Hexon Limited

The Willows

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

This inspection took place on 23 October 2014 and was unannounced. We previously visited the service on 23 June 2014. We found that the provider did not meet the regulations that we assessed in respect of staffing levels and we asked them to take action. At this inspection we found that appropriate action had been taken to make the identified improvements.

The service is registered to provide personal care and accommodation for 33 older people, and has a separate unit for people with a dementia related condition. The units are staffed separately.

The provider is required to have a registered manager in post and on the day of the inspection there was a manager registered with the Care Quality Commission (CQC); they had been registered since 7 December 2012. 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.

Summary of findings

People told us that they felt safe living at the home. However, we observed staff moving and transferring people inappropriately. This was a breach of Regulation 9 of the Health and Social Care Act 2008. You can see what action we told the provider to take at the back of the full version of the report.

Staff received appropriate training although a more robust system was needed to record people's induction training when they were new in post and some staff still needed to complete training on safeguarding adults from abuse. We did not see any evidence that care for people living with dementia was based on published research or guidance. This was a breach of Regulation 9 of the Health and Social Care Act 2008. You can see what action we told the provider to take at the back of the full version of the report.

Staff had been recruited following the home's policies and procedures to ensure that only people considered suitable to work with vulnerable people had been employed. Staffing levels had increased and this meant that there were sufficient numbers of staff to meet the needs of people who lived at the home.

People's nutritional needs had been assessed and people told us that they were satisfied with the meals provided by the home. We found that medicines were safely managed.

We observed good interactions between people who lived at the home and staff on the day of the inspection. People told us that staff were caring and this was supported by the relatives we spoke with.

People's comments and complaints were responded to appropriately and there were systems in place to seek feedback from people and their relatives about the service provided.

The management arrangements at the home were more consistent than we had seen at the last inspection. A deputy manager had been appointed and this meant that there was a manager on duty over a seven day period. People who lived at the home, relatives and staff told us that the home was well managed.

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

Care provided was not always safe; we saw unsafe moving and handling techniques being used by staff. This was a breach of Regulation 9 of the Health and Social Care Act 2008. You can see what action we told the provider to take at the back of the full version of the report.

Staff displayed a good understanding of the different types of abuse and were able to explain the action they would take if they observed an incident of abuse or became aware of an abusive situation.

We found that there were sufficient numbers of staff employed to ensure that the needs of the people who lived at the home could be met. Staff were recruited following policies and procedures that ensured only those considered suitable to work with vulnerable people were employed.

The arrangements in place for the management of medicines were satisfactory; medication was stored safely and record keeping was accurate.

Is the service effective?

Requires Improvement

The home did not provide effective care. We found the location to be meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). Staff we spoke with understood how to protect the rights of people's who had limited capacity to make decisions for themselves. However, we did not see any evidence that care for people living with dementia was based on published research or guidance. This was a breach of Regulation 9 of the Health and Social Care Act 2008. You can see what action we told the provider to take at the back of the full version of the report.

We saw that progress had been made towards staff completing mandatory training, although we advised the registered manager that the arrangements for induction training for new staff needed to be more robust.

People's nutritional needs were assessed and met, and people told us that they were happy with the meals provided by the home. We saw that staff provided appropriate support for people who needed help to eat and drink. People had access to health care professionals when required.

Is the service caring?

Good

Staff at the home were caring.

People who lived at the home and their relatives told us that staff were caring and we observed positive interactions between people who lived at the home and staff on the day of the inspection.

We saw that people's privacy and dignity was respected by staff and this was confirmed by the people who we spoke with.

Summary of findings

People were encouraged to be as independent as possible, with support from staff. Their individual care needs were understood by staff.

Is the service responsive?

Good

The service was responsive to people's needs.

People's care plans recorded information about their previous lifestyle and the people who were important to them. Their preferences and wishes for their care were recorded and these were known by staff.

People were able to take part in their chosen activities and their visitors were made welcome at the home.

