Chasewood Care Limited

Chasewood

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected this service on 14 and 15 February 2017. The first day of our inspection was unannounced. We told the provider we would return on 15 February 2017.

The service provides accommodation and personal care for up to 26 older people who may live with dementia. Twenty-six people were living at the home on the day of our inspection.

The registered manager had retired from their post in December 2016, but they had not de-registered at the time of this inspection. The provider had already appointed a new manager in the expectation they would register with CQC at the end of their probationary period. We have referred to the new manager as 'the manager'. Two deputy managers took charge of the day-to-day running and management of the service, because the manager was also the manager of the provider's other home, which did not have an appointed deputy manager.

People were safe from the risks of harm, because staff understood their responsibilities to protect people from harm and were encouraged and supported to raise concerns under the provider's safeguarding and whistleblowing policies.

There were enough skilled and experienced staff to support people safely. Staff understood the risks to people's individual health and wellbeing and knew how to minimise the risks. The manager had already identified that improvements were required in recording staff's knowledge about how to support people, to ensure their knowledge was available to be shared with new staff.

Medicines were stored, managed and administered safely by staff who were trained in medicines management. People were protected from risks related to essential supplies and equipment, through regular testing and service contracts with professional experts and equipment suppliers.

Accidents, incidents and falls were investigated and actions taken to minimise the risks of a re-occurrence for the individual. The deputy manager analysed accidents, incidents and falls and found they were attributable to each individual person's needs and dependencies.

People's needs were met effectively because staff had the necessary skills and experience and received appropriate training and support. The manager had identified a new training supplier to ensure all staff received training in line with the fundamental standards of care to support their induction training.

The manager understood their responsibility to comply with the requirements of the Deprivation of Liberty Safeguards (DoLS). They had applied to the Supervisory Body for the authority to restrict people's rights, choices or liberty in their best interests. Staff understood and acted within the principles of the Act to support people to make their own decisions.

People were supported to maintain a balanced diet that was suitable for their individual dietary needs and met their preferences. Staff monitored people's appetites, food intake, general health and moods and referred them to other healthcare professionals when they identified signs that the person was not their usual self.

People were cared for by kind and thoughtful staff who knew their individual preferences for care and their likes and dislikes. People were able to choose how they spent their day and were supported to socialise or spend time alone, according to their preferences. People enjoyed spending time with staff who took an interest in them as individuals.

Staff were guided and supported in their practice by a management team that they liked and respected. Staff shared a common purpose of delivering care that was focused on each individual person's needs.

Improvements were required in the system for ensuring the premises were safely maintained to minimise risks. The provider had not implemented an effective premises' maintenance policy and procedure. They had not instructed the manager and staff about their level of responsibility to report maintenance issues, or provided them with a reliable process, risk rating or timescale for taking action to repair and maintain the premises safely.

The provider had not followed their own policy, to ensure the measures they implemented to minimise risks to people's safety met the latest standards set out by the health and safety executive's guidance.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. People were safe from the risks of abuse, because staff understood their responsibilities to keep people safe from harm. Risks to people's health and wellbeing were minimised, because people were supported by a consistent team of staff who knew people well. People's medicines were managed and administered safely. Equipment and essential supplies were regularly tested and maintained.

Is the service effective?

Good

The service was effective. Staff had the training, skills and experience to meet people's needs effectively. The registered manager and staff understood their responsibilities under the Mental Capacity Act 2005 and acted in accordance with the Act. People were supported to maintain a balanced diet that met their needs and preferences. People were supported to maintain their health through referrals to appropriate healthcare professionals.

Is the service caring?

Good

The service was caring. People were supported by kind and caring staff who knew them well as individuals and who connected with them emotionally. Staff were mindful of and responsive to people's unspoken need for friendship. Staff respected people's personal needs and preferences for care and support. People were treated with respect and dignity.

Is the service responsive?

Good

The service was responsive. