Abbey Healthcare (Mill Hill) Limited

Abbey Healthcare- Aarandale Manor

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 comprehensive inspection took place on 20 December 2017 and was unannounced. This inspection was the first comprehensive inspection of the service since it was registered with the Care Quality Commission (CQC) on 9 March 2017.

Aarandale Manor is a care home. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Aarandale Manor accommodates up to 65 people across three separate units, each of which have separate adapted facilities. One of the units specialises in providing care to people living with dementia. At the time of this inspection, only the ground floor unit was operational and there were 15 people using the service.

There was a registered manager in post at the time of this inspection. 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 and their relatives confirmed that they felt safe living at Aarandale Manor. All care staff understood the term safeguarding and were able to describe the different types of abuse and the steps they would take to report any concerns. However, where we saw records and body maps had been completed for one person who had obtained significant bruising and skin tears whilst in hospital, an incident form had not been completed and the registered manager had not reported these concerns to the local safeguarding authority, for further investigation.

Care plans detailed people's risks associated with their health, care and support needs and provided guidance for staff on how to reduce or mitigate risk in order to keep people safe. However, some risk assessments did not contain sufficient information on the symptoms associated with certain health conditions such as diabetes.

Appropriate numbers of staff were observed supporting people as required. Appropriate recruitment procedures were in place to ensure staff were assessed as safe to work with vulnerable adults.

Training records confirmed that staff received the appropriate training necessary for their role. However, not all staff training records confirmed that all care staff had received an appropriate induction prior to starting work and where care staff were due to refresh their training this had not taken place. This meant that staff may not have had the appropriate training to support them in their role.

Most care staff confirmed that they felt supported in their role. However, records did not confirm that care staff had received appropriate formal supervision according to the provider's policy.

People received their medicines as prescribed. Systems and processes were in place to ensure the safe management of medicines.

Most care plans contained appropriate documentation confirming people's consent to care had been obtained. However, two care plans did not contain specific signed consent to care. Care staff were clearly able to explain their understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards and how this impacted on the care and support that they delivered.

People were supported to have maximum choice and control in their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

We observed people had developed positive and caring relationships with the care staff that supported them. People were treated with dignity and respect.

People ate well. People and relatives confirmed that they and their relative enjoyed the food that was presented to them and that they were always given a choice of what they wanted to eat. Drinks and snacks were available to people throughout the day.

Care plans were person centred and contained information about the person and how they wished to be supported. However, further information about people's wishes for end of life care and their cultural and religious requirements was not recorded.

The provider had a number of systems and process in place to monitor and oversee the provision of care and support. However, there was a lack of detail evidencing the actions taken to ensure where issues were identified that these were addressed and that the service had taken note of any learning in order to make improvements.

The provider had displayed their complaints policy which detailed guidance on how people and relatives could lodge a complaint. People and their relatives knew who to speak with if they had any concerns or issues to raise.

The senior management team were accessible to people and relatives who spoke positively about them and how the home was managed. However, some care staff shared some concerns about the management and the lack of support received around training and some staff members' specific roles.

At this inspection we found a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because care staff were not receiving appropriate training. You can see what action we asked the provider to take at the back of the full version of this 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 told us they felt safe living at the home. Care staff understood the term safeguarding and the steps to take to report any concerns. However, the service did not always make appropriate referrals where concerns were noted after a person had returned back from hospital.

Systems and processes to support safe medicine management and administration were in place.

Appropriate processes and systems were followed to ensure the safe recruitment of staff.

Sufficient numbers of staff were supporting people as required.

Accident and incidents were recorded including the actions taken to support the person and prevent any further accidents.

Is the service effective?

Requires Improvement

The service was not always effective. Not all staff had received an induction on commencing their employment or any required refresher training when required.

Most care staff confirmed that they felt supported in their role. However, records did not confirm that care staff received appropriate supervision as per the provider's policy.

People's care, support and health needs were assessed prior to their admission to the home so that the service could confirm that they could effectively meet the person's needs.

People were supported to eat and drink appropriately with a varied choice of food and drinks available throughout the day.

Is the service caring?

Good

The service was caring. People had developed positive caring relationships with all care staff that supported them. People were treated with dignity and respect.

People were supported to be as independent as practicably

possible.

People were able to express their views and choices on how they wished to be supported with their day to day needs.

Is the service responsive?

Good

The service was responsive. Care plans were detailed and person centred. However, detail on people's wishes and needs around end of life care and cultural and religious requirements was not recorded.

