Is the service effective?

Requires Improvement

The service was not always effective. Staff had access to regular training and supervisions which supported them to carry out their role. However, staff did not receive an annual appraisal.

People were given the assistance they required to access healthcare services and maintain good health.

All staff had received training on the Mental Capacity Act (2005) and understood the importance of obtaining consent from people.

We received positive feedback from people regarding the food choices on offer.

Is the service caring?

Requires Improvement

The service was not always caring. We observed that at times there was a lack of staff interaction with people.

Care plans contained information regarding people's backgrounds, family, likes and dislikes.

People's privacy and dignity was respected and people could choose their own daily routines.

Is the service responsive?

Requires Improvement

The service was not always responsive. On days when there were no planned activities, people were brought into the communal lounge and left to watch television with little stimulation.

Complaints were logged and responded to. However some people told us they were not familiar with the complaints procedure at the home.

Care plans were detailed and person centred and updated on a regular basis.

Is the service well-led?

Requires Improvement

The service was not always well led. The provider did not submit all required statutory notifications to CQC.

Staff were positive about the management and support they received.

The provider had a system for monitoring the quality of care with regular audits and a yearly feedback survey.

Green Trees Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

This inspection took place on 1 March 2017 and was unannounced.

This inspection was carried out by two adult social care inspectors. The inspection team was supported by 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.

Before we visited the home we checked the information that we held about the service and the providers including notifications and significant incidents affecting the safety and well-being of people who used the service and safeguarding information received by us. We reviewed the Provider Information Return (PIR) which the provider had sent to us. A PIR is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make.

During the inspection we spoke with eight people who used the service and four relatives. We also spoke with two of the registered providers, the registered manager (also a registered provider), senior carer, four carers, the cook and one healthcare professional visiting the home on the day of the inspection. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people when they may not be able to tell us themselves.

We look at the care records of eight people who used the service, which were held electronically. We looked at five staff files and other records related to the management of the service such as medicines records, complaints and quality assurance audits.

We requested feedback from the local placing authority.

Requires Improvement

Is the service safe?

Our findings

We received a mixed response when we asked people and relatives if they and their loved ones felt safe living at the home. One person told us, "I can't fault anything." A second person told us, "I have to go careful on those [stairs] as I did fall on them. I'm not very steady yet. I had a fall on the main stairs and got knocked about a bit so I always take the lift now. I feel safe and it's clean. The staff are always working." A relative told us, "I think [relative] is safe. I've not seen any signs of bad treatment. I'm satisfied with the cleanliness."

There was a risk that people were not safeguarded against the risk of abuse. The staff we spoke with told us they had received training and understood their responsibilities with regard to safeguarding people. They were able to tell us where to locate contact details for the Commission and the local safeguarding team. Staff were knowledgeable around whistleblowing. Staff told us they were confident that action would be taken if they raised concerns. A staff member told us, "You need to protect the individual you are caring for. You need to whistle blow when you see bad practice. I look out for body language, how people react and signs of abuse. I would report to the senior carer, if no action taken, then the manager and then higher, CQC." Another staff member told us, "[I would look out for] unexplained bruises which there is no explanation for, unexplained falls or maybe the resident suddenly isolating themselves. First action is to inform the line manager. I report it and also record on the system."

During the inspection, we identified one instance of unexplained bruising. There was also one instance of an allegation of physical abuse made by a person against a staff member which had not been reported to the local authority safeguarding team. We discussed this with the registered provider who confirmed that they had not referred the incidents to the local authority safeguarding team. They told us that they felt they knew what the outcome would be as there would be insufficient evidence to prove the allegation. The registered provider told us that that they may not have handled the situation well. We subsequently alerted the local authority safeguarding team to the concerns noted during the inspection.

The providers safeguarding policy stated, "It is not for front line staff to second-guess the outcome of an enquiry in deciding whether or not to share their concerns. There should be effective and well-publicised ways of escalating concerns where immediate line managers do not take action in response to a concern being raised." The registered provider had failed to effectively operate systems and processes to protect people from abuse.

