St John's Winchester Charity

Devenish House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on the 15, 18 and 19 April 2016 and was unannounced. Devenish House is a care home registered to provide accommodation for up to 21 older people who require nursing or personal care and the treatment of disorder, disease or injury. The home is located in the centre of Winchester and the accommodation is arranged over three floors. There is a small outside courtyard on the ground floor. At the time of our inspection there were 18 people living in the service.

A registered manager was in post at the time of our inspection, however they were absent during the inspection period. 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 told us they felt safe with staff and the staff we spoke with demonstrated their understanding of how to safeguard people and report their concerns. People were protected from the risk of abuse.

People had risk assessments in place that detailed their individual areas of risk and how these should be managed to keep people safe. All staff were updated daily on people's changing needs to ensure staff had the information they required to provide safe and appropriate care.

There were sufficient levels of suitably skilled staff available to meet people's needs. Whilst there had been some staff changes the provider had ensured staffing levels were maintained. Agency staff were checked for their suitability to work with people and as far as possible the same agency staff were used to provide a continuity of care for people.

There were processes in place for the safe ordering, storage and disposal of medicines and medicines were administered to people by trained staff. Guidance was available to staff on what the medicines were for and people's preferences for how to take their medicines. Some prescription medicines are controlled under the Misuse of Drugs Act 1971 these medicines are called controlled drugs (CD's). Procedures were in place and followed to ensure these medicines were safely managed.

Staff completed an induction into their role to ensure they were competent to carry out their responsibilities. Staff were supported by the registered manager and nursing staff through regular supervision and an annual appraisal. Staff completed a range of training to develop the skills and knowledge they needed to meet people's needs. Records showed staff had completed most of the provider's mandatory training with the exception of training in the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS).

The provider did not always follow their procedures to ensure people's rights were upheld in line with the MCA (2005). It was not evident that mental capacity assessments and best interest decisions were carried

out when people lacked the capacity to make their own decisions. This meant people could be at risk of inappropriate and unlawful decision making.

People were offered choice by staff and where people had made decisions, these were respected by staff. Staff were knowledgeable about people's preferences and acted to ensure these were met.

People told us the food was 'very good'. We saw that a varied and nutritious menu was offered and the chef was aware of people's likes, dislikes and food safety needs. People were asked for their feedback on the quality of the food and this was acted on. People were referred appropriately to the relevant healthcare professionals when staff had concerns about their wellbeing in relation to nutrition. People had experienced positive outcomes in their health through good nutrition management.

People's healthcare needs were attended to promptly and people were seen by a range of healthcare professionals as required.

People received care and support from staff who knew them well and were caring, compassionate and thoughtful in their approach. The relationships between staff and people receiving support demonstrated dignity and respect. People's diverse needs in respect of their spiritual beliefs and their preferences regarding staff gender choices were respected and met.

People's decisions for their end of life care were known and respected. People and their families were supported and staff acted with care and attention to ensure people at the end of their life received appropriate and person-centred care.

People's care plans were person-centred and included their preferences for how their care should be delivered. Care plans were regularly reviewed and updated with people's changing needs to ensure they remained current and appropriate. People and their relatives told us that the care provided at Devenish house had resulted in improvements to people's quality of life.

A range of activities was available for people to participate in if they chose to do so and people told us they enjoyed these. People's individual activity and social needs were met by a team of activity coordinators and volunteers.

A system was in place for people to raise their complaints and concerns and these were acted on quickly and appropriately.

Quality assurance systems were in place to monitor aspects of the quality of service being delivered and the running of the home. However, we noted that audits were not always effective in addressing the shortfalls identified. For example the actions taken to address omissions in people's medicines administration records had not prevented reoccurrences. Whilst people, their visitors and relatives' views had been sought on the quality of the service, it was not evident how the information had been used to drive continuous improvement to the service. The falls monitoring in place did not include identifying patterns and trends to ensure all possible measures had been considered and appropriate action taken to prevent reoccurring accidents. The systems and processes in place were not always effective in assessing, monitoring and improving the quality and safety of the service people received.

