Kevin Casey

Silverlea Residential Home

Inspection report

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Requires improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires improvement**

Overall summary

The inspection took place on 27 April 2015 and was an unannounced inspection. On the date of the inspection there were 18 people living in the home. The home is registered to provide care to 35 people in both single and double bedrooms, situated on four floors of the building.

A registered manager was in place. 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 spoke positively about the care provided at the home, their feedback demonstrated a high level of satisfaction with the service. For example people said staff were caring and attentive and they felt safe in the home.

We found bedrooms were nicely decorated and documentation was in place showing that appropriate safety checks on equipment such as fire, gas and electrical was undertaken. However areas of the building

Summary of findings

required decoration and we found some risks associated with the premises and equipment were not effectively managed. Radiators were unguarded increasing the risk of burns and some carpets presented trip hazards.

This was a breach of Regulation 12 (d) and (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people's health were appropriately assessed and plans of care put in place to keep people safe. Staff demonstrated a good understanding of risks posed to individuals and how to safeguard them from abuse.

People spoke positively about the food at the home. Arrangements were in place to ensure people were provided with sufficient quantities of suitably nutritious food and people's weights were regularly monitored.

We found the home to be meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). Staff we spoke with had a good understanding of DoLS and the Mental Capacity Act (MCA) and how to ensure the rights of people with limited mental capacity when making decisions was respected.

People's healthcare needs were met. The service had strong links with health professionals and plans of care contained their advice and expertise to help ensure effective care.

People's individual preferences were catered for. Care plans showed the service had assessed what was important to people and staff demonstrated a good knowledge of how to deliver care in line with people's individual preferences.

We observed care and saw staff delivered care in line with the requirements of care plans. Feedback from people and their relatives was that staff were kind and considerate, and our observations confirmed this. People were treated well by staff displaying a high level of dignity and respect. Staff had taken the time to develop strong relationships with people who used the service.

Arrangements were in place to provide a range of activities to people and their involvement in these was regularly assessed. Social and spiritual needs were assessed and appropriate plans of care put in place.

People and their relatives spoke positively about the management at the home and said they were effective in dealing with any concerns or queries. A range of audits and checks were undertaken by the home and there was evidence the service was committed to continuous improvement to the quality of its service.

We found although the service had taken appropriate action to keep people safe, allegations of abuse had not always been reported to us in line with the services statutory duties. We also found two instances were key policies were not followed putting people at risk. Improvements were required to ensure compliance with these policies was achieved and compliance with these policies was regularly monitored.

You can see what action we asked the provider to take at the back of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not always safe. Although people told us they felt safe in the home, we found several risks associated with the premises which needed to be rectified to ensure a safe environment. Risks to people's health were adequately assessed and staff knew of individual measures needed to keep people safe.

Medicines were safely managed, people received their medicines when they needed them and appropriate arrangements were in place to store them safely.

Staffing levels were sufficient to ensure people received timely care and safe recruitment procedures were followed to help ensure staff were suitable for the role.

Is the service effective?

Good

The service was effective. People spoke positively about the food. We found people provided with sufficient quantities and choice of suitably nutritious food served in a relaxed atmosphere. The service undertook appropriate monitoring of people's nutrition and managed any risks effectively.

We found the location to be meeting the requirements of the Deprivation of

Liberty Safeguards (DoLS) and the service was acting within the requirements of the Mental Capacity Act (MCA).

People and their relatives told us the home provided effective care. We saw good links were in place with health professionals and their advice recorded and followed to help ensure people's healthcare needs were met. Appropriate care plans were in place to assist staff deliver effective care.

Is the service caring?

Good

The service was caring. People and their relatives told us staff were kind and caring and treated them well. This was confirmed by our observations of care which showed staff treated people well.

The service had taken the time to seek information on people's biographies to help deliver personalised care. Staff demonstrated a good knowledge of people and it was evident they had built good relationships with the people they were caring for.

Summary of findings

Is the service responsive?

Good 

The service was responsive. People's needs were assessed in a range of areas to help ensure effective care. We saw evidence staff were familiar with people's plans of care and observed staff delivering care in line with people's individual needs. Where changes to people's health took place, we saw prompt action was taken by the service.

A range of activities were available for people and their involvement and social preferences was regularly assessed to help ensure their needs were met.

Is the service well-led?

Requires improvement 

The service was not always well led. People, relatives and staff spoke positively about management and said they were helpful and supportive.