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

Risks associated with people's care and support needs were assessed and provided clear information. This included guidance to all care staff on how to support people appropriately in order to reduce or mitigate any risk identified. Examples of risk assessments included falls, nutrition, moving and handling and choking. Individual risks associated with people's care and support needs were also identified and assessed. Examples included risk of pressure sores, strokes, diabetes, bleeding associated with the use of anti-coagulants and cardiac arrest. Risk assessments were reviewed on a monthly basis or when there was a

change to the person's condition.

However, we saw that one person's risk assessment was not being followed. The person was determined to be medium risk of falls. The person's falls risk assessment stated the person had a passive infrared sensor (PIR) installed on their room so staff would be alerted when the person was mobile. Observations confirmed that the PIR was installed and was working. Records showed the person had a number of falls since June 2016 and on one occasion had hurt their back and was admitted to hospital. The risk assessment stated that the person was unsteady on their feet therefore should be supervised when mobile. During the inspection, we observed the person in the lounge area trying to walk across the lounge to reach their walking frame which was placed at the other end of the room. The person was holding onto furniture for support. There were no staff present at the time and the person was unsupervised. We intervened and asked staff to attend to the person for support, as they were at risk of falling.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported with their medicines safely. A person told us, "All my medicines come. They give them to me straightaway." A second person told us, "They help me with my medicines and I'm in no pain." The registered manager oversaw medicines management at the home and usually administered medicines herself. When the registered manager was not available to administer medicines, trained senior care staff completed this. We saw that medication administration records (MAR) were clear and had been completed accurately showing that people received their medicines as prescribed.

Medicine storage areas were noted to be clean and secure. Sufficient stock levels of medicines required within the home were held securely and where medicines needed to be disposed of, there were procedures in place to ensure this was done safely and appropriately. Controlled drugs were stored and managed appropriately. Controlled drugs are medicines that the law requires are stored, administered and disposed of by following the Misuse of Drugs Act 1971.

Medicines were audited on a monthly by the registered provider. No concerns had been identified. Medicines at the home had also recently been audited by the local clinical commissioning group in which there were no concerns identified.

Staff files demonstrated that the provider followed safe recruitment practices. We looked at five staff recruitment records. Records showed the provider collected two references from previous employers, proof of identity, criminal record checks and information about the experience and skills of the individual.

When we asked people, relative and staff if staffing levels were appropriate to meet people's needs, we received a mixed response. One person told us, "There could be more staff on a Tuesday." A second person told us, "Could do with more help, not enough staff at all times and I have to wait for my needs to be met." A relative told us, "There seems to be enough staff whenever I visit." A second relative told us, "It depends on the workload. I think they need more supervising. They don't have time to talk to residents. One of them gets impatient and I've heard her shout 'Sit down'. They are usually, respectful." Comments from staff included, "There is a lot of duty to cover", "We could do with one more" and "It's a lovely home but I think they need a few more staff."

During the inspection we observed that people were not being supervised for long periods of time in the lounge area whilst staff completed tasks. This placed people at risk as some people were at risk of falling. On one occasion we observed that all the management team and staff were sitting in the dining area as the

lounge area was unsupervised. We discussed this with the registered manager who told us that people did not like staff sitting in the lounge as they felt they were being spied upon. However, when members of the inspection sat in the lounge, we found people engaging and willing to chat with the inspection team.

During the inspection there were fifteen people living at the home. During the day the home employed the registered manager, assistant manager, senior carer, care staff, cook and cleaner and during the night the home had a senior carer and a member of care staff. Staff rotas confirmed planned staffing levels were maintained. The registered providers were also present during the day. At night time, there were two care staff in the home; one working a waking night shift and one a sleep in shift. Staff who worked at night told us they were satisfied with the arrangement and had used the additional support if needed.

Weekly fire tests and regular evacuation drills were carried out that recorded the response times and any concerns. Risk assessments and checks regarding the safety and security of the premises were completed. There was a weekly fire safety checklist, which included checking escape routes, emergency lightings and evacuation equipment.