There was a positive culture in the home and staff were aware of and acted in accordance with the provider's values. Staff were supported to be clear about their roles and responsibilities through supervision, training and team meetings. Adequate arrangements were in place to provide leadership and management

support during the absence of the registered manager.

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

Good

The service was safe

People were safeguarded from the risk of abuse. Staff had completed relevant training and understood their roles and responsibilities in relation to protecting people from the risk of harm.

Risks to people had been identified and actions were taken to ensure their safety. All staff discussed people's needs daily to ensure they received safe and appropriate care.

People were supported by sufficient and suitably skilled staff to meet their needs safely. The same agency and bank staff were used to cover staff vacancies as far as possible to ensure a continuity of care for people.

People's medicines were managed safely.

Is the service effective?

Requires Improvement

The service was not always effective

Not all staff had completed training in the Mental Capacity Act 2005. The provider did not always follow their procedures to ensure people's rights were upheld in line with the MCA (2005). It was not evident that mental capacity assessments and best interest decisions were carried out when people lacked the capacity to make their own decisions. This meant people could be at risk of unlawful or inappropriate decision making.

Staff received an induction into their role, on-going relevant training and supervision of their work. People received their care from staff that were appropriately supported in their role.

People enjoyed a varied and nutritious diet which reflected their preferences and dietary needs.

People were supported by staff to access health care services as required and their healthcare needs were met promptly.

Is the service caring?

Good

The service was caring

People were cared for by kind and compassionate staff who knew them well.

People were given choices and made decisions about their care. People's privacy and dignity were respected by staff.

People were supported to make decisions about their preferences for end of life care and these were known and respected by staff. People received the support they needed at this time.

Is the service responsive?

Good

The service was responsive

People's care and treatment plans were person centred and reflected their preferences and decisions. People had experienced positive outcomes as a result of the care provided.

People's activity and social needs were met through a range of group based and individual activities provided by a team of activity coordinators and volunteers.

A system was in place for people to raise their complaints and concerns and these were acted on.

Is the service well-led?

Requires Improvement

The service was not always well-led

There were processes in place to enable the provider and registered manager to monitor and audit the service and make improvements. However, these were not always effective in identifying, and addressing shortfalls. Or preventing a reoccurrence when the quality and safety of the service people received required improvement.

It was not evident how information the provider sought from people was used to drive continuous improvement to the service.

There was a positive, open and inclusive culture in the home. Staff were aware of and acted in accordance with the provider's values to provide high quality care for people.

Staff were supported to understand their roles and responsibilities. There were adequate leadership and

management arrangements in place to support staff in the absence of the registered manager.	

Devenish House

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 the 15, 18 and 19 April 2016 and was unannounced. The inspection team consisted of one adult social care inspector.

Before the inspection we spoke with a team manager from adult services in Winchester to gather their views on the service. We reviewed the information we held about the service, which included previous inspection reports and statutory notifications. A notification is information about important events which providers are required to notify us by law. We requested a Provider Information Return (PIR) and this was completed by the provider before our visit. The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make.

During the inspection we spoke with five people and two people's friends or relatives. The registered manager was absent during our inspection. We spoke with the deputy matron, the director, the administrator, an activities coordinator, the chef, the property director, four care staff, and one nurse.

We reviewed records which included four people's care plans and monitoring records relating to people's care, people's medicine administration records, four staff recruitment and supervision records and records relating to the management of the service. These included; policies and procedures, staff training records, quality assurance records, accident and incident reports and staffing rotas for the period 14 March to 10 April 2016.

This service was last inspected on 5 September 2013 and no concerns were identified.

Good

Is the service safe?

Our findings

People told us they felt safe with staff. Staff we spoke with demonstrated their understanding of safeguarding and their responsibilities. A staff member told us how they had reported a concern and this had been acted on. Records confirmed that staff had completed training in safeguarding and staff had access to policies and procedures for guidance should this be needed. People were protected from the risk of abuse.