There was a complaints procedure in place and people were informed about how to make a complaint if they were dissatisfied with the service provided.

Is the service well-led?

Good

The home was well led.

There was a registered manager in post at the time of the inspection. A deputy manager had been appointed and this meant that there could be a manager at the home over a seven day period.

There were sufficient opportunities for people who lived at the home and relatives to express their views about the quality of the service provided.

The premises and equipment were regularly checked to ensure the safety of the people who lived and worked there.

The Willows

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 23 October 2014 and was unannounced. The inspection team consisted of an inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience who was part of the inspection team on this occasion had experience of regulated services for older people.

Before this inspection we reviewed the information we held about the service, such as notifications we had received from the registered provider, information we had received from the local authority who commissioned a service from the home and information from health and social care professionals. This was a follow up visit so we did not request a provider information return (PIR) from the registered provider.

On the day of the inspection we spoke with five people who lived at the home, three relatives or friends, five members of staff and the registered manager.

We spent time observing the interaction between people who lived at the home, relatives and staff. 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.

We looked at all areas of the home, including bedrooms (with people's permission) and office accommodation. We also spent time looking at records, which included the care records for three people who lived at the home, staff records and records relating to the management of the home.

Requires Improvement

Is the service safe?

Our findings

Although we saw that suitable mobility equipment was available to staff, on two occasions we saw staff carry out an 'underarm' lift. This type of lift is considered by health care professionals to be unsafe because there is a risk of injury to the person being assisted. On one occasion the registered manager intervened and advised staff to use a lifting belt and the person's walking frame. However, we felt that the staff would have continued with this lift if the manager had not intervened. This meant that unsafe moving and handling techniques were being used by staff, even though they had attended training on this topic. This meant there had been a breach of the relevant regulation (Regulation 9) and the action we have asked the provider to take can be found at the back of the report.

At the last inspection of the service we had identified that there were insufficient numbers of staff to meet the needs of people who lived at the home. This was a breach of Regulation 22 of the Health and Social Care Act 2008. The registered provider submitted an improvement plan to the Care Quality Commission informing us how they would make the necessary improvements to the service.

We received further information of concern in September 2014, again about the service being short staffed. We asked the provider to investigate; they carried out an investigation and submitted a response explaining how they would be increasing staffing levels. During this inspection some people who lived at the home still commented that there were insufficient numbers of staff on duty during the night. People told us that there were only two staff working during the night and one person said that staff were "Running around like a horse that has fleas." Some visitors also commented that the home sometimes seemed to be short staffed. However, another person who lived at the home told us, "If I pull the call cord someone comes straight away."

We noted that the staffing levels during the day and night had only recently been increased; this included an increase from two to three staff working overnight. This was recorded on the staff rota and confirmed by staff. Although it was too soon for us to assess the impact this would have on people who lived at the home, the registered manager told us that they expected the experience of people who lived at the home to improve, for example, call bells would be responded to more promptly.

The registered manager told us that they aimed to have five care staff on duty each morning and four care staff on duty each afternoon / evening, with three staff working overnight. The registered manager was on duty during the day, Monday to Friday, in addition to care staff. We checked the staff rotas for the week of the inspection and the previous week and found that these staffing levels had been maintained. This was confirmed by the staff who we spoke with, who also told us that the registered manager would help out with care tasks if they were exceptionally busy.

Ancillary staff were employed in addition to care staff. The registered manager told us that there was a cook on duty each day who worked from 8.00 am until 3.00 pm. There was one domestic assistant on duty for five days a week and two domestic assistants on duty on two days a week. Although staff had to help with the preparation of the tea-time meal, care staff were able to spend most of their time concentrating on supporting the people who lived at the home.

We spoke with five people who lived at the home. They all told us that they felt safe. One person said, "Yes, I feel safe because the carers are here." A relative who we spoke with said, "I have never seen anything wrong (at the home)."