Personal Evacuation Emergency Plans (PEEPS) had been completed that indicated the level of support people would require in the event of an emergency evacuation. Fire evacuation equipment had been installed on the upper floors, which was near the stairs. The staff we spoke with were confident on how to use the chair and was able to tell us how to evacuate people safely. Fire extinguishers were placed around the home and had been refilled.

Appropriate gas, electrical installation safety checks and legionella were undertaken by qualified professionals. Checks were undertaken on portable appliances to ensure people living at the home were safe. Checks on hot water were completed regularly to ensure the temperature was within acceptable limits.

On the day of the inspection, the home was mostly clean and well-maintained. However, we found there to be a strong smell of urine near the front door in the morning of the inspection and on the upper floor throughout the day, which we were advised emanated from one bedroom. We observed the bedroom to be clean and tidy and were advised that the smell remained even after the room was cleaned.

We also found dried faecal matter on a toilet surface in a person's bedroom. We brought this to the attention of the deputy manager who subsequently cleaned the toilet. We checked all other bathrooms and found them to be clean. We were advised that the cleaner was on holidays on the week of the inspection, and the management team and staff were responsible for cleaning the home in the cleaner's absence.

All accidents and incidents were recorded on an electronic system attached to the person's care record. Each record contained details of the incident or accident that had taken place, the actions taken, any investigative action taken and any lessons that were learnt.

Requires Improvement

Is the service effective?

Our findings

People who used the service and their relatives were positive about the staff and told us they had confidence in their abilities. One person told us, "Anything you want, you only have to ask. They come to ask me before I need anything." A second person told us, "Overall I think the staff know what they are doing." A relative told us, "Yes, they have been excellent with my relative and have always communicated with me"

Upon starting work at the home, staff underwent a formal induction. Their induction period included reading people's care plans and working alongside more experienced colleagues. Following induction, staff participated in training and refresher training which reflected the needs of the people living at the home. Training was completed on areas such as safeguarding, medicines, health and safety, first aid, dementia, moving and handling and infection control. The registered manager maintained a training matrix to monitor staff training requirements. The provider's system also alerted management where training was due for staff, which enabled the deputy manager to schedule training for staff. Staff were positive about the training they received. Comments from staff included, "Training was useful" and "My training is all up to date until 2018".

Staff confirmed they received regular supervision. Records showed that the home maintained a system of supervision. Formal individual one-to-one supervisions were carried out regularly. However, annual appraisals had not been completed. The provider had an appraisal policy which stated appraisals should be carried out annually. This was not being done. We fed this back to the providers and management team who told us that an annual appraisal would be carried out moving forward.

The Mental Capacity Act 2005 (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. People can only be deprived of their liberty so that they can 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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Where a DoLS had been applied for and granted, the DoLS authorisation was recorded in the person's care file. Statutory Notifications in this regard had been submitted to CQC.

Training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty and Safeguarding (DoLS) had been provided and most staff demonstrated an understanding of MCA and DoLS and when these should be applied. Some staff were unable to explain what a DoLS was, although staff understood the need for obtaining consent from the person that they supported. A staff member told us, "Of course! I wouldn't just go in and roll them over!" A second staff member told us, "I always ask for their consent prior to helping them." A person told us, "They always ask before. If you don't want anything done, they don't."

People's care plans contained care planning forms signed by the person if possible and, if not, by their relative that set out their preferences for their or their relative's involvement in their care. Where a relative had power of attorney, the provider completed an online check and recorded the information in the

person's care file.

People were generally positive about the food on offer at the home and how they were supported to eat and drink. One person told us, "I've been off my food lately but my appetite is coming back. They give me smaller portions and don't overload me. I get something else if I don't fancy the main meal, mostly fish. If I want a cup of tea I go downstairs and ask." A second person told us, "The food's not bad". A third person told us, "The fish was lovely." Staff told us that people had choices during meal times and that they enjoyed the food. Comments from staff included, "We accommodate and ensure everyone can have alternatives", "There is variety of food that fits all" and "They do enjoy food."

We observed lunchtime at the home and saw that most people ate in the dining room or lounge areas. Nobody required assistance with eating. Tables were laid with tablecloths and proper glassware and cutlery. The food looked presentable on the plates and people confirmed it was hot. One person was served the wrong meal which was noticed by the registered manager. The person said "I didn't think it was right but I didn't like to say anything". We observed another person who did not want to eat and they were gently encouraged to try and eat in a pleasant fashion by the registered manager and an alternative option was offered.