Some systems were in place to assess and monitor the quality of the service and make improvements following audits, incidents and people's feedback. This demonstrated the service was committed to further improvement of the service. However, we found two incidents of abuse were not correctly reported to us and two instances where the provider's policies were not followed, indicating that monitoring in this area could be improved. We also concluded more could have been done to consult and implement best practice guidance in relation to dementia care

Silverlea Residential 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 27 April 2015 and was unannounced. The inspection team consisted of two inspectors.

We used a number of different methods to help us understand the experiences of people who used the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. During our inspection we spoke with six people who lived at the home, two relatives, the manager, deputy manager, three members of care staff, and the cook. We reviewed the care records of six people who lived at the home and other documentation relating to the management of the service.

Prior to our inspection we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The PIR was returned by the provider and we reviewed this information prior to the inspection. We reviewed all other information we held about the provider such as notifications and complaints. We contacted the local authority commissioning team to ask them for their views on the service and if they had any concerns. As part of the inspection we also spoke with a health care professional who regularly visited the service.

Requires improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe in the home and comfortable in the company of staff who cared for them.

Documentation was in place which showed equipment such as fire systems, gas, window restrictors and electrical installations were regularly checked to help keep people safe. We undertook a tour of the premises. The home smelt pleasant and we encountered no offensive odours. Bedrooms were well maintained and decorated to the preferences of people who used the service. There were sufficient quantities of communal space including three lounge areas, a dining area and an appropriate number of bathroom facilities. An outdoor space was available at the front of the premises and people reported they had regular access to it. Although there was an ongoing programme of maintenance, we found the décor in some communal areas of the building was tired and would benefit from redecoration particularly to help produce an environment that was conducive to care that met the needs of people with dementia.

We found some risks associated with the premises and equipment had not been appropriately assessed and managed. During the inspection we identified one person had bed rails in situ. A risk assessment was not in place detailing how to manage the risk associated with bed rails such as entrapment. However when we pointed this out to the registered manager immediate steps were taken to address this shortfall. We asked the registered manager to consult relevant guidance to ensure that the risk assessment was suitable and sufficient and thoroughly assessed the relevant risks. We found the majority of radiators in the lounge areas, bedroom and corridors were operating at temperatures that presented a burn risk. They were not guarded to protect people from the risk of burns. (Health and Safety Executive Guidance "Health and Safety in care homes" HSG220, states steps should be taken to protect people from hot radiators through guarding). This meant there was a risk that people particularly those who are cognitively impaired could burn themselves on the hot surfaces present. There was also no current electrical wiring certificate in place which meant the electrical installations had not been checked in line with legal requirements to ensure they were safe. We found the carpet in the lower ground floor basement was raised in two areas which presented a trip risk particularly for people that may not be fully aware of their surroundings. The carpets in the lounge and entrance hall were also wearing and presented trip risks. The floor in the dining area was chipped in places which made it difficult to clean. We raised these issues with the owner and registered manager who confirmed they would prioritise maintenance in these areas to address these risks.

This was a breach of Regulation 12 (d) and (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safe staffing levels were maintained within the home. We looked at the staffing rota and spoke with the registered manager. Each care shift was led by a senior care worker and supported by care workers. In addition a cook was employed to deliver all aspects of food preparation and menu planning. A domestic worker carried out all cleaning duties. Laundry duties were performed by care staff. Our discussions with the manager and care workers assured us that laundry duties did not detract from the delivery of direct care. We looked at the dependence of people, observed the timeliness of care and spoke with relatives. We found there was sufficient staff of the right grade and experience available at all times to deliver care as described in people's care plans. For example, staff had time to regularly check on people and respond to any requests or help manage any anxieties.

We saw the service was employing effective staff recruitment and selection systems. There was a clear process which ensured appropriate checks were carried out before staff began work. These checks helped the service to make sure that job applicants were suitable to work with vulnerable people.

The risks to people's health and welfare were assessed in a number of areas to help staff deliver safe care. These included pressure area care, nutrition and falls and any risks specific to the person such as susceptibility to infections. Where risks were identified plans of care were put in place to help staff provide safe care. This showed an effective approach to risk management.

