Pine View Care Homes Ltd

# Pine View Care Home

**Inspection report**

420 Hinckley Road
Leicester
LE3 0WA
Tel: 01162 858 868
Website:

Date of inspection visit: To Be Confirmed
Date of publication: 17/03/2016

## 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? | **Requires improvement** |
| Is the service well-led? | **Requires improvement** |

## Overall summary

This inspection took place on 15 December 2015 and was unannounced.

Pine View Care Home is a care home that provides residential care for up to 15 people. The home specialises in caring for older people. At the time of our inspection there were 12 people in residence.

A registered manager was in post. The registered manager is also the provider. 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.

At the last inspection of the 20 November 2014 we asked the provider to take action. We asked them to make improvements in the assessing and monitoring the quality of service and improvements in the safety of the premises. We did not received an action plan from the provider to indicate the action they were going to take and be compliant. We found that the provider had taken the appropriate action in all three areas.

# Summary of findings

People were relaxed around the staff . Staff were able to explain how they kept people safe from abuse, and knew what external assistance there was to follow up and report suspected abuse. Staff were knowledgeable about their responsibilities and trained to look after people and protect them from harm and abuse.

Staff were recruited in accordance with the provider's recruitment procedures that ensured staff were qualified and suitable to work at the home. We observed there to be sufficient staff available to meet people's needs and worked in a co-ordinated manner.

Medicines were stored and administered safely, however some specialist medicine was not ordered in a timely manner which resulted in staff being unable to administer the medicine.

Staff received an appropriate induction and for their job role, however some staff have not received training and some lacked updated training.

Staff had access to people's care records and were knowledgeable about people's individual needs.

Staff communicated people's dietary needs appropriately, which protected them from the risk of malnutrition. People's care and support needs had been assessed and people were involved in the development of their plan of care.

People were provided with a choice of meals that met their dietary needs. Alternatives were provided for people that did not like the meal offered. There were drinks and snacks available throughout the day. Catering staff were provided with up to date information about people's dietary needs.

We observed staff were kind and caring, and observed people's privacy and dignity in the care they delivered. We observed staff speak to, and assist people in a kind, caring and compassionate way.

Staff had an understanding of people's care needs, though some information within the care plan was missing.

People were involved in the review of their care plan, and when appropriate were happy for their relatives to be involved. We observed staff regularly offered people choices and responded promptly to people's requests.

People told us that they were able to take part in their hobbies and interests when they chose to.

Staff told us they had access to information about people's care and support needs and what was important to people. Care staff were supported and trained to ensure their knowledge, skills and practice in the delivery of care was updated, though some of the courses had not been updated recently. Staff knew they could make comments or raise concerns with the management team about the way the service was run and knew it would be acted on.

The provider had developed questionnaires for people to express their views about the service. These included the views and suggestions from people using the service, their relatives and health and social care professionals.

Staff sought appropriate medical advice and support from health care professionals. Care plans included the changes to peoples care and treatment. People felt confident to raise any issues, concerns or to make complaints to the staff.

We saw that the provider and staff interacted politely with people and they responded positively.

The provider had a clear management structure within the home, which meant that the staff were aware who to contact out of hours. Care staff understood their roles and responsibilities and knew how to obtain support. Staff had access to people's care plans and received regular updates about people's care needs.

There were effective systems in place for monitoring of the building and equipment which meant people lived in an environment which was regularly maintained. However the internal audits and monitoring of person centred planning did not reveal areas that were not fully detailed.

Staff were aware of the reporting process for repairing faults and breakages, and had access to contractors contact number for routine maintenance and emergency repairs.

# 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?**

Good

The service was consistently safe.

There had been improvements to the garden area of the home.

People told us they received the care and support they needed.

People appeared relaxed in the presence of the staff that supported them.

People received their medicines at the right time and their medicines were stored safely. However shortfalls in the supply of medicines were not revealed by the audits done by staff.

**Is the service effective?**

Requires improvement

The service was consistently effective.

Staff had an understanding of Deprivation of Liberty Safeguards and the requirements of the Mental Capacity Act 2005. However the training for staff was not up to date, and for some staff not been arranged.

People enjoyed the food and received appropriate choices that provided a well-balanced diet and met their nutritional needs.

People were supported by a knowledgeable staff group, however a small number of staff training had not been updated recently.

**Is the service caring?**

Good

The service was caring.