A complaints policy was on display for people, relatives and visitors to refer to. People and relatives knew who to complaint to when they had concerns or issues to raise.

We observed a variety of activities taking place throughout the inspection. People and relatives confirmed that scheduled activities did take place where people were encouraged to participate.

Is the service well-led?

Requires Improvement

The service was not always well-led. Although the provider had a variety of systems and processes in place to oversee the provision of care and support, records did not confirm the actions taken to address any identified issues.

Where issues and concerns were identified, the service had taken note of any learning in order to drive forward improvements.

Due to the short period the home had been open, the service had not as yet obtained feedback from people, relatives and other stakeholders about the care and support that they received.

However, people and relatives confirmed that they felt able to give regular feedback to the management team and their ideas and suggestions were listened to.

Abbey Healthcare- Aarandale Manor

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 20 December 2017 and was unannounced. This inspection was the first comprehensive inspection of Aarandale Manor since the service was registered on 9 March 2017.

The inspection team consisted of two inspectors, a specialist advisor nurse and an expert by experience who spoke with people and relatives. An expert by experience is a person who has personal experience of using or caring for someone who has used or uses this type of care service.

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

During the inspection we observed how staff interacted and supported people who used the service. We spoke with eight people using the service, eight relatives and friends and 13 staff members which included the registered manager, regional director, regional manager, hospitality manager, the chef, the handy man, three nurses and four care staff.

We looked at the care records of nine people who used the service and medicines administration record (MAR) charts and medicines supplies for 14 people. We also looked at the personnel and training files of seven staff. Other documents that we looked at relating to people's care included risk assessments,

medicines management, staff meeting minutes, handover notes, quality audits and a number of policies and procedures.

Good

Is the service safe?

Our findings

People and relatives told us that they felt safe living at Aarandale Manor and with the care and support that they received from care staff. Comments from people included, "This hotel is safe and I have no worries. I feel I am in safe hands" and "They look after us really well." Relatives' comments included, "I am very happy and satisfied with their service because when my [person] came here she was very weak and now she is much better" and "Safe? Oh yes definitely. We have peace of mind."

All care staff demonstrated a sound understanding of the terms 'safeguarding' and 'whistleblowing' and the steps they would take to report any concerns to ensure people's safety. Training records confirmed that all care staff had received safeguarding training. One nurse told us, "I would call the safeguarding team." Another care staff explained that no harm should come to any person and if she had any concerns she would go straight to the nurse in charge.

During the inspection we found some minor concerns around risk assessments and the reporting of a potential safeguarding issue, we were confident that the service would address these issues immediately. In addition we also saw some good examples of risk assessments and the reporting of accidents and incidents which assured us that the service would improve and learn going forward. Based on these assurances we found that the service demonstrated characteristics of a safe service which we have rated 'Good'.

We saw documentation confirming that where people had unexplained bruising and skin tears within the home, a body map and incident form had been completed. The registered manager then completed an investigation to identify how the person sustained the injury and to ensure appropriate measures were implemented to prevent any further re-occurrences. However, where we saw records and body maps had been completed for one person who had obtained significant bruising and skin tears whilst in hospital, an incident form had not been completed and the registered manager had not reported these concerns to the local safeguarding authority, for further investigation. We brought this to the attention of the registered manager who acknowledged that these concerns should have been reported to the local safeguarding authority. The registered manager confirmed that they would complete an incident report to send to the relevant authority.

Care plans contained information about all general and individualised risks associated with each person's health, care and support needs. Care plans specific to each care need documented the risk and guidance for staff on how to support people appropriately in order to reduce or mitigate the risk identified. Risks identified included risk of falls, use of bed rails, skin integrity, risks associated with the use of specific blood thinning medicines and risk associated with the diagnosis of diabetes. However, risk assessments that had been completed for people diagnosed with diabetes did not always contain sufficient information for staff to identify the specific symptoms associated with diabetes especially where a person may present with a raise or drop in sugar levels. We spoke to the registered manager about this who assured us that this would be addressed.

Throughout the inspection we observed there to be sufficient staff available within the home in order to

meet people's needs appropriately and as required. The service did not currently use a dependency tool to determine staffing levels due to the low numbers of people currently living at the home. The registered manager explained that staffing levels were currently determined through observations and the complexity of people's needs. However, the registered manager did plan to introduce the dependency tool as a formal assessment once they had admitted 20 people to the home.

