

The Fremantle Trust

Sancroft Hall

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

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

Summary of findings

Overall summary

Our inspection of Sancroft Hall took place on 29 July and 12 August 2016. This was an unannounced inspection.

At our previous inspection of Sancroft Hall in September 2014 we found that the home was meeting the requirements of the outcomes that we assessed. These were: Respecting and involving people who use services; care and welfare of people who use services; caring for people safely and protecting them from harm, staffing, quality and suitability of management.

Sancroft Hall is a care home situated in Harrow. The home is registered to provide care to up to 50 older people. Care is provided in five 'houses' of 10 people each. Two of the houses are specifically for elderly Asian people, and some of the people residing at the home are living with dementia. At the time of our inspection there were 48 people living at Sancroft Hall.

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 who lived at Sancroft Hall told us that they felt safe. This was confirmed by a family member whom we spoke with.

We found that people were protected from the risk of abuse. Staff members had received training in safeguarding, and were able to demonstrate their understanding of what this meant for the people they were supporting. They were also knowledgeable about their role in ensuring that people were safe and that concerns were reported appropriately.

The medicines for people who lived at the home were given to them correctly, and were generally well stored and recorded. Recent training had been provided for staff administering medicines. We had concerns about guidance available for staff administering PRN (as required) medicines to people. Guidance was limited and did not provide information about how and when staff members should be giving PRN medicines to people. The registered manager told us that they would immediately address this concern.

Staff at the home supported people in a caring and respectful way, and responded promptly to meet their needs and requests. There were enough staff members on duty to meet the physical and other needs of people living at the home. People who remained in their rooms for part of the day were regularly checked on.

Staff who worked at the home received regular relevant training and were knowledgeable about their roles and responsibilities. Appropriate checks took place as part of the recruitment process to ensure that staff

were suitable for the work that they would be undertaking. All staff members received regular supervision from a manager, and those whom we spoke with told us that they felt well supported.

The home was meeting the requirements of The Mental Capacity Act 2005 (MCA). Assessments of capacity had been undertaken and applications for Deprivation of Liberty Safeguards (DoLS) had been made to the relevant local authority. Staff members had received training in MCA and DoLS. The home had undertaken capacity assessments of people's ability to make decisions about their care. Where necessary they had involved other professions and family members in making decisions about people's best interests.

People's nutritional needs were well met. Meals were nutritionally balanced and met individual health and cultural requirements as outlined in people's care plans. Alternatives were offered where required, and drinks and snacks were offered to people throughout the day. The home had involved other professionals such as dietitians where they had concerns.

Risk assessments for people were up to date. However, we found that some care plans did not always include guidance for staff members about how they should meet people's needs and had not always been updated to reflect changes in need. The daily records of care for one person did not reflect anxieties and concerns that they had demonstrated during our inspection. We noted that actions had been put in place to improve the quality of care records. Although these were still in progress we could see that some improvements had already been made.

The home provided a range of individual and group activities for people to participate in throughout the week. This was confirmed by people whom we spoke with, and we saw photographic and other evidence of activities both within the home and in the wider community. Staff members engaged people supportively in participation in activities. People's cultural and religious needs were supported.

People who lived at Sancroft Hall knew how to complain. We were given examples of complaints that people told us had been dealt with quickly.

Care documentation showed that people's health needs were regularly reviewed. The home liaised with health professionals to ensure that people received the support that they needed.

There were systems in place to review and monitor the quality of the service, and we saw that action plans had been put in place and addressed where there were concerns. Issues around the quality of people's care plans had been identified and plans were in place to ensure that staff members were enabled to develop the skills and knowledge they required to make improvements in this area. Policies and procedures were up to date and staff members were required to sign that they had read and understood any new or amended ones.

The registered manager was new to the home and was working to improve the quality of care and support that people received. While some of these improvements had not yet been achieved, they had taken action to ensure that there was an on-going process of continuous improvement. In addition to improvements in relation to staff support, medicines administration and care records, we saw that they had, for example, requested works to take place to create a more dementia friendly physical environment and to create a more suitable medicines storage area.