Safeguarding policies and procedures were in place and the home had a readily available copy of local safeguarding protocols to ensure they followed the agreed procedure. Care staff with whom we spoke were able to demonstrate a good understanding of safeguarding issues and were able to give examples of how they would identify and act on

Requires improvement

Is the service safe?

abuse. Staff also knew the principles of whistleblowing and assured us they would make use of whistleblowing if necessary. This gave us assurance that action would be taken by staff to report any concerns to people's safety.

Where people displayed behaviours that challenged, appropriate care plans were in place to guide staff on how to reduce distress and anxiety. Staff and management we spoke with had a good understanding of people who used the service and how to keep them safe. Where incidents occurred, these were appropriately documented within care plans, incident forms and/or behavioural charts as appropriate. There was evidence that investigations were undertaken and preventative measures put in place to help keep people safe and learn from incidents and refer onto health professions if necessary. Records were kept of any unexplained bruising and investigated to determine the cause.

Medicines were managed safely. Medicines were administered to people by trained care staff. We looked at the provider's medicines policy. The policy demonstrated the provider had taken steps to ensure they complied with current legislation and best practice in the administration of medicines.

We inspected medication storage in the home. We found the storage cupboards were secure, clean and well organised. We saw the controlled drugs cupboard provided appropriate storage for the amount and type of items in use. The treatment room was locked when not in use to ensure medicines were stored securely.

Some prescription medicines contain drugs which are controlled under the Misuse of Drugs legislation. These medicines are called controlled medicines. We saw controlled drug records were accurately maintained. The giving of the medicine and the balance remaining was checked by two appropriately trained staff to reduce the risk of misuse.

Creams and ointments were prescribed and dispensed on an individual basis. The creams and ointments were properly stored and dated upon opening. All medication was found to be in date.

We saw evidence people were referred to their doctor when issues in relation to their medication arose. Annotations of changes to medicines in care plans and on Medication administration records (MAR) were signed by care staff. We saw all "as required" medicines were supported by written instructions which described situations and presentations where "as required" medicines could be given.

We found medicines were administered appropriately and the details recorded. We saw medication administration records (MAR) were complete and contained no gaps in signatures. We saw that any known allergies were recorded. We asked the senior care worker about the safe handling of medicines to ensure people received the correct medication. Answers given demonstrated medicines were given in a competent manner by well trained staff. We carried out a random sample of supplied medicines dispensed in individual boxes. We found on all but one occasion the stock levels of the medicines concurred with amounts recorded on the MAR sheet. On the one occasion the medicines did not concur with the recorded stock level we found the medicines had been administered as directed; the problem was with inaccurate recording of stock levels. We raised this with the registered manager who said they would investigate immediately. We examined records of medicines no longer required and found the procedures to be robust and well managed.

We asked support staff to describe what actions they would take in response to a person becoming acutely ill and needing emergency care. The answers we were given demonstrated staff were able to competently deal with a range of common emergency situations. Written emergency protocols were in place to guide staff which included evacuation and a missing persons protocol.

Good

Is the service effective?

Our findings

People said that the food provided by the home was good and told us they were provided with regular drinks and snacks. For example, one person said, "Nice meal and we get a nice cup of tea." Another person told us, "Very good, it's all cooked here, fresh." A relative we spoke with commented positively on the quality and presentation of food. We saw people were given a choice both at breakfast and lunch. We observed the lunchtime meal. Lunch was provided in the dining room or in the lounges for people who needed more assistance. We saw appropriate support was provided by staff and plans of care were followed. For example, we observed one person had their meal cut up as per their care plan to help them and another person was physically supported in line with their care plan. The lunch was unhurried with a little time between each course and there was a pleasant atmosphere.

We spoke with the cook and saw there was a variety of food available with winter and summer menu cycles increasing the variety of food provided. If people wanted something different such as their main meal in the evening arrangements were in place to ensure this was provided. Cooked breakfasts were available every day. We saw cakes had been baked for the afternoon tea. Fresh fruit was readily available for anyone who requested it. The cook demonstrated a good understanding of people's dietary needs and an awareness of people's likes and dislikes which helped to ensure people were provided with food that met their individual needs.

People's weights were regularly monitored and care plans were in place to ensure people's nutritional needs were met. In the care plans we looked at we saw people's weight was stable indicating these people were provided with sufficient quantities of food.

People told us they had choice in what they did and where they went within the home. During our observations we saw staff always asked people's consent before helping with care tasks such as assisting them to the table at lunchtime. People were given choices such as what they wanted to eat, drink and do. We saw care plans focused on ensuring people were given choices in terms of care activities. We did find that care plans were not always signed by the person or a best interest decision recorded if they lacked capacity. We raised this with the manager who agreed to take action to ensure that this was consistently done in the future.