Risks to people had been assessed in relation to a number of areas such as the risks from falls, moving and handling, developing a pressure ulcer, malnutrition, the use of bed rails, and risks from pain and medicines. Staff, including agency staff, told us about the strategies in place to minimise the risks to people and demonstrated a thorough understanding of people's risk areas and needs. For example; a care staff member told us about why a person was at risk of falling and the plan in place for further investigation of their health issues. They went on to explain the equipment used to support the person and the monitoring staff completed to check other factors that could influence the person's mobility. They told us how equipment had been arranged to enable the person to independently mobilise safely at night. The person's risk assessment reflected this information. Records confirmed that risk assessments had been completed and updated to reflect people's current needs and the arrangements in place to minimise risks to people. People told us they felt safe and had the support and equipment they needed to stay safe. A person said "Yes it's safe; it's wonderful you just have to ring the bell".

We observed a morning handover attended by all staff and the deputy matron. All staff were updated on people's needs, including areas of risk and actions required to manage these risks. For example; people's re-positioning needs to prevent the development of a pressure ulcer, food and fluid needs and preferences to support people at risk of poor nutrition and hydration, and healthcare, behaviours and any emotional factors which may influence their responses or needs. There was a recorded list of all people and their health conditions, mobility needs and dietary and fluid requirements. The handover was recorded and included the priorities and observations required and actions to be taken. Actions were taken as described, for example; healthcare referrals, food and fluid monitoring and dietary changes. We noted that all staff participated in the discussion of people's needs and made observations and suggestions. People were cared for safely because risks to people were anticipated, identified and managed by staff who communicated and acted on people's needs.

At the time of our inspection there were staffing vacancies for nursing and care staff. Recruitment was underway and some posts had been recruited to. Staffing changes had caused some disruption to the established team and during the process of recruitment there had been a high use of agency and the provider's bank staff. We reviewed the staffing rotas for the period 14 March to 10 April 2016. Records showed and staff confirmed that staffing levels had been maintained during this period to ensure there were sufficient staff to meet people's needs.

The deputy matron told us and records confirmed that, as far as possible, the same agency staff were used to cover vacancies and provide a continuity of care for people. People and their relatives told us there were

sufficient staff to meet people's needs. A person said "Oh yes enough staff, if someone goes off sick then they get the agency in" and a relative commented "There is always the same agency staff". One staff member said "I think there is enough staff here to meet people's needs in a way that is not rushed and routines don't take over from what an individual needs and wants". Continuity of care was supported by nursing and care staff who had worked in the home for many years, including the deputy matron who had worked there for 14 years. They told us the quality of staff provided by the agency had been high with some agency staff having specialist experience which had enhanced the skills within the team, such as wound care. New agency care staff worked alongside more experienced staff to learn about people's needs prior to working alone. There were sufficient, suitably skilled staff to meet people's needs.

The home used two agencies for temporary staff. Records showed both agencies provided written confirmation that safe recruitment checks had been completed. Staffing records confirmed the provider carried out pre-employment checks to protect people from the employment of unsuitable staff. These included criminal records checks, a full employment history including a written explanation for any gaps in employment, character references and confirmation from previous employers of the person's satisfactory conduct. The provider checked nurses had current registration with the Nursing and Midwifery Council (NMC) which confirmed their fitness to practice safely. People were protected from the employment of unsuitable staff.

Nursing staff administered people's medicines and completed medicines training every two years. A competency assessment was not currently carried out to check staff remained competent in medicines management and administration. However, we saw the registered manager had introduced a competency assessment tool to nursing staff at their meeting in February 2016 and this was planned to be used in the near future.

There were processes in place for the safe ordering, storage and disposal of medicines. There were records of daily temperature checks for the fridge and clinical room to ensure they were within a normal, safe range for the storage of medicines. Some prescription medicines are controlled under the Misuse of Drugs Act 1971. These medicines are called controlled drugs (CD's). Providers are required to have procedures in place to ensure CD's are safely managed and that staff follow these to keep people safe. We checked the arrangements for the storage, recording and administration of CD's, including an observation of nursing staff in this process. We found the processes to be appropriate and that legal requirements were met.

Protocols were in place for people's 'as required' medicines. These are medicines people take as and when needed for example; some pain relief medicines or medicines to help calm people if they became agitated or anxious. Information was included in the protocols about whether other things should be tried with the person before administering medicines. They also included under what circumstances the medicines should be given, what effect the medicine should have on the person and when medical advice should be sought. This guided staff on the appropriate use of these medicines to protect people from risk of taking medicines they don't need.