Drinks were not readily available at this mealtime. A person said to a member of care staff, "Don't forget my water". Ten minutes later her glass remained empty and the person asked again. It remained empty and we intervened by asking the registered manager about this, and were told, "They've gone to get some more. She's already downed one glass."

Care plans contained detailed information regarding people's food likes and dislikes. We saw that these were person centred and described types of meals to offer people. One care plan contained specific information on how to serve the person's meal and what staff should do if the person refused to eat, which was offer alternatives, which was observed during mealtime. Daily records showed what people had to eat.

We saw that another person had a history of not eating and had been referred to the dietician. There was a treatment plan in place from December 2016 which included a fortified diet. The plan listed the person to be reviewed after eight weeks and their weight should be between 65kg-68kg. The review had not taken place with the dietician. We fed this back to the registered manager and assistant manager who confirmed that the review had not taken place and also the person was not following the fortified plan. Records showed the person's weight had fallen to 64.9kg in February 2017. The person was weighed regularly, which showed their weight to be stable since December 2016. We requested that the registered manager make a follow up appointment with a dietician which was confirmed afterwards as having been done.

People were supported to maintain good health and have access to healthcare services and received on-going healthcare support. Care plans detailed records of appointments with health and care professionals. We also saw evidence that following appointments, people's care plans were updated accordingly.

Requires Improvement

Is the service caring?

Our findings

We received mostly positive comments from people and relatives regarding the caring nature of staff. One person told us, "Everyone is so friendly. It's lovely. They are great." A second person told us, "I am happy here." Comments from relatives included, "I have a peace of mind that [my relative's] care could not be better provided anywhere else. It's a home from home" and "[My relative] is happy here."

The registered manager told us that people could choose their own routines at the home. She told us that people could get up when they wanted in the morning and there was no set breakfast time. This was confirmed by our observations and comments from people. A person told us, "I get up when I want at quarter past nine and go down for breakfast. I get myself in to bed at night when I want and after I watch the news." People's preferred routines were recorded in their care plan.

People told us that their dignity and privacy was respected. Staff could tell us how they ensured care was provided to people in a way which ensured their dignity was maintained. Comments from staff included, "Before entering their rooms, I would knock on their door" and "When shower them I make sure that the door is always closed." A person told us, "I have a shower downstairs and it's private. They take their time and sometimes I do the washing on my own and that makes me feel independent. They're all very pleasant and helpful." We saw that there were two shared bedrooms in the home. We saw that there was a partition available for staff to use when assisting people with personal care.

During the inspection, we observed how staff interacted and supported people. Some people could not let us know what they thought about the home because they could not always communicate with us verbally. We used the Short Observational Framework for Inspection (SOFI), which is a specific way of observing care to help to understand the experience of people who could not talk with us. We wanted to check that the way staff spoke and interacted with people had a positive effect on their wellbeing. During the SOFI we saw that people were generally left unattended and were either passively watching television or dozing off to sleep. Some people engaged in conversation with the inspection team during this time. We observed a member of care staff towards the end of the observation enter the lounge and greet people as they had just started their shift. We observed the staff member gently converse with people and answer questions people had. However, despite this kind interaction observed that people were generally left unattended in the lounge area whilst care staff were completing tasks or were sitting in the dining room with some members of the management team. We discussed our observation findings with home management at the end of the inspection and were told that people did not like staff sitting in the lounge as they felt staff were spying on them. The registered manager told us that from the dining room, they could observe and check on people in the lounge through the glass door.

People's bedrooms were pleasantly decorated and contained personalised items such as pictures and photographs. Relatives told us that they were free to visit at any time. A relative told us, "I can come and visit whenever I want."

Staff we spoke with had a good understanding of people's individual backgrounds, ages, likes and dislikes.

Staff told us they had read peoples care plans. Care plans were detailed and person centred and were reviewed and updated on a regular basis. Care plans contained important information to enable staff to get to know the person such as details of their family members, professional background and religious observances. People's care plans described people's needs and preferences.