People who used the service, their relatives and staff members spoke positively about the management of the home. We were able to see evidence that the registered manager was working to improve the quality of care and support.

We found one breach 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 the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe. Medicines were safely administered and recorded. However, guidance for staff on the administration of PRN (as required) medicines was not always in place.

Risk assessments were person centred and up to date.

Staff understood the principles of safeguarding of adults at risk, how to recognise the signs of abuse, and what to do if they had any concerns.

Requires Improvement ●

Is the service effective?

The service was effective. The home was meeting the requirements of The Mental Capacity Act 2005 and Deprivation of Liberty Safeguards 2007.

Staff members received the training and support they required to carry out their duties effectively.

People were supported to maintain good health and to access health services when they needed them.

People chose their meals and were provided with the support they needed to eat and drink.

Good ●

Is the service caring?

The service was caring. People who used the service and their family members told us that they were satisfied with the care provided by staff. We observed that staff members respected people's privacy and dignity.

Staff members spoke positively about the people whom they supported, and we observed that interactions between staff members and people who used the service were caring and respectful.

People's religious and cultural needs were respected and supported.

Good ●

Is the service responsive?

The service was not always responsive. The quality of care plans was variable, and did not always provide guidance for staff on meeting people's identified needs.

People were able to participate in of individual and group activities, including activities outside the home.

The service had a complaints procedure and people knew how to make a complaint. Complaints had been dealt with to people's satisfaction.

Requires Improvement ●

Is the service well-led?

The service was not always well-led. The registered manager had made a number of improvements to the quality of care at the home. However some of these improvements were yet to be completed.

There were systems in place to monitor the quality of the service and we saw that these were evaluated with improvements made where required.

The registered manager demonstrated leadership and accountability. He was approachable and available to people who used the service, staff members and visitors.

Staff members told us that they felt well supported by the manager. People and family members of people who used the service felt that the home was well managed.

The registered manager had a good working relationship with health and social care professionals and organisations.

Requires Improvement ●

Sancroft Hall

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 29 July and 12 August 2016, and was unannounced. The inspection team was comprised of one inspector, a specialist advisor 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.

During our inspection we spoke with eight people who lived at Sancroft Hall and a visitor. We also spoke with four care staff, the activities co-ordinator, a deputy manager and the registered manager.

We spent time observing care and support being delivered in the main communal areas. We looked at records, which included seven care records, eight staff records and records relating to the management of the service.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information included in the PIR along with other information we held about the home.

Is the service safe?

Our findings

People who lived at the home told us that they felt safe. One person told us, "They look after me. I've never been let down." Another person said, "I'm very well looked after."

Medicines were managed and recorded appropriately, and administered to people safely. An up to date medicines policy which included procedures for the safe handling of medicines was available to staff. Staff administering medicines had received training in safe administration of medicines. .. Medicines records were checked on a daily basis, and we saw that further regular monitoring of medicines had taken place such as monthly audits and 'spot checks'. We saw that records were in place to show that regular blood tests had taken place for people who required this in relation to medicines such as warfarin. Medicines controlled under the Misuse of Drugs Act 1971 had been prescribed for three people. These were safely stored and managed in accordance with current regulations and best practice guidance.

On the first day of our inspection we identified that the arrangements for the storage of medicines awaiting return to the pharmacy were not clear to us. We found some medicines that were being returned to the pharmacy in an open plastic box within the medicines storage room and had not been locked away. However, when we returned for the second day of the inspection the registered manager was able to explain the procedure followed for the safe storage of medicines and the return to the pharmacy. We were shown the returns records and that lockable storage had been provided for medicines. Further, details were provided to us after the inspection.

We looked at the PRN (medicine as required) protocols for four people. These only contained information in relation to the prescription. There was limited information or guidance in relation to the circumstances in which such medicines should be given. For example, for a person who received PRN medicines in relation to anxiety the only information we found about this was when the matter had been discussed at a meeting with the person's community psychiatric nurse. The care documents had not been updated to reflect this. We could not be sure that staff administering PRN medicines had clear advice and guidance.