People told us the staff were kind and caring and they were treated with kindness and compassion.

We saw positive interactions and relationships between people using the service and staff. Staff engaged with people in a respectful manner.

People's wishes were listened to and respected. Staff were attentive and helped to maintain people's privacy and dignity.

**Is the service responsive?**

Requires improvement

The service was not consistently responsive.

People using the service and where appropriate their relatives were involved in reviewing care plans.

People were offered activities which did not meet their individual preferences.

People said they felt able to approach the manager and staff if they had complaints.

# Summary of findings

When staff knew people's needs, preferences and requests they were met promptly.

**Is the service well-led?**

**Requires improvement**

The service was not consistently well led.

The provider's quality assurance system had not consistently identified minor discrepancies in policies and procedures, missing information in care plans and shortfalls in the supply of medicines.

The service had a clear management structure and had regular monitoring visits by the provider.

There was a system in place to support staff, including regular staff meetings and supervision where staff had the opportunity to discuss and develop their roles.

# Pine View Care Home

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 15 December 2015 and was unannounced.

The inspection team consisted of two inspectors.

We looked at the information we held about the service, which included 'notifications'. Notifications are changes, events or incidents that the provider must tell us about. We also looked at other information received sent to us from people who used the service or the relatives of people who used the service and health and social care professionals.

We contacted commissioners for health and social care, responsible for funding some of the people that lived at the home and asked them for their views about the service.

During the inspection visit we spoke with four people who used the service, and 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 also spoke with the provider [who is also the registered manager], three care workers and the cook. There were no relatives visiting at the time of our visit.

We also looked in detail at the care and support provided to four people including their care records.

Good

# Is the service safe?

## Our findings

At our inspection of 20 November 2014 we found that the grounds of the home were unsafe for people to use.

The provider sent us an action plan outlining how they would make improvements.

At this visit we saw that there had been improvements to fence at the back of the garden which had been replaced. There had also been improvements to the greenhouse and shed and they had been made safe. The disused furniture and equipment had also been cleared from the garden.

When we looked around the home we noted there was a broken door lock to the cellar area. We informed the provider, and this was replaced before we left the home. The premises were now being maintained to ensure the safety of people using the service.

There were systems in place for the maintenance of the building and its equipment. We looked at the maintenance book and records that confirmed this and where shortfalls were identified, repairs and improvements were recorded.

During our visit we observed that people were relaxed and happy in the presence of the staff.

Staff were able to talk about the various types of abuse and how they would recognise the signs of abuse and their responsibility if they suspected abuse had occurred. They were confident that if they reported suspected abuse it would be dealt with appropriately by the senior staff. Staff were aware of the policy and procedure and would be able to find the appropriate contact information.

The staff told us about safeguarding training and the last time this was updated. We viewed the training matrix which confirmed this. A member of the care staff said, “We have regular training updates that remind us of our responsibility to keep people safe and what we have to do.”

Another said, “I have been trained to recognise the signs of abuse and I would take any concerns to a senior.” The senior staff confirmed they would document concerns raised with them and report to them to the provider or the local authority.

Staff said they had attended Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training. Staff described ways in which they would work with someone who presented with behaviour that challenged. Staff were also aware about the provider’s whistle blowing policy and were able to explain how they would use it if their concerns were not acted on.

We saw a range of equipment used to maintain people’s independence and safety such as walking aids, hoists and wheelchairs which were stored safely and were available when required. Staff were aware of how to use this equipment safely. We saw people being hoisted safely in the lounge before being transferred to other areas of the home. We saw staff using the footrests on wheelchairs appropriately, which meant that people were transferred safely.

We looked at people’s care plans which showed that staff had considered the potential risks associated with their care and support needs. Care plans we looked at demonstrated that individual risk assessments had been completed and regularly updated for risks, including falls, manual handling, the risk of developing pressure ulcers and nutrition. The staff we spoke with were aware of their responsibility to keep risk assessments up to date and to report any changes and act upon them. For example, when a pressure ulcer was identified, staff sought advice from the appropriate health professionals.

Staff described to us how they supported people safely. This was consistent with people’s plans of care, as well as staff being able to explain safety in general terms. Records confirmed that advice was sought from health care professionals in relation to risks associated with people’s care and risk management plans, were also reviewed regularly.