Records confirmed that the provider followed safe recruitment processes to ensure staff recruited and employed were safe to work with vulnerable adults. A number of checks and assurances had been completed which included criminal record checks, written references, proof of identity and confirmation of nurses PIN registration and validation.

The process used for ordering people's monthly medicines to ensure that these were received on time and making sure people had their medicines when they needed them were clear and understood by all staff involved with this process. We looked at a sample of Medicine Administration Records (MAR) for 14 people who used the service.

There were appropriate arrangements in place for recording the administration of medicines. These records were clear and fully completed. Records showed people were receiving their medicines when they needed them, there were no gaps on the MARs and any reasons for people not taking their medicines were recorded.

Controlled drugs were stored and managed appropriately. Controlled drugs are medicines that the law requires are stored, administered and disposed of by following the Misuse of Drugs Act 1971.

Some people needed blood tests to monitor their medicines, we saw that these were done and doses adjusted when necessary. There were clear guidelines available for staff to follow if people were prescribed fluid thickeners.

One person received their medicines which were disguised in food or crushed. When medicines were being administered covertly to people we saw there were the appropriate agreements in place which had been signed by the GP, family and pharmacist.

When medicines were prescribed to be given 'only when needed', or where they were to be used only under specific circumstances, there were protocols in place which were tailored to the individual and provided guidance to staff on how these medicines were to be administered. Medicines were only administered by qualified nurses. Records showed that all qualified staff had completed medicines management training.

People and relatives confirmed that they and their relative received their medicines appropriately and no concerns were noted. One relative told us, "I believe the staffs are giving out the medicine on time."

The provider recorded all accidents and incidents that took place within the home. All information relating to an accident or incident was recorded with details of the person, details of the incident or accident that had taken place, the actions taken, any investigative action taken and any lessons that were learnt. Staff knew how to report accidents and incidents.

The safety of the building was routinely monitored and records showed appropriate checks and tests of equipment and systems such as fire alarms, emergency lighting, gas and electrical safety, legionella, lifts and hoisting equipment were undertaken.

Each person's care plan contained a Personal Emergency Evacuation Plan (PEEP) detailing how the person was to be supported and kept safe in the event of a fire or other emergency. The provider had appropriate contingency plans in place to support any emergency event.

People were protected by the use of safe infection control procedures and practices. The home was clean and well maintained on the day we visited. Staff had access to personal protective equipment (PPE).

Records confirmed that all care staff had received food hygiene training. We saw that all food preparation and storage areas were clean and appropriate food hygiene procedures had been followed. This included cleaning schedules, specific food preparation areas for meat and vegetables, records of cooked food temperatures and food storage temperatures.

Requires Improvement

Is the service effective?

Our findings

People told us that they were happy living at Aarandale Manor and felt well supported by care staff who knew what they were doing. One person said, "I am happy here, the staffs are very friendly." A second person told us, "Couldn't ask for any better" One relative commented, "They seem to know what they're doing. I think they do get training." A second relative when asked about whether they felt staff were skilled and trained responded, "They [care staff] are really good." However, despite these positive comments, people may not have been receiving effective care because some staff had not received appropriate training and supervision to carry out their role effectively.

Most care staff told us that they had received an induction and training in a number of topics including safeguarding, medicines management, first aid, manual handling and the Mental Capacity Act 2005 (MCA). However, records seen did not confirm that care staff had received an induction on commencement of employment. Certificates confirming that care staff had received mandatory training were not always available within their files. The registered manager provided an overview of all staff employed and the training they had attended and when it was due to be refreshed. This highlighted that a high number of staff had not received refresher training in a number of topics such as manual handling practical, basic life support practical, safeguarding and first aid (e-learning). The training overview also did not evidence that training on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) had been provided. One nurse commented that, "I have only had one training since starting work here." We brought this to the attention of the registered manager, regional manager and regional director who agreed that the provision of regular and on-going training to support care staff in their role required attention.

Following the inspection, the provider submitted information evidencing that there had been issues with the data contained within the training overview and that computer systems had not correctly reflected the actual training staff had received and the dates training had been delivered. However, records that we looked at did not confirm that care staff had received appropriate training to support them in delivering effective and safe care.

Most care staff told us that they felt supported in their role. One staff member said, "I am happy here. It's all about teamwork, we support each other." However, supervision records seen did not confirm that staff received regular supervision as stated within the provider's supervision policy. The policy stated, 'There is no legal requirement for the number of supervisions however 4 -6 year is recommended and good practice.' One nurse who had been in post approximately five months told us that she had only received one supervision with the registered manager since she started her employment. Due to the above issues we identified we were unable to confirm that care staff received the required support and training to effectively carry out their role.