We discussed our concerns about medicines with the registered manager. They demonstrated that they had taken action to ensure that medicines were stored and disposed of correctly. They told us that they would take action to review the guidance for administration of PRN medicines and to ensure that protocols and care plans were updated to provide detail about the circumstances in which such medicines should be given. They showed us records of discussions that had taken place with staff members in relation to safe management of medicines, and told us that they would ensure that procedures were reinforced with the staff team following our inspection.

Risk assessments for people who used the service were personalised and had been completed for a selection of areas including people's behaviour, medicines, falls, pressure ulcers, infection control and moving and handling. We saw that these were up to date and had been reviewed on a regular basis.

Specific risk in relation to pressure area care was well managed. The care records for one person who was

identified as at risk showed that regular Waterlow skin integrity assessments had been completed on a monthly basis. Monitoring charts had been completed in relation to regular repositioning. Guidance on taking proactive actions to prevent pressure area sores was provided to staff. There was evidence that daily mattress and pump checks were in place for people using pressure relieving mattresses.

There was an up to date policy on safeguarding that included contact details for the local authority. Staff members that we spoke with demonstrated that they understood the principles of safeguarding, and how they would respond to and report suspicions and concerns that a person may be at risk of abuse. We saw evidence that training in safeguarding had been received by all staff members. We looked at the safeguarding records for the home which showed that safeguarding concerns had been appropriately managed.

The home looked after small sums of money for people. We saw that these were well recorded and receipted. Family members and appointees were involved in the processes for money management and there was recorded evidence that they were kept up to date about how people used their money.

We looked at the home's staffing rotas. These showed that each unit within the home had one or two staff members on shift at any time and there were 'floating' staff members available to provide extra support in any unit as required. The manager and assistant managers also supported people where required. In addition the home had an activity co-ordinator, catering staff and domestic workers.

We observed that people received care and support when they required. We saw that staff members responded promptly to ensure that people were provided with the assistance they needed. There were enough staff members to support people to take part in activities. People told us that they did not have to wait long for assistance if they required it. During our inspection we saw that there were enough staff members on shift to meet the needs of people using the service. The registered manager told us that staffing was sometimes 'tight' but they sought solutions to this. For example, on one unit, they had asked domestic staff to come in early to serve breakfast so that staff could support people who wished to have a morning shower or bath.

The eight staff records we looked at showed that appropriate recruitment and selection processes had been carried out to ensure that staff were suitable for their role in supporting people who used the service. These included checks of references relating to previous employment and of criminal records.

Staff members were seen wearing disposable aprons and gloves when supporting people with their care. We also observed that catering and domestic staff used appropriate protective clothing. Anti-bacterial hand rub was located in several areas of the home to minimise the risk of spread of infection. Soap and paper towels were accessible in bathrooms.

Checks of equipment were carried out. Moving and handling equipment, such as hoists and the home's lift were inspected and serviced regularly in accordance with the Lifting Operations and Lifting Equipment Regulations (LOLER) 1998.

Temperatures of fridges and freezers, hot water temperatures and the storage of medicines were monitored closely.

Fire action guidance was displayed and fire equipment had been regularly serviced. Fire drills were carried out quarterly and we noted that these included and included drills during that night. Emergency evacuation plans were in place for individuals. Accident and incident records were well maintained and showed that

appropriate actions to address concerns had been put in place. The provider maintained an out of hours emergency contact service and staff we spoke with were aware of this.

The home's records demonstrated that actions had been undertaken to reduce health and safety risks to people.

Is the service effective?

Our findings

People that we spoke with were positive about the support that they received from staff members. One person told us, "I would be happy to stay here, but I don't know how long I will be here. They look after me and I have no complaints." A family member told us, "The place is very nice, overall it's very accommodating. I can't find any fault."