Staff with whom we spoke said they had received training in the Mental Capacity Act 2005 (MCA) and specifically on the Deprivation of Liberty Safeguards (DoLS). Staff demonstrated a good understanding of the Mental Capacity Act and DoLS which showed this training had been effective. The Care Quality Commission (CQC) monitors the operation of the DoLS which applies to care homes. No people at the home were subject to DoLS. We spoke with the manager and deputy manager regarding the procedure to ensure the home acted within the law regarding DoLS. Their responses demonstrated a good understanding. Furthermore in the absence of any need for DoLS we were, through our observations, assured people's needs were assessed to ensure the minimum of restrictions were in place to deliver a safe environment in which to deliver care.

We saw that care plans recorded whether someone had made an advanced decision on receiving care and treatment. The care files held 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) decisions. The correct form had been used and was fully completed recording the person's name, an assessment of capacity, communication with relatives and the names and positions held of the healthcare professional completing the form. We spoke with staff who knew of the DNACPR decisions and were aware that these documents must accompany people if they were to be admitted to hospital.

Staff were complimentary about the training and support they received and thought this made them effective in their work. During induction to the service, staff received training complying with the Skills for Care Common Induction Standards to ensure they were given the skills and knowledge to enable them to meet the needs of the people using the service. We looked at the training records of the two most recent new members of staff. We saw their files demonstrated they were progressing towards completing their induction training. We looked at a sample of staff training records and found staff had access to a programme of training. Mandatory training was provided on a number of topics such as safeguarding adults, manual handling, food hygiene, first aid and fire safety. Additional training was provided on specialist topics such as

Good

Is the service effective?

dementia and diabetes. Whilst staff had all completed a range of relevant training we found some aspects were overdue for refreshment. For example for some staff we found training updates in the areas of manual handling, food hygiene and health and safety were four months overdue . The manager assured us this shortfall would be addressed as a matter of urgency. Discussions with staff revealed a good knowledge of the subjects we asked them about indicating that overall the training system was effective.

People and their relatives spoke positively about the care delivered in the home. For example, one relative said, “My [relative] has only been here for a short time but is putting on weight and mobilising well following a fractured hip” and “The care is really good delivered by caring staff.” Records showed arrangements were in place that made sure people's health needs were met. Specific health related care plans were in place where risks to people’s health were identified such as how to effectively manage and reduce the risk of Urinary Tract Infections (UTIs). Care plans demonstrated that people had access to a range of health professionals such as community matrons, district nurses, chiropodists and community mental health workers. Records of their visits and any relevant advice was recorded in the care files to enable staff to consult. The health professional we spoke with told us that the service was pro-active in contacting them to discuss any changes to people’s health. They said that staff followed their advice and delivered effective care. We saw care plans had been created based on health professional input for example eating and drinking care plans to reduce the risk of choking. We saw after a period of time this care plan had been reviewed by the external professional and they had reported an improvement in the person’s condition demonstrating effective care had been delivered. We saw in one case a person had been subject to detention under the Mental Health Act 1983 immediately prior to admission to the home. We saw immediately prior to admission there had been established a strong relationship between the home and the local mental health services. We saw from care records where any indication of potential relapse had been seen, professional advice had been promptly sought. We saw evidence of regular medication reviews to establish the person on the minimum dose of medicines conducive to good health. This showed that robust arrangements with other professionals were in place to help ensure effective care.

Good

Is the service caring?

Our findings

People who used the service told us staff were kind and friendly. One said, "I love it here, it's like a hotel." Another person told us, "Couldn't be nicer people." A relative with whom we spoke said, "All my family are happy the care delivered is of a high quality; we chose well when deciding to place our [relative] here".

We observed care within the communal areas of the home. People appeared clean and tidy in appearance and wearing appropriate clothes. This indicated that the service was meeting their personal care needs. Staff were available to respond to people's individual needs within reasonable timeframes for example if people requested assistance or became anxious. Staff spoke patiently to people to aid understanding and engaged them in conversation as well as carrying out care tasks. We saw staff showed a regard to people's privacy and dignity for example speaking quietly about confidential matters and providing privacy during personal care. We saw people at the home appeared at ease and relaxed in their environment. People responded positively to staff with smiles when they spoke with them and looked comfortable in the company of staff.