The provider told us he reviewed and monitored accidents and incidents on a regular basis. This was to identify possible trends and to prevent reoccurrences. The provider also told us that accident and incident audits were completed to ensure the appropriate action had been taken. We saw these on the day, and these included the outcome and any follow up action resulting from the incident.

Regular fire safety checks were carried out, and each person had a personal evacuation plan that detailed how the person should be supported in the event of an emergency. We saw evidence where staff had used the provider’s procedures for reporting incidents, accidents and injuries. The provider was aware of his responsibilities

Good

# Is the service safe?

and notified us of incidents and significant events that affected people's health and safety. The provider was aware of other relevant authorities that were required to be informed if a health and safety issue came to light. We observed good moving and handling techniques in line with care instructions. Hoists were regularly serviced which meant people could be moved safely within the home.

Our observations confirmed that there were sufficient staff available to meet people's needs. Staff responded in a timely manner to people's needs and requests for assistance. We noted that though there was not a member of staff in the lounges and other communal areas of the home all of the time. However we saw staff responded promptly to people's needs and requests, as they were close by and answered people's verbal prompts for assistance, as well as alerts made by people through the call bell system.

Staff told us there were always sufficient staff on duty and that they were happy to cover any absences in the first instance by doing additional shifts. Duty rotas indicated that the staffing levels of two care staff plus one person in the kitchen currently meet the needs of the people living at the home but would need to be kept under review if people's needs altered and they became more frail.

People's safety was supported by the provider's recruitment practices. Staff described the recruitment process and told us that relevant checks were carried out on their suitability to work with people. We looked at staff recruitment records and found relevant pre-employment checks had been carried out before staff worked unsupervised.

People told us that they received their medicines when they should. We looked at how medicines were handled and found that the arrangements at the service were appropriate, efficient and managed safely. The provider had a medicines policy and other medicines information was available for staff to refer to. We observed from a distance how the staff conducted the medicine round. We saw this was conducted methodically and safely, with care and in a competent manner. We heard the staff give people clear explanations and instructions when informing them how their medicine should be taken. We also saw where staff ensured that medicines had been taken before going to the next person.

We looked at the records for four people who received medicines. These had people's photographs in place, and were completed appropriately, with all medicines being signed for. Information about identified allergies, and people's preference on how their medicine was offered was also included. Some people were prescribed 'PRN' (as required) medicines. We saw medicine protocols were in place, and these guide staff to the circumstances and regularity when these medicines should be given.

Medicine audits were in place and completed regularly. However they did not reveal that one person had ran out of a specialist medicine prescribed by a hospital consultant. The provider took immediate action and arranged for the medicine to be delivered the day following our visit. That meant the person was without their continuing course of medicine though this was for a short time only.

Due to this oversight the provider also changed the way in which staff monitored the amount of medicine in the home. Staff now record medicines on a countdown system, which meant that in the future they will be prompted when any medicine stocks require replenishment.

Medicines were stored safely and at the correct temperatures so that they remained effective. We saw there was a record of storage temperatures maintained on a daily basis. Staff were aware of what to do if the storage temperatures were not within those set by good practice.

Requires improvement

# Is the service effective?

## Our findings

People told us that they were encouraged to make choices about their care and support. We saw where people chose where to eat their meals with most people opting for the dining room. We noted that people had choices of communal areas to relax in, and saw where staff asked people where they wanted to go following their meal, and where some people changed lounges throughout our visit. That meant staff promoted people's choice and preferences.

Staff told us they received training on commencing work at the home. One member of staff said, "We have training most months that covers lots of areas." They also told us that some of the training was undertaken outside of the home and lead by outside professionals. This demonstrated that a range of different learning methods were used. They went on to explain that staff met at least every month to discuss and update various care practices. Staff also described clinical and support supervision sessions. They all told us they could go to the care manager or the provider if they felt they needed additional training. A new member of staff who had not worked in care before described their learning programme. They said, "I would not be expected to do anything I did not feel confident with, I know I can always ask."

Staff said there was enough training and they didn't feel they had any gaps in their knowledge. We looked at the overall training matrix which was up to date with the training staff had undertaken. Some staff had not had recent training in a number of essential areas, for example some staff had not had updated first aid training with only six of the 13 staff that had refresher training since 2013. There was a similar position where three staff had training in food safety, two in 2012 and one in 2014. None of the remaining staff had completed a food safety course which included the 'stand in' cook, on the day of our visit.