This was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care staff had not received an appraisal as they were yet to complete a year of employment with the

provider.

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 authorisation 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. Where people were deprived of their liberty the registered manager had made appropriate applications to the local authority for DoLS to be considered for authorisation.

Most care plans confirmed, where appropriate, that people had consented and/or their relative had been involved in decision making processes relating to their care. However, we found two care plans where we could not evidence that this had taken place. We provided feedback to the registered manager about this who assured us that this would be addressed.

Where people lacked capacity, this had been documented within the care plan and where required a best interests decision had been taken with the involvement of a relative or next of kin. Decisions such as having bed rails, receiving personal care and leaving the home had been discussed and implemented.

Records seen did not confirm whether training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) had been provided. However, the staff we spoke with demonstrated a clear understanding of the principles of the MCA and how this was to be applied when supporting people. One staff member explained, "MCA is about where someone doesn't have capacity to take decisions, we in partnership with family and social worker would take decisions in the person's best interest." Another care staff told us that, "I would assume capacity unless it was documented otherwise." We observed throughout the inspection that care staff always asked people's consent and permission prior to assisting them.

The registered manager ensured that a comprehensive pre-admission assessment was completed prior to any person arriving at the home to ensure that the service would be able to effectively meet the health and support needs of the person. The assessment of need covered a number of areas including personal hygiene, communication, medicines, skin care and social activities and was completed in partnership with the person, their relative and any other involved health and social care professional. Once the relevant information had been obtained, a care plan was compiled detailing how support and care was to be provided in each of the assessed areas as per the person's choice and wishes.

Where people were assessed to have specific health care needs which required the use of specialist equipment, the service ensured that the equipment was ready and available in time for the person's admission. Care plans were reviewed on a monthly basis to ensure that they were current and reflective of the person's needs.

The registered manager ensured that all meal times were protected so that people were supported to enjoy their meal without any interruptions. We observed people were supported appropriately with their meals where required. Menus were on display in the dining area and offered two main choices for the main meal and a selection of alternatives if people did not like what was on offer. Food was well presented and looked and smelt appetising. A choice of drinks and snacks were available throughout the day and night. The home

offered a 'nite bite' menu which included a variety of snacks and a choice of sandwiches for people who wanted something to eat later during the evening. The registered manager emphasised the importance of meal times, to all staff, for people with their relatives and told us, "An integral part of getting people to eat is having their family with them."

Menus were compiled by the hospitality manager and the chef based on feedback that they received from people and their relatives. People and relatives confirmed that they enjoyed the food that was provided. Comments from people included, "The food is always tasty; we do have a few choices in what we have" and "The food is delicious like home made." One relative commented, "My [relative] likes their food but sometime she wants to eat West Indian food."

The service recorded and monitored people's weights on a monthly basis. Where people's food and fluid intake was required to be monitored, appropriate charts were in place and had been completed. Where low food and fluid intake was recorded, appropriate actions had been taken to ensure concerns were addressed which included relevant referrals to health care professionals to help ensure that people's nutritional needs were met.

The care team within the home worked together to ensure that people received effective care and support at all times. We observed a comprehensive handover meeting in the morning on the day of the inspection which included visiting each person's room with a brief overview of how the person had been the day before, during the night and follow up actions that needed to be completed for the person. The handover involved the registered manager, the nurse in charge and the care staff team. The registered manager also confirmed that they worked closely in partnership with the local GP surgery with whom they had an arrangement for regular weekly visits so that people could be seen where required. The GP was also available on an ad-hoc basis as and when people's health needs required attention.

The service was also working closely with local hospitals and named trust assessors to ensure that people who were admitted to hospital from the home, were supported and assessed appropriately upon discharge to ensure a smooth transition back to the home, with the appropriate care and support in place to support with any change in health and care needs.

Care plans documented all involvement people had received from a variety of health and social care professionals. This included details of visits from the GP, podiatrist, chiropodist and mental health professionals such as psychiatrists and DoLS assessors. Records included details of the visit and any actions to be taken as an outcome of the visit.

The home was clean and odour free. All areas of the home were accessible by people including the garden and outdoor spaces. The dementia unit on the second floor had not been finalised and was not open to new admissions. However, we saw that the provider had used appropriate decoration and signage around the home and especially on the dementia unit to support people living with dementia in order to meet their needs and promote their independence.

Good

Is the service caring?