The service had sought information on people's biographies and preferences to aid staff in understanding people. This ensured staff did not see people as a person with dementia but as a person who had had a rich life and helped plan appropriate future care that met their needs. Staff spoken with demonstrated that they were aware of the needs of the people they were supporting and their individual personalities and preferences. Most of the staff at the service had been there for a number of years and given there were only 18 people at the home these two factors gave staff good opportunity to develop strong relationships with people and our observations confirmed this to be the case.

Care plans considered people's choices, opinions with a focus on ensuring that people's dignity and respect was maintained. We saw evidence people's spiritual and religious needs were met, for example some people were supported to access religious services.

Care planning focused on the need to maintain people's independence. For instance we saw one person required their oral medicines administered by care staff yet they were able to apply topical medicines and instil their own eye-drops and this was encouraged to help maintain this person's independence.

People told us they felt listened to by staff and the management team. For example, one person told us how they had been able to discuss a recent concern with the owner and they felt much better for it. Care records commonly had information showing care needs had been discussed with people who used the service and/or their relatives. However in one case we found a person had no known relatives or close friends. Despite the home having a policy on advocacy no lay advocate had been found for the person and our scrutiny of care plans demonstrated care decisions were made with no external support. The registered manager assured us the matter would be addressed as a matter of urgency.

Care plans were in place for people living with dementia who were coming to the end of their life. We saw evidence of a palliative care approach. Care plans considered physical, psychological, social and spiritual needs of people to maximise the quality of life of people and their family. Care plans specifically stated the importance of staff knowing their end-of-life wishes. We spoke with staff who were able to demonstrate they knew what those wishes were which helped ensure that appropriate and compassionate end of life care was provided.

People reported they had access to visitors and we saw there were no restrictions on their access to the premises.

Good

Is the service responsive?

Our findings

We found people's needs were assessed to help staff deliver appropriate care. This initially took place on admission to ensure the provider could immediately meet their individual needs. A range of more detailed care plans were then put in place which provided information on how to meet people's needs in a range of areas which included continence, mobility and personal hygiene. Where risks and/or specific needs were identified personalised care plans were in place for example around behaviour. The home was in a transition period transferring care records to a new format. As such there were some inconsistencies in the way information was recorded in care plans and the quality of care documents. For example, one person's skin integrity care plan was blank however information on how to provide appropriate care was noted within other care plans. However, discussions with staff and the management revealed a good understanding of people's individual needs and plans of care. The manager assured us this transition would be completed in the coming months to ensure a greater level of consistency in the quality of care plan documents.

Through observing care we saw evidence staff provided appropriate care in line with the requirements of care plans. For example people utilised appropriate pressure relieving equipment and were offered support with mobilising, food and drink in line with their plans of care. Staff were able to appropriately monitor the communal areas to ensure that responsive care was provided when people needed it. For example, we saw a person coughing and another crying out for assistance, they were both provided with appropriate support by care staff. This demonstrated staff were responsive in providing assistance to these people which met their needs and preferences.

Where new health needs or concerns were discovered, short term care plans were put in place for example for to help staff manage infections. We spoke with staff about certain elements of people's care. Their answers demonstrated they had a good understand of people's needs and were aware of when changes had recently taken place.

We found the service was responsive in raising issues such as anxiety and sore skin with the relevant health professionals. Responsive care planning and communication was in place for example where one person had moved from the home to a specialist mental health service and later back to the home. We saw evidence of staff from the home contributing to multi-disciplinary meetings to ensure care remained seamless as the person passed between services. We saw since the person had returned to the home the high level of interaction between the health professionals and care home staff had continued to ensure a high level of care.

Care plan reviews took place with people and their relatives. These were an opportunity for people to provide feedback on the care. Care reviews we looked at showed people/their relatives were happy with the care provided indicating a high level of satisfaction with the service.

People told us there were a range of activities available such as playing bingo, dominoes, memory based activities and arranged trips out. One person told us that the service helped them to go outside and visit events in the community. We saw that the deputy manager acted as the activities co-ordinator and this allowed a planned daily activity schedule to be in place. People had activities assessments in place which evaluated their involvement in activities and whether they met their individual needs.

Systems were in place to record and investigate verbal and formal complaints. We found no complaints had been received by the home in the previous 12 months. People and their relatives told us they had no cause to complain and told us they were highly satisfied with the service.