When we spoke with staff they demonstrated they were aware about people's individual needs and told us how individual people were best supported. We saw how changes to people's care and support plans were communicated between the staff at the handover meetings and recorded in a communication book.

We saw documentation in the care plans that indicated staff understood about capacity and the need to assess and record those people who lacked capacity in certain areas to ensure decisions were made in their best interest. Some people's care files included information that confirmed peoples possible deprivation of liberty (DoLS) had been correctly considered although decisions from the local authority were not always available. We reminded the provider of the need to inform CQC of DoLS applications that had received approval or where an approval had been updated and reapproved.

We confirmed that six of the staff group had undertaken recent training in MCA and DoLS, however that left four staff that had not had any refresher training since 2012 and three that had not undertaken any training. That meant peoples' liberty was protected from a number of the staff group that were fully informed.

Staff told us that people had varying levels of capacity and understanding, and saw how staff supported them to make decisions about their daily life. We saw where people were asked for their consent to care, for example before assisting someone a staff member asked, "Do you want to go through to the lounge," and waited for their agreement before assisting them.

People told us they had sufficient amount to eat and drink. On the day we visited the cook was on their day off and the provider deputised a member of care staff to prepare the breakfast and lunch time meals. We saw where the cook had made minor changes made to the menu to ensure people had a suitable choice of meals. On the day of our visit we saw that one person did not want any of the main course choices on offer. The cook then substituted what the person requested. That demonstrated peoples individual meal choices were promoted.

People's dignity was supported and we saw where people were assisted discreetly. Assistance was provided for those who needed it, where aprons were provided and food cut up where appropriate. Staff offered people cold drinks throughout the meal. We also saw that jugs of drinks were available in all communal areas and that staff encouraged and supported people to take fluids outside of mealtimes.

The food offered to people was well presented and looked appetising. The cook was aware of people's individual needs through a list in the kitchen. The cook used this where people needed their food fortified if at risk of weight loss. The menus offered people the choice of a balanced and varied diet. Staff recorded people's fluid intake and

Requires improvement

# Is the service effective?

usually totalled the amount a person took although there was no record of the goal they were setting out to achieve. Anyone at risk of malnutrition also had their food intake recorded.

We observed good interactions between staff and people using the service at lunchtime in order to make it a social occasion. People could choose where they ate their meals and most chose to use the dining room. At lunchtime we observed staff supporting people to be as independent as possible and we were aware that some people choose to have their meals outside of the set mealtimes. One person said when their lunch was served, "I am not hungry now I may fancy it at four o'clock." Another person said, "The food is always good", and another added, "Very good food here."

We saw from people's care records that an assessment of their nutritional needs and a plan of care was completed which took account of their dietary needs. People were weighed regularly to ensure they had an adequate diet. These were recorded and provided a record which could be interrogated and ensure staff were aware of any weight loss or gain. We saw where one person had been referred to a specialist service for their weight loss. This confirmed the staff knew how to meet peoples individual health needs.

Good

# Is the service caring?

## Our findings

People were complimentary about the staff and their attitude. One person said, “The staff are all kind and friendly,” another said, “Nice people [staff] here, we have quite a laugh.” People told us the staff contacted their relatives if they became unwell or if they required a visit from the doctor.

The conversations we heard between people and staff were polite and caring. For example as staff gave people their lunch they checked if they were happy and needed any additional help. We saw good interactions and spoke with staff who knew and understood the people they were providing care to. We observed that staff understood the importance of being at eye level with people when talking to them. That ensured each had eye contact and confirmed the person understood them.

A member of staff said, “We are like one big family here.”

We made observations throughout our visit, in the communal areas of the home, and more discreetly at lunch time. Throughout the time we saw people had developed positive relationships Staff spoke with people in a friendly and respectful manner using the name the person preferred.

We observed staff treating people with dignity and respect and being discreet in relation to people’s personal care needs. For example, when a person was moved using the hoist, the staff took care to ensure their clothes remained in place and covered them. However during our inspection a community nurse carried out a dressing in the lounge in front of other residents rather than using the person’s bedroom or the bathroom. We reminded the provider and staff they had a shared responsibility to ensure people’s dignity was promoted and in such cases would also reduce the risk of cross infection.

We observed the staff interacting appropriately with people and providing activities to meet people’s needs. There was an activity plan in place but when people were not keen to join in the planned activity the member of staff organised a group activity to which some people participated in. We observed where the staff then encouraged others into socialising about the activity. That meant staff were aware about involving people indirectly in the activity and so provided stimulation to the group.