Training records evidenced that most staff had undertaken training on safeguarding adults from abuse. Although progress had been made since the last inspection, five of the 18 staff had still not completed this training. The home had safeguarding policies and procedures in place and submitted alerts to the local authority as required. We saw that care plans included information about any safeguarding investigations that had been carried out by the local authority and the outcome, including actions that needed to be taken by the home. This showed that managers were open about concerns raised. We saw the outcome of one safeguarding investigation and noted that CQC had not been informed of this safeguarding incident. We reminded the registered manager that CQC needed to be informed of safeguarding allegations as well as the local authority.

Staff who we spoke with were able to describe different types of abuse. Staff were able to tell us what action they would take if they observed an incident of abuse or became aware of an allegation. Staff told us they felt all staff within the team would recognise inappropriate practice and report it to a senior member of staff.

Requires Improvement

Is the service safe?

Care plans included assessments that identified a person's level of risk. These included a nutritional assessment, a falls assessment, a moving and handling assessment and a pressure care assessment. We noted that staff were required to sign to record that they had read people's individual risk assessments. Assessments and risk assessments included information for staff on how to reduce the identified risks and these had been reviewed regularly.

We checked the recruitment records for three new members of staff. Application forms had been completed that recorded the applicant's employment history, the names of two employment referees and any relevant training. There was also a statement that confirmed the person did not have any criminal convictions that might make them unsuitable for the post. We saw that a Disclosure and Barring Service (DBS) check had been obtained prior to people commencing work at the home. Most employment references had also been received, although a reference for one person had been received when they had already been working at the home for 2 weeks. The records seen evidenced that only people considered to be suitable to work with vulnerable people had been employed.

We observed the administration of medication on the day of the inspection. We noted that the member of staff did not sign the medication administration record (MAR) chart until they had seen the person swallow their medication. They explained to people what they were doing and gave people a drink of water to help them to swallow tablets.

There were two medication trolleys in use for the two different areas of the home. We saw that trolleys were locked and were stored in locked medication rooms. There was also a MAR chart book for both units. We saw that, when people refused medication that was prescribed to be taken 'as and when required' (PRN), a code to record this was used and the reason was usually, but not always, recorded on the reverse of the MAR chart. We discussed this with the registered manager who told us that they were in the process of agreeing protocols for the administration of PRN medication.

There was a system in place to check that the medicines prescribed by the GP were the same as those supplied by the pharmacy. Medication was supplied in blister packs that were colour coded to match the colours recorded on the MAR chart. This helped identify for staff the correct times of administration and helped to reduce the risk of errors occurring.

We checked the storage and recording of controlled drugs (CD's) and saw that this was satisfactory. Two staff signed the records in the CD register and on the MAR chart. We checked a random sample of CD's and the balance of medicines corresponded to the records in the CD register. We checked the records for medicines returned to the pharmacy, including CD's, and saw that these were satisfactory.

There was a dedicated medication fridge in the treatment room and we saw that fridge temperatures were usually recorded on a daily basis, although we noted that on three dates in October fridge temperatures had not been recorded. However, we saw that the fridge had been consistently working at the appropriate temperature. We advised that temperatures should also be taken and recorded in the cupboards where the medication trolleys were stored, to ensure that medication was stored at the correct temperature. The deputy manager agreed to action this immediately.

The deputy manager told us that only three staff were qualified to administer medication at the home. The training record showed that these three people had completed medication training and this was confirmed by the staff who we spoke with. One of these three people were always on duty during the day to ensure that medicines were administered safely.

We were concerned that none of the night staff had completed medication training. We were told that, if someone needed medication during the night, one of the three trained people would be contacted and they would come to the home to administer the medication. Although staff told us that someone could attend the home promptly, we were concerned that this could cause a time delay in people receiving medication such as pain relief medication. However, this was not raised as an issue on the day of the inspection by people who lived at the home or relatives, and we had received no information of concern previously.

Requires Improvement

Is the service effective?