People's records included a medicines administration profile that outlined their personal preferences for taking their medicines. For example; a person preferred to have their medicines placed in a pot on their table and they took this themselves. Another person self-administered a medicine and a risk assessment had been completed to check it was safe for them to do so. A relative told us how staff had "sat down and gone through all of Mum's medicines" so the person and their relatives understood their use. People were supported by staff to take their medicines in the way they chose and were informed about their use.

Requires Improvement

Is the service effective?

Our findings

Records demonstrated that new staff had undertaken the industry recognised standard induction to their role to ensure they could provide people's care effectively. A new care staff member said "I'm still learning, everyone is so helpful. I was an additional staff member for three weeks and did my training alongside a senior carer". This meant new staff were supported to learn about people's needs.

All staff were required to complete the provider's programme of mandatory training that included; moving and transferring, fire safety, safeguarding, the Mental Capacity Act (MCA) 2005 and DoLS, basic food hygiene, infection control, health and safety and first aid. We viewed the training records for staff which confirmed staff had received training as described. However, records showed there was a low completion rate for MCA (2005) and DoLS training. The administrator told us further training in the MCA and DoLS was being planned, along with training in dignity and respect and equality, diversity and human rights. Staff told us the quality of the training was good and delivered face to face.

Nurses completed other training relevant to people's healthcare needs such as; medication management, catheterisation, and syringe driver training. A person said "The nurses know what they are doing; all the staff are very good". People were supported by staff that had access to a range of training to develop the skills and knowledge they needed to meet people's needs.

Care staff told us they were well supported in their role. Records showed care staff had three monthly supervision with a nurse, and on occasion the registered manager. Nurses had supervision with the registered manager. A staff member said "There is enough support here, you feel like you can always talk to someone to get support if needed". Annual appraisals were completed to identify staff learning and development goals and review staff performance over the previous year. Staff had access to continuing professional development training such as qualifications in health and social care. People were supported by staff who received professional development and support in their role.

The deputy matron explained that most people living in the home had the mental capacity to make their own decisions about their care and treatment. 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.

Not all staff had completed training in the MCA (2005) and DoLS. When care staff had concerns about people's mental capacity they told us they referred to the nurses who carried out an assessment. The assessment was a 'mini-mental test' and was used to determine a person's general cognitive ability. It was not a mental capacity assessment, which determines whether a person can make a specific decision at a specific time. For example; bed rails were used for a person who lacked the mental capacity to make a decision about this. A risk assessment had been completed; however this did not include an MCA assessment or a best interest decision making process. Whilst the provider's mental capacity act policy

stated a mental capacity assessment would be carried out where a person may be unable to take a decision, this had not been carried out. People's rights were not always protected because decisions had not been made in accordance with the Mental Capacity Act 2005. This meant people could be at risk of inappropriate and unlawful decision making.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes 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 registered manager had identified a person who they believed was being deprived of their liberty. They had made a DoLS application to the supervisory body which had not yet been authorised. The application included details of the restrictions in place to support the person safely. However, a best interest decision making process was not followed or recorded prior to submitting the application. This is a requirement of the MCA to ensure that any decision made on behalf of a person who lacks capacity is made in their best interests. The provider's DoLS policy stated they would only seek authority for a DoLS when this was 'clearly shown to be in their best interests'. There was a risk that restrictions might be placed on people unlawfully, while the provider awaited the assessment from the local authority to determine whether the restrictions were needed and lawful.

The failure to ensure decisions were made in accordance with the Mental Capacity Act (2005) is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us the food was 'very good' and that they were able to make choices about what they had to eat. Care staff confirmed that when people asked for alternatives to the menu the chef and kitchen staff were 'really good' and they always provided the person's choice. One person told us about how they had lost weight and was really pleased with this. Another person told us how they had put on weight and achieved a health improvement. We observed staff during a lunch period and saw people were supported to have a meal of their choice by organised and attentive staff.