Requires improvement

Is the service well-led?

Our findings

A clear management structure was in place which included a deputy manager and the registered manager. We saw the management team were highly visible in the home throughout the inspection. Staff told us the management team were supportive to them and always available for advice and guidance. Staff told us their views and suggestions were taken seriously. When we spoke with the registered manager and the deputy manager separately it was clear they both shared the same common understandings and aspirations for maintaining and improving care. People and their relatives also spoke positively about management for example one relative told us, "When we were looking for a home for our [relative] we were impressed by the openness and helpful nature of the manager."

The home had appropriately reported notifications of deaths to us in line with its statutory responsibilities. However, it not reported any allegations of abuse to us since 2013. We identified two incidents of physical aggression between services users which took place in late 2014. Although appropriately documented , investigated and action taken to help protect these people, these had not been reported to the Commission in line with the service's statutory responsibilities. We reminded the provider of the importance of reporting all incidents of this type in the future.

The home was in the process of transferring care records to a newly improved format. These care plans were more detailed and contained more person specific information for example details of all the pressure reliving equipment within the skin integrity plan. However this process was not yet complete which meant some care plans were of significantly higher quality than others. Some plans were very generic with a lack of personalised information. Further work was required by management to ensure all care plans were completed to a consistent high quality.

We found the provider had a range of policies and procedures in place which set out how the service would comply with legal requirements and/or best practice. However we found two policies which were not being routinely followed. The advocacy policy had not been followed, as someone without a relative had not provided with an advocate during care plan review. The home had also not followed their bed rail policy, in assessing the risks posed by bed rails to one person. In addition, some training had not been promptly provided in line with the organisations mandatory training procedures. A system should have been in place to regularly assess and ensure that care is delivered in line with the organisation's policies. The registered manager agreed to make immediate changes to ensure these policies were followed in the future.

There was evidence the provider was committed to further improvement of the service. They had recently initiated the "Pressure Ulcer Safety Cross" following training and advice from external health professionals. This had provided staff with a greater level of expertise in identifying and taking actions on sores and set up systems for monitoring the development of any sores. We saw that no pressure ulcers had been reported in the home in 2014, an indicator that the prevention strategy was effective. The deputy manager showed us the "Social Care Commitment" which the home had recently signed up to, this aims to improve workplace quality in social care. Although progress was in its infancy, this showed a commitment to further improve the service.

The registered manager told us the majority of people living at the home had dementia. We found more could have been done to ensure dementia care was delivered in line with best practice particularly in terms of environmental considerations. Some areas of the building were not dementia friendly for example the dimly lit lower ground floor and lack of appropriate signage throughout the home. We concluded more could have been done to utilise best practice guidance to produce an environment conducive to good dementia care. **We recommend that** the service explores the relevant guidance on how to make environments used by people with dementia more dementia friendly.

Audits were undertaken in a range of areas to help assess and monitor the quality of the service provided. This included medication audits, infection control, kitchen and food, environmental audits and monitoring of incidents. Hospital admissions and pressure ulcers were audited monthly to check for any trends. Although most audits were sufficient and demonstrated that issues were identified and action taken, we found the medication audit could have been more detailed to provide evidence that a thorough check on all aspects of the medicines management system was undertaken.

Requires improvement

Is the service well-led?

Incidents were fully investigated this included falls, safeguarding incidents, any bruising, and behavioural incidents. We saw these had been investigated and lessons/learnt preventative measures were put in place to assist the service improve. These were collated monthly and audited for any trends.

Disciplinary procedures were in place and we saw evidence these had been followed to help ensure staff performed to the required quality. Staff performance and development was monitored through regular supervisions and appraisals. Disciplinary procedures were in place and we saw evidence these had been followed to help ensure staff performed to the required quality.

The registered manager told us an annual satisfaction survey was sent to relatives and visiting health professionals. We looked at the most recent survey conducted in 2014 which showed the responses to be overwhelmingly positive. Where minor issues had been raised we were provided with assurance that these had been dealt with helping the provider to continuously improve.

Staff and management meetings were periodically held. We looked at the minutes from recent meetings which showed care quality issues were discussed with staff to help improve the service and deal with any concerns.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 (d and e) Care and treatment was not always provided in a safe way for service users as the premises were not fully safe to use. Systems were not fully in place to ensure equipment used by service (bed rails) was fully safe.