People's ability to communicate were recorded on care plans for staff to understand how people communicated. The plans described how people communicated, an example was that a person should not be spoken with in a loud voice and to avoid conversation in relation to continence as the person may feel embarrassed.

People had key workers and had reviews with their key workers every month which were documented on care records. A person told us, "Keyworker? What's that? [Named carer] looks after me. We all have someone." The reviews focused on people's well-being, clothes and food. The review did not focus on activities. This was fed back to the assistant manager who informed us that he had devised a form that included activities and was planning to introduce this on the reviews. We saw evidence that the form had been created.

Care plans documented that advanced care planning and end of life care was discussed with most people and their relatives. People's choices and wishes were recorded in relation to planning the way in which they wanted to be cared. Staff had received end of life care training in association with a local hospice. We saw a thank you card received from the relative of a person who had recently passed away which stated, "To the team. Thanks for your care from [relative]. It was a great comfort to us. [relative] was happy there."

Requires Improvement

Is the service responsive?

Our findings

During the inspection, we did not observe people engage in any planned activities. There was little interaction, activity or stimulation for people. People were always seen in the lounge and positioned to watch television throughout the day. People, relatives and staff told us that on set days there were activities such as a physiotherapist and hairdresser on a fortnightly basis, weekly musical entertainment on a Thursday and Sunday and additional regular shows throughout the year. We were advised by the registered manager that day trips did not take place. Feedback received from people was very positive with regard to the weekly musical entertainment and all people we spoke to could tell us of the days the music entertainment took place. However we received consistent feedback that on the days where there was no planned activities, people were left unattended watching television. Comments from people regarding activities included, "I like the musicians on Thursday and Sunday. Outside people used to go to clubs but they do nothing here", "Good entertainment on Sundays and Thursdays", "There are no trips out. We've got music on Thursday and Sunday and can go into the garden in summer" and "Never mind. I've got my music and the telly." A relative told us, "[Relative] goes to Thursday and Sunday music. Otherwise it's all day long in the lounge where [relative] sits and goes to sleep."

Throughout the inspection we observed people sitting in the lounge area either watching television, sleeping, passively watching their surroundings or walking around. We observed one person do a crossword puzzle; another person read greeting cards and another person care for their therapy doll, all without support or engagement from staff.

Care plans contained a social section which detailed people's preferences for activities. This section was very person centred. However there was very little evidence that showed that activities took place regularly with people based on their preferences. Records did not show if people went outside or if people received individualised activities during the days when there were no scheduled activities. We discussed this with the registered provider and manager who told us that they had tried to engage people in activities such as bingo and board games, but they said people were not interested. One staff member told us, "I can't go and join in. I haven't seen anyone moan. There could be more, maybe bingo, puzzles or cards. Because most residents have dementia. I feel like they don't take it in. They get bored and frustrated. Most just want to sleep."

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care records were kept electronically on the providers care management system which staff could access to update daily records at any time which was recorded on the care record. Where changes occurred such as advice from a medical professional or other material change, care records could be updated in an instant. This was evident during the inspection, when medical advice was requested from the GP on the morning of the inspection, the persons care file was updated straight away which meant that staff had instant access to people's information.

There was also a facility for care staff to assign an alert to the registered manager when they had noted a

concern regarding a person's health. This meant that the registered manager was alerted to any potential concerns in a timely fashion for prompt follow up.

All care plans listed people's health conditions and support needs. There was an 'About Me' section for each person providing information on people's background, family history and people's routines and what might upset them or make them anxious. This meant that staff can use the information to get to know people and build positive relationship with them.

Reviews were undertaken regularly with people, which included important details such as people's current circumstance and if there were any issues that needed addressing. There was a daily log sheet, which recorded key information about people's daily routines such as behaviours and the support, provided by staff. When a person's care plan was reviewed, staff were required to confirm via the electronic care management system that they had read the changes made to the updated care plan.

Pre-admission assessments were carried out with people before offering a placement. The assessments covered important areas such as allergies, medical history, next of kin, support needs, mobility and weight. This enabled the provider to ascertain if the service was able to accommodate people's needs.