Our findings

People told us that they were very happy living at Aarandale Manor and that care staff were caring and kind. People and their relatives told us that they had developed positive and caring relationships. Comments from people included, "They look after me quite well", "The care is excellent, the staffs are very caring and very professional" and "I am very comfortable here." Feedback from relatives included, "We found here a pleasant atmosphere and warmth", "The standard of care here is very good beyond my expectation; I had recommended this care home to other people" and "[Registered manager] and team have been amazing. They are a really good team."

We observed that the whole care staff team including the registered manager, the hospitality manager and the handy man knew people really well and were available at all times to support people when required in a way which respected their choices, preferences and wishes. People also responded to all staff positively and confidently and knew the staff they were speaking with. One relative told us, "They have got to know [relative] really well. They know what his habits are and what he likes."

The registered manager ensured that care staff understood that people and their care was of utmost priority and made sure care staff were constantly reminded of this with the display of signs around the home stating, 'Our residents do not live in our workplace, we work in their home.' The registered manager told us, "Care has to come from the heart. They [people] need love, attention, stimulation and food."

People, relatives and visitors to the home told us that care workers were polite, respectful and always protected their and their relative's privacy. One person told us, "They always knock on my door and ask if they can come in." We observed care workers speaking kindly and sensitively with people, while they were eating their meals in their rooms. We observed appropriate moving and handling interactions when care workers were assisting people to move from the dining area to their bedrooms and we also observed people who wanted to mobilise independently, being allowed to do so at their own pace. We also observed polite and respectful interactions, even with people who exhibited behaviours that challenged.

Care staff demonstrated a clear of understanding of how they respected people's privacy and dignity. One care staff explained, "We always ask people what they like and get their consent. Only if they agree do we do anything."

Care staff understood the importance of promoting people's independence in order for them to continue to remain as independent as possible even whilst living at the home. One care staff told us, "We encourage them [people] depending on the situation by showing them how to do things and explaining to them to promote their independence." Care plans also recorded people's level of independence and how they wished to be supported. Although we did not observe this practice during the inspection, one care plan stated, 'As a result of her dementia and arthritis [person] finds it difficult to eat by herself however she does occasionally attempt to eat by holding or reaching out for cutlery. This should be encouraged and if she attempts to eat herself you should assist her."

Good

Is the service responsive?

Our findings

People's care plans were person centred and provided information on how people wished to be supported according to their level of need and requirements. In addition each person had a life history booklet that had been completed by a relative or friend which gave detail about the person's childhood, adolescence and adulthood. The document provided information about people's likes and dislikes in relation to food, hobbies and interests.

The care staff team knew the people they supported and demonstrated knowledge and awareness of people's likes and dislikes and how they wish to be cared for. One relative told us, "My [relative] isn't able to describe the problems she has at night time. So I think the staffs of the home help her during the night." Care plans were reviewed and updated where required on a monthly basis. However, care plans did not always contain person centred information around the person's cultural and religious needs and preferences especially in relation to end of life care. We found that in most care plans, at pre-assessment stage, it had been recorded that end of life preferences were, 'not discussed at this stage'. There was no information available about how the person wished to be cared for at the end of life stage, whether they would prefer to end their days at the home or in hospital or, whether funeral arrangements have been made. Currently the home was not supporting anyone that had been assessed as requiring end of life care.

Care plans were compiled based on the information collated as part of the pre-admission assessment of need. However, the way in which care plans were constructed, were not always easy to navigate around and certain information was not easy to locate without going through the entirety of the care plan. This meant that care staff may not have had easy access to pertinent information to ensure people were supported in response to their needs, choice and preferences. We fed back our findings to the registered manager and the senior management team about the above issues who stated that they would look at the care plans so that they could be improved.

Care staff demonstrated a good level of understanding in relation to supporting people with protected characteristics. Protected characteristics for people can include, their age, religion, sexuality and disability which should not be discriminated against according to the Equality Act 2010. One care staff explained, "Everyone is equal for me. Everyone is human. I hear a lot of things about discrimination. For me I have to give care to them."

People and relatives confirmed that they were regularly involved in the planning, delivery and review of their and their relatives care and support needs. One relative told us, "Yes I have seen [relatives] care plan and we are definitely involved in his care. It is an open relationship."