Our findings

The home had a specialist unit for people living with a dementia related condition. Six staff had undertaken training on dementia awareness and a further nine staff were currently working on a distance learning training pack. However, we found that there was no specific dementia care model being followed at the home. In addition to this, there was little evidence that guidance from, for example, the National Institute for Health and Clinical Excellence (NICE) on dementia care had been recognised and acted on by the staff at the home. This meant that people living with dementia may not have been receiving the most appropriate support. In addition to this, there was little evidence that the premises had been designed to create a dementia friendly environment. This meant there had been a breach of the relevant regulation (Regulation 9) and the action we have asked the provider to take can be found at the back of the report.

We saw that induction training consisted of a day spent with the registered manager discussing topics such as security of the premises, infection control, completion of the accident book, staff rotas and fire safety. The registered manager told us that new employees shadowed experienced care workers as part of their induction training and the staff who we spoke with confirmed this. However, we did not see any records on the day of the inspection to support this.

We checked the recruitment and training records for two new members of staff. The records for one new employee showed that they had provided the home with a certificate to evidence they had attended dementia awareness training. However, there was no evidence of any other training completed by this member of staff. The registered manager told us that this person's previous place of employment had declined to give the employee copies of their training certificates. Because of this, the manager had decided that they needed to undertake all mandatory training again.

We checked the records for another new member of staff. These showed that they had completed induction training on 20 October 2014. We did not see any evidence that this person would be 'shadowing' an experienced member of staff or that they would be completing moving and handling training prior to 24 October 2014, when they were first recorded on the staff rota. In addition to this, they had not provided evidence of their previous training.

We advised the manager that new employees should not be involved in moving and transferring people until they had received appropriate training, and that they needed systems in place to determine the training achievements and needs of new employees before they were allowed to work unsupervised.

We looked at the training records for a care worker who had been employed at the home for a longer period. This care worker had attended training on infection control, falls awareness, fire safety, the control of substances hazardous to health (COSHH) and safeguarding adults from abuse (although this had not been validated by the manager to evidence that the training had been completed). There was also a record of the training this staff member had completed whilst working in another care setting; this showed that they had experience of care work prior to commencing work at The Willows.

All staff had recently commenced distance learning on Common Health Conditions – they confirmed this on the day of the inspection. Most staff had completed training on moving and handling, infection control, food hygiene, health and safety, fire safety, healthy eating, the use of hoists and approximately 50% of staff had completed training on the risk of falls, diabetes, end of life care, mental health and caring for people with unmet complex needs. Staff were in the process of completing training on stroke awareness and dementia.

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the Mental Capacity Act 2005 (MCA) legislation which is designed to ensure that the human rights of people who may lack capacity to make decisions are protected. Discussion with the registered manager showed that they understood the principles of the MCA and when it would be appropriate to submit a Deprivation of Liberty Safeguard (DoLS) authorisation form to the local authority for them to consider whether the measures taken by the service to keep people who were living with a dementia related condition safe were in accordance with the MCA.

Requires Improvement

Is the service effective?

We saw that some care plans included a two-stage capacity assessment; this is a commonly used assessment to determine whether a person has the capacity to make decisions about their life. Care plans recorded a person's capacity to make decisions. One care plan that we reviewed recorded, "(The person) has been diagnosed with later stage dementia but is able to make some choices in some areas of their daily living. (The persons) facial and touch communication show they enjoyed being spoken with one to one." Relatives told us they were involved in decision making when this was deemed to be appropriate.

We asked visitors if they thought staff had the right skills and attitude to carry out their role. One visitor told us, "Very much so, that's one reason why we came here" and another said, "I think the staff are wonderful."

We also asked people if staff had the right attitude to do the job. Most people responded positively but two people were not too sure about this. One person said, "One of the night workers can be abrupt" and another said, "Pretty good – 80 – 90% of staff. Odd ones can be a bit brusque." People were not able to give us the names of staff who they were referring to. We discussed this with the registered manager who told us that they would investigate this matter further.