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). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The care records showed that assessments relating to people's capacity to make decisions had been undertaken and that these followed the code of practice associated with The Mental Capacity Act 2005 (MCA). Care plans provided information for staff about how they should support people to make decisions. We saw that applications had been made to the relevant local authority team in relation to Deprivation of Liberty Safeguard (DoLS). These were in place for all residents of the home regarding restrictions in place for people who were under continuous supervision and unable to leave the home unaccompanied due to risk associated with lack of capacity to make decisions. The registered manager maintained a record of when DoLS authorisations were due for renewal, and we saw that renewal applications had been made at least two weeks prior to the end of each person's current DoLS authorisation.

Training in MCA and DoLS had been provided to all staff at the home and the staff members that we spoke with demonstrated that they were aware of the requirements of the MCA and understood their roles and responsibilities in relation to this.

People were asked for their consent with regards to care planning and risk assessment and this was recorded in their care plan. Where people were unable to record consent, the home asked family members or other representatives to support any such decisions, and this was recorded.

Training records for staff members showed that new staff members received induction training that met the requirements of the Care Certificate for staff working in social care services. We saw evidence that core training was refreshed on a regular basis. The training programme included additional training sessions, for example, dementia awareness, positive behavioural approaches and end of life care. The provider also supported staff members to undertake qualification training and we saw certificated evidence that a

number of staff members had achieved or were working towards accreditation under the Qualification Credit Framework for staff working in health and social care services. The home's training matrix showed when training had been received, or was due, for each staff member. This was reviewed on a weekly basis, and we saw that training had been booked for staff members requiring refresher training. This showed that staff had been provided with the skills and knowledge they required to support people effectively.

Staff members that we spoke with told us that they received the support that they needed to undertake their duties effectively. One staff member told us, "I have regular meeting with my manager, and I can always get support and advice immediately if I need it." The records that we viewed showed that staff had received supervision from a manager on a regular basis and that annual performance appraisals had taken place during the past year. We also saw that regular staff meetings took place and that these were well attended. The minutes of recent staff meetings showed that there was a focus on the care needs of people who used the service, and of how this care was delivered and recorded. The registered manager held additional meetings for night staff who were unable to attend meetings during the daytime, and for domestic staff at the home.

People's health care needs were met and monitored. Records showed that people regularly received health checks. They had access to a range of health professionals including; GPs, dieticians, opticians, chiropodists, psychiatrists, and dentists. They also attended hospital appointments.

The home's physical environment was suitable for the needs of the people who lived there. People told us they were happy with their bedrooms and the layout of the home. A staff member told us about how they had involved people in deciding how a communal area was refurbished, using pictures to achieve consensus on furnishings and colour scheme. People were able to use a lift to move between floors and there were hand rails on each corridor to aid mobility. The doors between units within the home were not locked so people were able to move around the home if they wished. The garden was accessible for wheelchair users. The registered manager told us about changes that they were making to the service to provide a more dementia friendly environment. We saw for example, that door frames were painted blue. This helped to aid orientation for people living with dementia or visual impairments. There were signs on bathroom doors. We were shown a room that had been prepared for a person who was due to arrive at the home. We were told that staff had worked with the person's family to ensure that items such as photographs and ornaments that were important to the person were in place so that they were able to settle into an environment with familiar things around them. The registered manager also showed us an empty room that had just been redecorated. Light switches and doors had contrasting surrounds so that they were easy to identify for people with visual impairments and well as people living with dementia. They told us that when rooms and communal areas were refurbished that contrasting surrounds to aid orientation and recognition would be introduced throughout the home.

People's individual dietary and nutritional needs were met. The daily menu was displayed at the reception area. We saw that this was easy to read but did not include pictures. We did not see menus displayed in the dining areas. However we saw that people were asked what they wanted to eat, and were shown the food that they could choose from where required. There were at least two choices provided for each meal and, where people did not want what was on the menu we saw that they were offered alternatives. The home catered for special diets and individual preferences. For example two of the units within the home provided support to people of Asian origin. A separate 'pure vegetarian' kitchen was used to prepare Asian vegetarian meals for people who chose these. Where people did not wish to eat what was on the menu, we saw that staff members offered alternatives.