An activity co-ordinator was in post and supported people to participate in a variety of activities during the week. Care staff were responsible for initiating activities during the weekend. An activity timetable was available in the main lounge which listed a variety of activities such as shopping trips, cookery, arts and crafts, reading the newspaper and pampering. On the day of the inspection we observed people participate in a ball game and watch a movie. People and relatives confirmed that they and their relative participated in

activities as and when organised. One relative told us, "My [relative] likes singing and therefore she likes any activity which involves singing." Another relative stated, "[Activity worker] has been doing a lot with [relative] such as maths quizzes."

Daily progress sheets were completed for each person which detailed how the person had been during the day and the support that they had received. Activity records were also kept detailing the activities that the person had been participated in throughout the day. This ensured that care staff, at each change of shift, were able to read a clear account about the person so as to enable them to continue providing care that was responsive to the person's needs.

A complaints policy was available and on display in the main reception area. The policy detailed the processes in place for receiving, handling and responding to comments and complaints. People and relatives we spoke with told us that they felt able to complain if they needed to and were confident that their complaint would be dealt with appropriately. One person told us, "My son knows everything, I don't need to know about the manager, most of the staffs are very good." Relative's comments included, "I would go to [registered manager]. She has an open door policy and I am assured that concerns would be addressed." The service had only recorded one complaint since it had begun providing a service. Records seen confirmed that this complaint had been addressed according to the provider's policy.

Requires Improvement

Is the service well-led?

Our findings

People and relatives knew the registered manager well. We observed throughout the inspection that the registered manager knew people and their relatives well and was seen to be available at all times. We also noted that the registered manager interacted politely with people and responded well to them. One person told us, "There is a lovely atmosphere here. I don't think I could get any better." Another person commented, "People [staff] are good here." One relative told us that the manager was, "on it" and that "she is hands on, good with the staff and knows her residents." Another relative commented that the manager was 'on the ball' and that if they had any issues they felt confident to go and speak with the manager.

Most care staff were also positive about the registered manager and the support that they received. Comments from staff about the management of the home and the registered manager included, "She [registered manager] is good. She has a good heart. I learn a lot of new things from the manager" and "manager is supportive." However, two staff members did comment that they did not feel supported as they had not received supervision and that their position was not valued by the management.

The provider and the registered manager had a number of systems and processes in place to monitor the safety and quality of service that people received. This included audits covering health and safety, medicine management, dining experience, care plans, staff files and nutrition. However, we were unable to evidence what actions had been taken where issues had been identified and what learning outcomes had been identified in order to implement improvements. We were shown a regional manager's audit that had been completed between 31 October 2017 and 27 November 2017. This had identified similar issues that we had found around training records, however, an action plan had not been developed stating how the issues identified were to be addressed and by when. The registered manager confirmed that she addressed issues as and when they were identified but had not always recorded her actions. The regional director assured us that as from January 2018, newly formulated audit tools were to be implemented which would generate weekly reviews for areas of improvement.

The provider had just recently appointed a deputy manager to support with the management of the home which would support and enable the registered manager to concentrate on the overall management of the home. This would include prioritising the monitoring of safety and quality in care service delivery. During this inspection we found that the regional management team and the registered manager were keen to engage with the inspection process and were aware of and agreed with the concerns that we had identified.

The service was yet to carry out a quality assurance exercise with people, relatives and other stakeholders as the service had only been providing care since August 2017. However, people and relatives confirmed that they felt able to feedback to the manager as and when they needed to and that the manager was responsive to their ideas and suggestions.

Records confirmed that a residents meeting had taken place in October 2017 and relatives meetings had taken place in October 2017 and November 2017. The minutes documented discussions around food, activities, staffing and forthcoming events.

There was an open and transparent culture at the service. Relatives told us that the service always communicated with them about their relatives especially where significant incidents or accidents had occurred or where their relative had been taken ill. We were also told that relatives could approach the nurses and care staff on duty and who gave them the desired information about their relative. One relative said that the management was very good and that he could approach the manager with any concerns he had. The relative told us that he was kept informed of any concerns and illness that his relative had.

The service worked in partnership with other agencies to support care provision. We noted that that the service maintained positive links with a variety of healthcare professionals including local hospices, the palliative care team, the GP and the local authority quality team. The home had also recently become part of the continuing care consortium as an approved provider for people who were in receipt of continuing care funding.

Care staff told us and records confirmed that they were supported through a variety of processes including supervisions, handover and team meetings. The service had only held one team meeting since it had opened in August 2017. Care staff told us that the staff meeting was informative and that their ideas and suggestions were listened to.

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 Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that staff received such appropriate training and support as is necessary to enable them to carry out the duties they were employed to perform.