We saw that care plans included details of a person's medical conditions and any special care needs they had to maintain their general health. Information had been obtained about specific conditions to ensure that staff were aware and well informed, and this was included in the person's care plan. People's assessments and care plans were reviewed on a regular basis to ensure that there was an up to date record of the current health care needs.

There was a record of any contact people had with health care professionals, for example, GP's and Speech and Language Therapists. This included the date, the reason for the visit / contact and the outcome. We saw advice received from health care professionals had been incorporated into care plans. Details of hospital appointments and the outcome of tests / examinations were retained with people's care records.

We asked people who lived at the home if they were able to access their GP or other health care professionals when they needed them. They told us, "The manager would get the GP if I needed them." Visitors also told us that they were happy with how the home contacted health care professionals when they were needed. One visitor told us, "Doctor has been called out and an ambulance once too – all okay."

People had patient passports in place; these are documents that people can take to hospital appointments and admissions with them when they are not able to verbally communicate their needs to hospital staff. They include details of the person's physical and emotional health care needs. This meant that hospital staff would have access to information about the person's individual needs.

Assessments had been completed to identify any risks to a person due to poor nutrition. People's specific dietary requirements were known to staff and we saw that they were also recorded on a notice board in the kitchen. One visitor told us that their relative had diabetes and that they were provided with an appropriate diet by the home. We saw that care plans recorded any special dietary needs. One care plan recorded, "Staff and the cook are aware that eggs exacerbates (the person's) colitis." We saw that, when nutrition had been highlighted as an area of concern, food and fluid charts were used to monitor a person's dietary intake. Staff told us that people's meals were named by the cook to ensure that people received the right choice and the right special diet.

We asked people who lived at the home about the meals provided and the responses were very positive. People told us, "Excellent and homemade cakes too", "Meals are lovely – I don't eat mince and the staff know" and "My carer knows my likes and dislikes."

We observed staff assisting one person to eat and drink and noted that this was unhurried and carried out with a caring approach. People were provided with adapted crockery and cutlery so that they were able to eat independently.

Good

Is the service caring?

Our findings

People told us that staff cared about them. One person said, "Of course they do – they are very caring" and another said, "I am sure they do – very friendly." We asked people's relatives if they thought people received individualised care and they responded positively. One person said, "Having a main carer helps" and another said, "I think they see them all as individuals here." All of the people we spoke with told us that they had some choice and control over their care.

The registered manager had carried out an assessment for each member of care staff to check how effective they were at treating people with dignity and respect. They met after the assessment to discuss any areas that the registered manager felt required improvement. We saw these records in staff files. All of the people we spoke with told us that staff respected their privacy and dignity and this was supported by the visitors who we spoke with. Each person also had a specific care plan in place about promoting their privacy and dignity.

However, we saw that one person's care plan recorded that they only wished to receive personal care from a female care worker. We were aware that, on some nights, there were only male staff on duty. There was also a recorded complaint in respect of this issue and the outcome recorded, "Female carer will carry out (this person's) needs." The registered manager told us that this was no longer the person's wish but acknowledged that the care plan had not been updated. They agreed to check this with the person concerned and then update the care plan accordingly.

People also told us that staff encouraged them to be as independent as possible and most people said that staff allowed them the time to do things for themselves. One person said, "(The staff) are not harassed – they go at my pace" and a relative told us, "(Staff) let him do what he can, even shave." However, another person said that staff were busy and could not give them a lot of time. It was anticipated that the increase in staffing levels would alleviate these concerns.

Staff told us that they had a fifteen minute handover meeting at the changeover from one shift to the next. They told us that this ensured that information was shared between all members of the staff team. They said that communication between staff, and between the care staff and managers, was good and this ensured they were aware of people's up to date care needs.

We observed that staff displayed kindness and empathy towards people who lived at the home. People looked appropriately dressed, their hair was tidy and they looked cared for. The staff who we spoke with were clear that they would treat people as individuals and promote their independence. They acknowledged that sometimes it took a long time for people to see to their own personal care and to mobilise, but understood that it was important for people to retain the abilities they had. They said that they were confident all staff were patient and allowed time for people to help themselves.