One person who we spoke with confirmed they were involved in decisions about their care though we did not obtain confirmation that anyone living at the home had signed their care plan or risk assessments to agree their plan of care. Staff told us they performed monthly care plan reviews or more often if needed. Where people were unable to take part in reviews, when appropriate staff involved peoples relatives and with person’s permission.

When we observed people in the communal areas of the home, they appeared relaxed and chatted with staff in a friendly way.

We asked the staff about promoting people’s privacy and dignity. They spoke about offering choices when dressing, at mealtimes and when people were assisted to bed and got up as well as closing doors when personal care was provided. We observed people were appropriately dressed. Staff also talked about knocking on closed doors and waiting for a reply before entering rooms. We saw this being carried out, where staff waited to be invited into a toilet.

Staff were also aware of confidentially and the importance of not disclosing people’s personal details and information outside their professional limits. Staff explained they would not discuss or divulge information to anyone but would refer enquiries on to senior managers.

Staff said they had enough information to meet people’s needs and were kept up to date with any changes through information at handovers from senior staff.

Prior to our inspection visit we contacted a range of social and health care professionals and they told us that they had no concerns about the care provided.

Requires improvement

# Is the service responsive?

## Our findings

Throughout our visit people appeared relaxed and conversations we heard between people and staff were polite and caring. People told us they received the care and support they needed to maintain their daily welfare. One person said, "I can vary my time for getting up and have my breakfast when I want." We observed people having breakfast up to 10 o'clock in the morning and being offered choices including a cooked breakfast, which promoted people's individual choice.

However, we observed a member of staff pour tea mid-morning from a tea pot that already had milk added to it. We were told the milk was added to the pot to cool the tea down and we did see additional milk added as people requested it. We also asked if coffee was an option and were told it would be if someone asked for it. However when someone asked for coffee, they were told, "We have only got tea at the moment" and they were given a cup of tea. However, another member of staff noted the person had not drank their tea and replaced it with a cup of coffee. This suggested that when staff knew a person's needs and preferences they were met.

Care plans were in place, were well detailed and kept up to date. However we found some had missing information. For example the type and size of sling a person needed when being transferred. That means people were placed at risk where information was missing from plans of care.

We saw that the staff gained information from a placing social worker or visited a person prior to them moving into the home. We saw staff had undertaken a well detailed pre-admission assessment that directly informed the person's assessment of needs, which then determined the person's individual care plan.

Care plans showed that people's plans of care were reviewed regularly and relatives were invited to attend review meetings. We also saw where health care professionals were involved, and confirmed what staff had told us.

We saw the staff group worked well as a team in an organised and ordered way. We saw how staff conversed effectively with people and gave clear details about the care being offered. Where people could not communicate verbally with staff, communication passports had been introduced and detailed how people reacted to questions. For example the communication passport document detailed how people reacted to questions and how they were feeling by using facial expressions or gestures. That meant staff were able to communicate and understand people's needs.

Throughout our inspection the staff we spoke with demonstrated an awareness of the likes, dislikes and care needs of the people who used the service. We observed that people had the opportunity to make choices about moving around the home including going into the garden. Staff described how they offered people choices about what they wore by holding up two garments if they were not able to respond orally.

We observed staff responded promptly to people's requests for assistance throughout our visit. We saw an activities plan in the foyer of the home, which suggested what pastimes staff could offer people. We did not see any staff undertaking activities at the time of our visit. One person told us a new member of staff does activities on a regular basis, but they were not interested on what was offered that day. We could not confirm from the training matrix that staff have had recent training on providing activities for people with dementia. This meant people were involved in activities in the home that did not meet people's preferences. We saw staff had recorded what activities people had undertaken.

We heard Christmas music being playing throughout the home, however the televisions were also turned on and this provided a confusing environment for people, particularly for those people living with dementia. We heard one person saying to staff, "The music needs turning down," and the member of staff then responded.

We saw where the provider circulated an annual questionnaire to people who used the service, their relatives and visiting health professionals. These could be returned anonymously, and if completed people could be assured their experiences were recorded. The last questionnaires had been circulated in March 2015 where people were asked for comments on the food and catering, and May 2015, when a general questionnaire was circulated. We looked at a number of the returned forms, and comments from people living in the home included, 'carers very friendly', 'always busy but got the time to talk to you'. There were no negative comments.