People's dietary needs and preferences were documented and known by the chef and staff. The home's chef kept a record of people's needs, likes and dislikes. The chef met with people as they were admitted to the home to discuss their preferences and needs. People's dietary needs were met such as the consistency of their food, vegetarian diets, reduced sugar and fat options and allergens. People were referred appropriately to the dietician and speech and language therapists (SALT) if staff had concerns about their wellbeing.

People were regularly asked for their feedback on the quality of the food and their preferences. A daily comments sheet was completed to detail; what was eaten, the quality of food, the flavour, presentation, smell and any feedback. The chef told us they acted on feedback, explaining that "People ask for specific items for meals and we do that, they didn't like a cheese so we changed it, as long as we can, we always do".

We observed people were supported with their hydration needs. People were given regular drinks of their choice and had jugs of water to hand. One person had four drinks to hand, which were a milkshake (especially made), fruit juice, coffee and water. Care staff told us they observed people's fluid intake and a staff member said "If we see people are not drinking, we tell the nurses, we encourage fluids and find out why". Staff were aware of people's preferences for drinks and we observed people receiving the drinks they preferred.

People's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals. For example; during our inspection we noted the

deputy matron was working with the GP to decide on an appropriate course of treatment for a person who had changed needs. Other healthcare professionals such as; tissue viability nurses, chiropodist, SALT, optician and dentist attended to people's needs as required. Staff discussed people's healthcare needs at handover and arrangements were made to follow up on any issues identified and ensure these were actioned. People's changing needs were monitored to make sure their health needs were responded to promptly.

Good

Is the service caring?

Our findings

People received care and support from staff who had got to know them well. The relationships between staff and people receiving support demonstrated dignity and respect. A person's relative said "The care they give, it's very personal, it's not like a job, it's like they want to do it, they allow Mum to keep her dignity and maintain her privacy, they speak to her like she is a friend, it is not regimented and they show compassion".

Staff told us about people's histories, their interests and preferences. Staff spoke about people in a caring and informed manner. For example; staff told us about people's families, their preferred foods, their past employment, their hobbies and spiritual beliefs. A person said "I was asked what I thought of it here and I said 'its heaven' they are all out to help you, it's lovely they are pleasant and it's a lovely atmosphere, they know what you need".

People's wishes in respect of the gender of care staff that supported them with their personal care were respected. People were supported with their needs relating to spiritual support. Clergy visited the home to conduct services and people received individual support from church members and staff. One staff member told us how they sang hymns with a person and did some 'bible study' as they talked through bible chapters. Staff knew, understood and responded to people's needs in a caring and respectful way.

We observed staff speaking about people and with people in a caring way and people told us staff showed them care. For example a person said "They put plants on my balcony for me as I love the outside and they visited me in hospital". Another staff member left notes for a person to let them know what football was on TV. They were also hoping to organise a trip to a football match for people who 'loved' football. A relative told us how staff had shown care to their relative and said "When she came back from hospital they were all lining up to welcome her back and give her a hug". A staff member said "When you have had time with residents you go home a happy person it gives you motivation". People were supported by caring and compassionate staff.

Staff we spoke with had a good understanding of people' rights to make choices and decisions about their day to day care and treatment. A staff member said "We offer choice with everything, what to wear, what and where to eat, and whether to stay in their room or socialise". Staff told us when people refused care they would report this to a senior carer or nurse and another approach may be tried, such as a different staff member or a different explanation of the proposed care. A staff member said "We are not here to push people into things". We observed staff discussing people's choices, with them such as their food choices, whether they wanted to get up and whether they wanted to participate in an activity. Where people had made decisions to refuse medicines or food this had been discussed with healthcare professionals and their decisions were respected. People made decisions in respect of their care and treatment and these were respected by staff.

The provider's philosophy of care stated 'the most important aspect' of the home was the 'recognition of people's rights to run their own lives'. We observed staff demonstrated this principle in their practice. For example; where people had expressed a choice or a decision, staff respected this. This included decisions

made by people about their healthcare treatment, their daily routines and their end of life care.

People and their relatives were given support when making decisions about their preferences for end of life care. Where necessary, people and staff were supported by other healthcare specialists. Services and equipment were provided as and when needed. People's care plans included information about their wishes, advance decisions and funeral arrangements. Staff spoke with care and compassion when discussing the needs of people at the end of their lives. They were attentive to visiting family, and discussed people's needs with sensitivity and care at handover to ensure all staff were aware of any changes, needs or preferences.