In one of the care plans we reviewed we saw that the person had a 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) form in place. The form had been signed appropriately and it recorded that this decision had been discussed with the person's relative. We noted that this had been highlighted in the person's care plan so that this decision was known to staff.

Good

Is the service responsive?

Our findings

We observed that staff (including the cook) spent time chatting to people who lived at the home. We saw one person having nail care and other people watching the TV. There was an activities chart filled in for each person and this included details of their visits out with family and friends, trips to the hairdresser, watching entertainers and watching films on the TV. One person who lived at the home told us, "I am a TV addict. The carer says I have got square eyes!" One person mentioned that there was a shortage of the type of books they liked to read. We discussed this with the registered manager who said that they would speak to this person and ensure suitable books were available.

In the dementia unit, we saw that staff encouraged people to take part in activities. If people did not respond to one activity, they tried another activity to see if people were more interested. People left the group and re-joined whenever they wished to do so. The Short Observational Framework for Inspection (SOFI) that we carried out in the dementia unit did not highlight any concerns about staff interaction with people who had a dementia related condition.

We saw in care plans that people's needs had been assessed when they were first admitted to the home, that care plans had been developed to record people's individual needs and that care plans were regularly reviewed and updated accordingly. We saw that care plans included information about a person's previous lifestyle, their hobbies and interests and their family relationships.

We overheard conversations between people who lived at the home, relatives and staff and it was clear that staff knew people well, including their likes and dislikes and their individual preferences for care. Relatives told us that they were always made welcome at the home.

Assessment tools had been used to identify the person's level of risk. These included those for pressure care, tissue viability and nutrition. Where risks had been identified, risk assessments had been completed that recorded how the risk could be managed or alleviated. Assessments and risk assessments had also been reviewed on a regular basis.

We observed that staff were able to recognise changes in a person's behaviour that indicated they were not well. Staff were aware that people needed different levels of support on different days or at different times of the day, due to their fluctuating health needs or capacity for decision making.

The complaints procedure was displayed in the home. We asked people if they knew how to express concerns or make a complaint. All of the people we spoke with told us that they would not hesitate to speak to the registered manager or other staff. One person said, "The manager is a good listener - she believes me and I trust her" and another told us, "I would tell the manager – I get on well with her." A visitor told us that they had made a complaint about the furniture in their relative's bedroom. They said that the manager had listened and "The problem was quickly sorted out." We saw that this was the only complaint recorded in the home's complaints log since our last inspection of the service.

Good

Is the service well-led?

Our findings

At the previous inspection we had been concerned that the registered manager was not always present at the home as they had been asked to work at other homes belonging to the registered provider to cover vacant nursing shifts. At this inspection the registered manager told us that they had informed the registered provider that they would no longer be able to do this. In addition to this, a deputy manager had been appointed. The registered manager and the deputy manager now covered the seven day period between them; this meant that there was always a manager on duty.

We saw that meetings had been held with people who lived at the home although these were infrequent. The most recent meeting had been in May 2014. Topics discussed included meal provision, dignity and activities. We asked people if they had been consulted about their care via surveys or questionnaires. One person said, "Never asked but would do" and another told us, "None, but would do if asked". However, the registered manager told us that a satisfaction survey had recently been distributed to people who lived at the home, and that they were waiting for the completed surveys to be returned. The registered manager told us that responses would be collated, analysed and the outcome would be displayed on the home's notice board.

The registered manager told us that the cook regularly had a 'ten minute meeting' with people who lived at the home to talk to them about their meal choices. These meetings were not recorded.

The organisation had carried out satisfaction surveys during 2014 for relatives and staff; the responses had been collated and analysed by the organisation's head office. We did not check these on the day of the inspection as we had seen the same surveys at the previous inspection in June 2014.