We looked at how the service handled complaints. We received mixed feedback from relatives regarding how the service responded when they raised concerns or a complaint. One relative told us, "Sometimes you don't like to say anything in case you put their back up." Another relative told us, "I'm not sure what I would do about complaints. Air the grievance with a manager I suppose". We asked people living at the home about complaints and received the following feedback, "I wouldn't know what do" and "I'd go to the office if there was anything wrong. There's a man around and I'd go to him first". We did not see any information regarding complaints displayed around the home. The statement of purpose refers to a complaint procedure in the residents guide; however a member of the management team told us that this guide was only given to relatives and not people who used the service.

We saw that there were had been four complaints recorded in the providers care management system within the past year. Two had been made by people who used the service regarding the actions of a member of care staff and two had been made by relatives. All complaints had been logged and investigated and an action was noted such as speaking with the staff member or having a meeting with the complainant.

Requires Improvement

Is the service well-led?

Our findings

We received mainly positive feedback from people regarding how the home was managed. Comments from people included, "[Registered manager] in charge. She's the manager. Sometimes she comes and talks to me. I think she does a good job", "[Registered Manager] is in charge and that man. I don't know if that's her husband. And there's [deputy manager], [registered managers] son. I like him" and "We all get on fine." A relative told us, "I don't know who is actually in charge. I'd say it was well run."

Staff spoke positively of the support they received from the management team at the home. Comments from staff included, "Managers are alright, they are supportive", "I find they are understanding. I do feel I can bring things up straight away and they deal with things fast", "Yes it is well managed", "Here every day. I don't have any problems" and "They truly support us a lot."

Despite the positive feedback we received, we found aspects of the service were not always well-led. The providers had not ensured that staff had appraisals. As detailed in the safe section of the report, we found that the registered providers had not always appropriately notified the local authority when there were safeguarding concerns. The providers also had not notified CQC of such notifiable matters. A notification is information about important events which the provider is required to send us by law. A failure to notify CQC of incidents has an impact on the ability of the CQC to monitor the safety and quality of the service.

This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

There were systems in place to monitor the safety and quality of the service provided. These included monthly quality assurance audits completed by the registered provider in areas such as infection control, food safety, staff training and supervision, care plans and risk assessments, medicines management and health and safety checks. The service also used an external provider to complete a yearly health and safety and infection control audit of the service and had completed an infection control action plan.

The home requested feedback from people, staff and professionals through questionnaires and surveys. The feedback was carried out by an external organisation and focused on the CQC's five key questions. The feedback was analysed and action plan was created. The results of the feedback for 2016 were generally positive. However there was some negative feedback received. An action plan was in place, which we noted had not yet been completed. The provider told us that they had recently received the action plan from the external company and were in the process of completing their own action plan.

As all care records were kept electronically, the registered manager was able to access people's care records remotely. The registered manager told us that she checked on daily recording at night and first thing in the morning to ensure that any concerns reported overnight were actioned the following morning. The registered manager was also able to check that regular night checks on people took place as scheduled as entries made were timed.

At our last inspection, we noted that staff meeting did not take place. We saw that this was still the case as

there staff team were small. We saw that information regarding people was communicated through a daily handover. The registered manager showed us that important messages such as changes to people's condition or medical updates were communicated to staff through a message on the care management system which staff accessed once they logged on at the start of their shift.

Residents and relatives meetings did not take place at the service. This was confirmed by the registered manager during the inspection. We were advised that people could feed back and raise concerns with their key worker during their monthly key working sessions which was documented on people's care records.

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 18 Registration Regulations 2009 Notifications of other incidents 18(1)(2) The registered provider did not inform CQC of other notifiable incidents

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care 9(1) The provider did not ensure that appropriate activities were organised and provided to people on a daily basis.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment 12(1) The provider was not protecting service users and was not doing all that is reasonably practicable to mitigate identified risks associated with people's care and support needs.

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

13(1)(2)

The provider did not ensure people were protected from abuse because they did not alert the local safeguarding authority to safeguarding concerns.