People told us they enjoyed the meals. People were offered hot and cold drinks and snacks throughout the

day. People's nutritional needs were assessed and monitored, and guidance for staff members on supporting people with dietary needs and poor appetites were contained within care plans. The care records showed that people's daily food and fluid intake was recorded and monitored, and any concerns were raised and passed on appropriately. However we had concerns about the recording of fluid intake. Some records were not completed in detail so it was difficult to determine whether or not people received an adequate amount of liquid in relation to their needs. For example there was no indication of target fluid intake in the charts that we saw. Some charts referred to glasses or cups, without indicating the size of these. We discussed this with the registered manager who told us that they would ensure that the importance of recording fluid intake in detail was discussed with staff.

Where there were concerns about weight loss or poor food or fluid intake we saw from people's records that relevant professionals were consulted and guidance developed for staff. We observed that one person was experiencing difficulties in eating their lunch and had to be supported and encouraged by staff. We saw that the person's GP had been involved and a referral to a dietician had been made.

Medical appointments and visits by health professionals were recorded along with the outcome for each. Important information was passed on to incoming staff members at a 'handover' at the beginning and end of each shift.

Is the service caring?

Our findings

People told us that staff members were caring. Comments included, "The staff are very caring," and, "They are marvellous and efficient." A family member told us, "The staff are very friendly. [My relative] just asks and he gets it."

We saw that staff members interacted with people in a positive and respectful manner. We observed staff initiating conversations with people and chatting to them with them when providing support.

We observed that where people required personal support, this was provided in a timely and dignified manner. Some people chose to spend time in their rooms. We saw that staff members checked on their welfare regularly and asked them about any needs or wishes in relation to care and support.

Staff members spoke positively about the people whom they supported. They were able to describe their knowledge of people's individual needs. One staff member told us, "I really like the people I support. I learn something new every day."

People were supported to maintain the relationships that they wanted to have with friends, family and others important to them. The family member that we spoke with talked positively about the approach of staff members. During the second day of our inspection we saw that two people were going out with family members. The registered manager told us that where people's partners and other family members visited, staff members were encouraged to ensure that they had privacy.

The provider had a policy on personal relationships and sexuality. We asked about the home's approach to supporting people's sexuality. The registered manager told us that they would expect staff to support people with discretion and dignity and to respect people's rights in relation to their personal preferences.

Care plans included information about people's cultural and spiritual needs. People's care plans included information about their histories, interests and faiths. The staff members that we spoke with were knowledgeable about people's individual cultural needs and interests. Arrangements had been made for faith representatives to visit the home on a regular basis. Some people visited a local place of worship on a weekly basis with the support of staff members. Staff members working in the two units within the home which supported people of Asian origin were able to communicate with people in their first language and had had understanding and experience of their cultural needs. We saw that decoration of the communal areas included, for example small altars and other items that reflected people's cultural origins. We observed that staff members in these units engaged people in culturally relevant activities. For example, we saw a well-attended singing and music session taking place. A day centre for people of Asian origin run by the same provider was situated next door to the home. The manager of the day service told us that people who lived at the home were invited to participate in cultural events and activities. Although we did not see this happen during our inspection, we noted that activity records maintained by the home confirmed this.

Care plans also recorded information about peoples' end of life preferences and needs. This included

information about whether or not people wished to remain at the home or be admitted to hospital, along with information about how they would like to be supported by staff at the home. Some end of life plans had not been completed. The registered manager told us that this was a difficult subject for some people to discuss and the home's approach was to build up a picture gently and in their own time, involving family members where appropriate. A staff member that we spoke with told us about the end of life care training that they had recently participated in. They told us, "it's not easy to deal with but I want to make people's last days as good as they can possibly be." We saw recorded evidence that the home worked with palliative care nurses and other health professionals to support people at the end of life.

Is the service responsive?