Staff meetings were held; we saw that there were separate meetings for day staff and night staff. The most recent meeting was in August 2014. Topics discussed included team working and COSHH, and we noted that people had been asked if they had any concerns or issues they wanted to raise. The staff who we spoke with confirmed that they attended staff meetings and that these were a 'two way' process; information was shared with them but they got the opportunity to ask questions, raise concerns and make suggestions for improvement.

This care home includes a special unit for people living with dementia. We noted that surveys and meetings for people who lived at the home, relatives and staff did not ask specific questions about the care and support of people living with dementia, or refer to any up to date guidance on how these people should be supported. Staff are currently undertaking distance learning training on dementia awareness so it would be timely for these topics to be addressed by the registered manager.

Staff also had supervision meetings with a manager but we noted that these were more like mini training sessions rather than supervision. Supervision meetings are meetings that take place between a member of staff and a more senior member of staff to give people the opportunity to talk about their training needs, any concerns they have about the people they are supporting and how they are carrying out their role. However, staff told us that they could speak to the manager at any time; they said she was approachable, listened to them and that they were confident she would take action about any concerns raised.

There was a staff risk assessment in place that addressed areas such as infection control, clinical waste and the risk of dermatitis.

We saw that accidents and incidents were recorded and monitored. The audit for September 2014 recorded that there had been five accidents during that month. There was a record of how many people had attended an Accident and Emergency unit following a fall and any action required by the home to alleviate the risk of the person falling again.

The registered manager had also carried out an audit in respect of first aid in September 2014. The deputy manager told us that the pharmacist who supplied medication to the home had carried out an audit of the medication system. They said that the pharmacist had been satisfied with the systems in place and how staff were managing the administration of medicines. We did not see the pharmacist's report on the day of the inspection. Care plans were reviewed and updated on a regular basis to ensure that staff had up to date information to follow.

Good

Is the service well-led?

We saw an up to date gas safety certificate (the home uses calor gas) and evidence that portable electrical appliances had been tested. However, we were unable to determine if the portable electrical appliance test was out of date. The senior staff member who we spoke with said that they would ensure appliances were re-tested if their records showed this was required.

Mobility hoists had been serviced in October 2014 and the passenger lift had been serviced in March 2014. There was a fire risk assessment in place and in-house tests of the fire alarm system were being carried out on a regular basis. In addition to this, weekly checks were being carried out on call bells and window opening restrictors. Only one person at the home had been provided with a bed rail and the registered manager told us that this was fixed to the person's bed. We advised the registered manager that it was good practice to check these fixings periodically to ensure that the bed rail remained safe to use.

There were policies and procedures in place about how to deal with emergency situations such as flood and loss of power. However, these needed to be combined to form a contingency plan for the service. We were aware that contingency plans had been produced for other services within the organisation. There were individual personal emergency evacuation plans (PEEPs) in place for each person who lived at the home. These provided sufficient information to enable people to be evacuated from the building effectively if the need arose.

The manager attended training provided by the local authority on a variety of topics including end of life care, DNACPR, diabetes, food hygiene, medication and safe use of the hoist. She had kept her practice up to date in order to retain her nursing PIN number (although she was not employed at the home as a nurse). We did not see any evidence of innovative practice although people who lived at the home told us that the home was well managed. One said, "(Name) is a good manager" and another person said, "On the whole, yes – the home is well managed." We asked visitors to the home if there was a positive culture. They all told us that there was a positive culture and comments included, "Homely, friendly – staff all interact" and "People and staff are treated like friends."

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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The registered person had not taken proper steps to ensure that each service user was protected against the risks of receiving care or treatment that was inappropriate or unsafe, by means of the planning and delivery of care and, where appropriate, treatment in such a way as to ensure the welfare and safety of the service user. The registered person had not taken proper steps to ensure that each service user was protected against the risks of receiving care or treatment that was inappropriate or safe, by means of reflecting, where appropriate, published research evidence and guidance issued by the appropriate professional and expert bodies as to good practice in relation to such care and treatment.