A person told us how staff protected their dignity when they were supported with personal care and said "They are all very caring and they do the best they can, it's a very good home". Staff described to us how they supported people in a dignified way, for example; a staff member said "I always make sure curtains are shut, doors closed, and towel over their middle and I put their night clothes back on as soon as they are washed".

Good

Is the service responsive?

Our findings

People's care and treatment plans were personalised. The examples seen were thorough and reflected people's needs and choices. An example of this was a person's care plan for their communication needs. This included how they communicated, their related health needs and how staff should support the person to communicate. Information included what the effect of their communication difficulties could be on the person such as isolation and frustration and what the person liked, such as hand holding and reassurance and their care needs at night. Care plans were structured to include people's preferences in how care should be delivered and any risks staff should be aware of.

People's needs were reviewed regularly and when their needs changed. Where necessary other health and social care professionals were involved. An example of this was a person who had experienced some deterioration in their cognition. As a result of a review and assessment of their needs they had been referred to the older persons' mental health team. Care plans reflected people's up to date needs following their review.

Daily records were completed by nursing and care staff. These contained information about the care people had received, their mood, their activities, their visitors and any issues identified. Monitoring records were completed in relation to any risks identified such as; skin integrity, food and fluid intake, behaviours that may challenge others, and blood glucose levels. Handover between staff at the start of each shift ensured that important information was shared, acted upon where necessary and recorded to ensure people's progress was monitored.

People and their relatives told us about the improvements they had made as a result of the care they received in the home. For example a person told us that as a result of planned weight loss and support with their mobility their legs were getting stronger. A person's relative said "Mum has improved so much from independent living since she came here with her medicines, hydration and nutrition". Another person told us how they had gained weight resulting in improvements to their health and abilities. People were supported to maintain and make improvements in their health and wellbeing because their needs were responded to.

Where people required support with their personal care they were able to make choices and be as independent as possible. One person told us "I have a good wash every day as I don't want a bath". People's care plans included information about the choices people had made and staff we spoke with were aware of these.

People had a range of activities they could be involved in such as; movement classes, arts and crafts, movies, talks of interest and trips out. People were able to choose what activities they took part in and suggest other activities they were interested in. In addition to group activities people were supported individually to meet their needs and circumstances, for example if they were bed bound or preferred individual activities. An activity co-ordinator told us how they supported people individually with activities such as; board games, a massage, or going in to town to the shops or for tea and cakes. People were

supported with their activity needs.

There were three activity co-ordinators who worked at the home and they were supported by volunteers. An activity co-ordinator described their role as "Rather luxurious, I can just be with people, I spend time with them finding out what they want to do. Whether that is a small gesture like a flower in their room or reading a story, one to one communication is really the most important thing". Minutes of an activities coordinator meeting showed staff had discussed the importance of giving 'devoted' time to people in recognition that not all people were able to leave their room. People told us they enjoyed the activities on offer and their choice to participate or not was respected.

Notable days such as; St. Patrick's day, Easter, Valentine's day and Mother's day were celebrated with special food, entertainment and gifts. A person's relative said "The effort put into Christmas is amazing, they make everyone feel welcome you would never know you were in a home".

The provider had a complaints procedure and this was displayed in the home. We reviewed complaints received since July 2015. There had been five complaints during this period and records showed they had been responded to. A system was in place for people to raise their complaints and concerns and they were acted on.

Requires Improvement

Is the service well-led?

Our findings

Quality assurance systems were in place to monitor aspects of the quality of service being delivered and the running of the home. This included internal audits such as; medicines management audits, care plan audits and personnel audits. However, we noted that audits were not always effective in addressing the shortfalls identified. For example, we found some recording gaps in people's Medicines Administration Records (MARs). These meant records could not confirm that people had always received their medicines as prescribed. The deputy matron said when gaps were identified; the person responsible was spoken to and reminded of the guidelines. The monthly medicines audit on 22 March 2016 stated 'gaps on MAR's were identified and staff advised'. However, we found that omissions had reoccurred after this audit. This meant action taken to respond to the shortfall had not been effective. Ensuring people's medicine records are accurately completed is important to avoid mistakes in the administration of medicines and protect people from the risks associated with medicines.