Requires improvement

# Is the service responsive?

The complaints procedure was displayed in the dining room of the home. When we spoke with people they confirmed that they would talk to the staff or care manager if they had any concerns. One person said they would involve a relative if they thought it important enough.

Staff confirmed they would report any complaints or concerns on to the provider. The provider had a system in place to record complaints, and confirmed he had not had any formal complaints since our last inspection. The provider told us that any lessons learnt from complaints were communicated to all staff to prevent any reoccurrence. People could be assured that their complaints were taken seriously and acted upon.

Prior to our inspection we contacted social care professionals for their views about the service. They told us that the management team responded well to concerns and as a result the care of people using the service had improved.

Requires improvement

# Is the service well-led?

## Our findings

People living at the service told us they had a good relationship with the provider and regularly saw him visit the home.

Staff told us they enjoyed working at Pine View Care Home, one member of staff said, "I could go to [named staff] with anything." Another said, "We all get on well, many of us have worked here for a number of years."

We saw evidence where people that used the service, their relatives and visiting professionals were asked to contribute to the quality assurance process and were sent questionnaires, so were enabled to comment about the quality of service offered by the home. Staff confirmed people at the home participated in the process and if necessary staff assisted them in completing questionnaires. We saw where people who lived at the home and their relatives were also invited to meetings with the provider and staff, with minutes being available to us. That means the provider embraced the quality assurance process but also assisted in providing an open culture in the home.

However the quality assurance (QA) process did not reveal that one person had run out of a special type of medicine, and another where a care plan had missing information about the individual equipment used when moving the person. When we pointed this out to the provider he took immediate steps to rectify the issue. We also noted there were not enough supplies of ingredients to produce the planned lunch time meal, and the cook used alternatives to ensure the meal was served on time. This however is another area where the quality assurance system fell short, and food was not ordered prior to the permanent cooks' day off. There were further issues where the QA process had not picked up where staff training had not been updated (see effective for details).

The home had a clear management structure and was visited regularly by the provider. The care manager understood their responsibilities and displayed commitment to providing quality care in line with the provider's visions and values. They told us they kept their knowledge about health and social care updated and knew how to access support from health and social care professionals and, as well as the provider.

Staff demonstrated a good understanding of their roles and responsibilities and also knew how to access support. Staff had access to people's plans of care and received updates about people's care needs at daily staff handover meetings.

There was a system in place to support staff, including regular supervision, and staff meetings where staff had the opportunity to discuss their roles and training needs and to make suggestions as to how the service could be improved. Staff told us that their knowledge, skills and practice was kept up to date. We viewed the staff training matrix, which showed that some staff had updated refresher training for their job role.

We saw staff received regular supervision, with sessions being planned in advance. The provider indicated he preferred 'hands on' supervision and liked to oversee staff performing tasks, for example administering medication. Were there any shortfalls, these were discussed and the session was then recorded. We viewed the staff files and saw a number of supervisions had been placed on staff files.

There was a system in place for the maintenance of the building and equipment, with an ongoing record of when items had been repaired or replaced. Staff were aware of the process for reporting faults and repairs, and the 'business continuity plan' was available in the office. This file included instructions where gas and water isolation points were located and emergency contact numbers if any appliances required repair. The care manager confirmed she knew where the file was kept. That meant the management team also had access to external contractors for maintenance and any emergency repairs.

We viewed records which showed that essential services such as gas and electrical systems, appliances, fire systems and equipment such as hoists were serviced and regularly maintained.

We saw care documentation that supported people had received the care they required. Some of these were placed in people's bedrooms so they could be completed at the time care was taking place.

We found some of the information in the policy and procedures file needed to be updated, for example the current recruitment policy mentioned criminal record bureau (CRB) checks, and others mentioned the 2008 Health and Social Care Act. These have both been superseded by different processes and updated legislation

Requires improvement

# Is the service well-led?

so require to be changed to reflect the new legislation. Some information was also missing from policies and procedures, for example the colour coding for mops and buckets that were used for cleaning and disinfection purposes. That meant staff could be assured of using the appropriate colour coded items in the correct areas, and lessen the possibility of cross infection in the home.

The commissioners who funded people's care packages shared their contract monitoring report with us. The report showed that the home was meeting the quality standards set out in the contractual agreement.