Our findings

People told us that the home was responsive. One person told us, "There's always something going on. They ask us what we want. When the weather is nice we do things outside."

The registered manager told us that, before any new person moved to the home their individual care and support needs were assessed to determine if the home was able to meet their needs. We saw that an assessment had been put in place for a person who was due to move to the home and that staff members had liaised with their family and health and care professionals to develop a transition plan.

The care plans that we looked at were up to date. However we found that these were variable in relation to the level of information recorded about people's needs. Some plans were person centred, and contained detailed guidance for staff in relation to meeting people's identified needs. Other plans did not always include information about how the person should be supported. For example, one person's assessment identified that they had a need in relation to communication. Their care plan did not show what this need was or how they should be supported by staff. The plan specified that 'this is well documented in the risk assessment.' We found that there was no information in either the person's care plan or risk assessment that detailed how staff should provide support in relation to these behaviours.

Although information about, for example, people's histories and personal interests, communication, health support, behaviours, mobility and dietary needs were completed in some people's files, these were not documented for others. For example, the home had recently introduced a 'Life Story' section to the care plan which outlined their personal history. We saw that these had been completed for some people, but not for others. Some people's mental health needs were not fully documented in their care plans. Two care plans that we saw referred to specific mental health conditions. However, there was no information about how these affected each person, and what staff members should do in response to behaviours that indicated that there may be a concern. We saw that information about one person's mental health needs was recorded in the notes of a review meeting, but their care plan had not been updated to reflect this. Another person's care plan referred to the fact that they displayed behaviours that were challenging.

Staff maintained daily care notes for each person. These included information about activities, behaviours, health issues and any monitoring that was taking place for the person and were read by incoming staff members at the start of each shift. We looked at some people's care notes. Although these appeared good for most people, we saw that a care record for a person who had demonstrated anxiety about a specific personal issue both to us and to staff members during our inspection, did not include any record of this, even though it was completed subsequently. These concerns meant that we could not be sure that people's care records fully reflected their support needs.

This demonstrated a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) 2014.

We discussed our concerns about care documentation with the registered manager. They told us that they

were aware of the fact that the quality of records was not always consistent and that they had been working to address this. We saw that they had been providing coaching to staff members who were responsible for developing care plans and that care plans had been discussed at recent team meetings. They showed us an email to the provider that identified their concerns about ensuring that staff members were able to develop skills in developing effective and effective consistent care plans. There was recorded evidence that training was being planned to address this issue.

A wide range of activities took place at the home. On the first day of our inspection we saw that seated exercise sessions and a country and western music event were taking place. We observed that people sitting in one of the communal areas were asked and encouraged to participate in these events. We saw staff members engaging in board games with people. When we returned to the home to complete our inspection we observed a singing session taking place. Other activities at the home included reminiscence activities, arts and crafts and quizzes. A group of students had been coming to the home to engage people in arts and drama based activities. The home had recently set up a 'men's group' and we saw a record of a meeting with interested participants to decide on the activities that they wished to do. One of these was furniture restoration. The activities co-ordinator showed us an example of a small table that the group had re-painted and we saw photographs of people engaging in this activity. We also saw photographs of people participating in other events such as parties, cooking sessions, barbecues and art and craft activities. A staff member showed us pictures produced by people that were displayed on the wall in a communal area. Most people spoke positively about the activities. Two people told us that they were always asked if they wished to participate but they did not always choose to do so. One said that, although they were asked to participate in activities, they spent most of the time in their room.

Activities also took place outside the home. For example, in addition to regular visits to local places of worship, we saw that people had been on outings to Ruislip Lido, a local park and a garden centre during the month before our inspection.

The home had its own hairdressing salon and a hairdresser visited regularly. There was also a small shop that was open during the afternoon. This contained items such as toiletries and confectionery. The registered manager told us that although some people were supported to go on shopping trips, they sometimes required items before a trip could be organised, and the shop was designed to cater for this and for the needs of other people who did not regularly go out. We saw that stocks of wine, beer and sherry were stored within the shop area. The registered manager told us that these were not for sale, but that some people liked a drink with their meals and the home kept these items in order to accommodate this.