We saw the registered manager had introduced a competency assessment for staff administering medicines. This had not yet been implemented. Competency assessments are used to identify any gaps in staff knowledge and skills so these can be addressed.

Annual and quarterly health and safety monitoring meetings were held with the registered manager and property director. This included a review of risk assessments, training and accidents and incidents. Actions were identified and completed as required. Whilst numbers of falls were included as part of the accident and incident monitoring, a system was not in place to include identifying patterns and trends, for example, the timings, reasons or outcomes of the falls. This was important to ensure all possible measures had been considered and taken to prevent reoccurring accidents.

We reviewed the residents survey carried out in 2015. The survey was discussed and completed with people by volunteers to encourage people to give their views freely. The survey asked for people's satisfaction levels with; staff attitudes, facilities, quality of care, food, cleanliness, choice, information and suggestions. People had mostly commented they were satisfied with the service they received. However, some results expressed areas for improvements such as; choice, response to requests, information and room temperatures. Whilst the registered manager had reviewed and commented on the results, they had not included any plans or actions taken in response to the feedback. Feedback from the relatives and visitors survey had not been summarised or commented on. It was therefore not evident how information gathered to evaluate and improve the service from people and their relatives had been used to drive continuous improvement.

An annual development plan was in place and this was based on the requirements of the Health and Social Care Act Regulations (2014) called the 'fundamental standards'. The plan for 2016 had been developed in January 2016. The plan did not always provide sufficient detail of the improvements to be undertaken. For example; whilst the plan had identified the 'need for staff to continue to understand the importance of (mental) capacity' the plan did not specify how this would be achieved. The plan did not identify the specific improvements required to ensure effective governance systems were in place. Although the provider had a system in place to measure and review the delivery of care against the current relevant guidance and

legislation this lacked sufficient detail to ensure it would effectively raise the standard of care people received.

The provider had not operated effective systems or processes to assess, monitor and improve the quality and safety of the home. Risks identified to people's health, safety and welfare were not always effectively mitigated. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service promoted a positive culture. Staff told us they worked to the values of; care, compassion, competence, communication, courage and commitment and these were displayed in the home. We observed staff acted in line with these values. For example in the care they showed when discussing people and their needs, in the effective communication we witnessed from staff during the handover, and in the comments made to us by people and relatives about staff commitment and the quality of care people received. For example a person's relative said "If I had to come into a home I would want to come somewhere like this. There is a good level of dignity, it feels discreet and people are well taken care of they don't have to worry."

The registered manager and deputy matron supported staff to be clear about their role and responsibilities. Records showed this was achieved through staff supervision, training and team meetings. Staff told us they were confident to question practice and report concerns about the care offered by colleagues. For example a staff member told us how they had reported the conduct of an agency staff member and this had been acted on. Another staff member said "We are a supportive team and we will challenge each other". Staff told us they communicated well with each other to share ideas and solve problems. Minutes of the recent care assistants meeting evidenced staff had raised issues with each other as well as in relation to people's care and made suggestions for improvements. A staff member said "If we find something that would make life better for someone we ask matron (registered manager) and she is really good at doing that". Another staff member said "Everyone who finds something wrong they bring it up and it's taken on board and it doesn't happen again".

The registered manager was absent during our inspection. Arrangements were in place to provide management support and leadership during their absence. The deputy matron was acting as manager and was supported by the provider's directors. Staff spoke positively about the current management arrangements and although staff had experienced some uncertainty due to the absence of the registered manager they told us they were adequately supported in their role. Care staff made positive comments about the nursing team such as "Nurses are great – good at their job and supportive, lovely and a good team".

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 Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured that decisions made on behalf of people who lacked the capacity to make their own decisions were made in accordance with the MCA (2005). Regulation 11 (1)(2)(3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not operated effective systems or processes to effectively assess, monitor and improve the quality and safety of the home and effectively mitigate identified risks to people health safety and welfare. Regulation 17(1)(2)(a)(b)