Regular residents meetings took place on each unit within the home. We looked at the notes of the most recent meetings and saw that people had been involved in discussions about planning activities and menus. The home also held occasional meetings for family members.

The home had a complaints procedure that was available in an easy read format. People who lived at the home told us that they were able to complain. People told us that when they had complained action had been taken. Examples we were given included a person's shower unit being replaced by a larger one, more green vegetables being provided at lunchtime, and a person being able to move to a new room. We looked at the home's complaints log and saw that complaints had been addressed quickly and to people's satisfaction.

Is the service well-led?

Our findings

People spoke positively about the management of the home. People told us that they saw the registered manager regularly. We were told, "He is always up and down here," and, "The manager is a very kind and understanding man."

The registered manager for the home was supported by two assistant managers. Senior care workers were also in post. During our inspection we saw that assistant managers and senior care workers took responsibility for each unit at the home. The registered manager was seen to spend time in each unit and communicated positively with people who lived at the home, staff members and visitors. We saw that he made a point of having lunch with people, and he told us that he tried to do this on a regular basis.

We reviewed the policies and procedures in place at the home. These were up to date and reflected good practice guidance. There was a process in place to ensure that staff members were required to sign when they had read the policies.

The staff members that we spoke with told us that they felt that the registered manager was supportive and approachable. One staff member told us, "I feel really happy to come to work with this new manager. He is very supportive and makes sure that we get lots of training to help us support people."

Staff members had job descriptions which identified their role and who they were responsible to. The staff members that we spoke with demonstrated that they understood their roles.

There were systems in place to monitor the quality of the service and we saw recorded evidence of these. Regular audits took place at the home. We saw that regular health and safety monitoring took place, and that the registered manager undertook a recorded monthly 'walk round' review of safety and practice at the home.

The provider undertook regular monthly monitoring. We saw that the most recent visit had taken place during July 2016 where concerns had been identified in relation to people's care plans. Monthly monitoring of medicines took place. We also saw a recent infection control audit. Each of these monitoring records contained information indicating reasons for any concern, along with action plans with timescales for completion. We saw that appropriate actions had been put in place.

However, some actions had not yet been completed. For example, care planning and environmental improvements. We asked the registered manager about this. They showed us email correspondence and other records that showed that they had followed up concerns and had requested further support where appropriate. However, we noted that they were still awaiting action from the provider or others, for example in relation to the provision of care planning training for staff.

The registered manager was relatively new to the home. A staff member told us, "[The registered manager] has worked hard to help us change things. The care plans are getting better. He has really improved the way

we give medicines to people." We saw evidence that improvements had been made, for example in relation to training and the frequency of staff supervision, the range of activities available to people and the quality of some of the care documentation . The registered manager told us that, "some of the changes are easy, but some take longer as staff have had to respond to new ways of working and this requires a longer term change in knowledge and practice." We noted that requests they made to the housing provider in relation to creating a more dementia friendly environment and improving the storage facilities for medicines had been positively responded to, and they told us that they were hoping that these works would be carried out soon.

Regular monitoring of incidents, accidents and 'near misses' had also taken place. The provider had promptly submitted notifications to CQC where required.

Satisfaction surveys took place annually. The most recent survey of the views of people who lived at the home and their family members had been analysed and showed high satisfaction rates. Where issues had been raised, actions had been taken to address these.

Minutes of staff team meetings showed that information and concerns arising from quality monitoring activities were regularly discussed. The registered manager told us that urgent information was communicated to staff immediately, and the staff members that we spoke with confirmed that this was the case.

Records showed the home worked well with partners such as health and social care professionals to provide people with the service they required. Information regarding appointments, meeting and visits with such professionals was recorded in people's care files.

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 9 HSCA RA Regulations 2014 Person-centred care People's care plans did not include information or guidance about meeting all their identified needs. Regulation 9(3)(b)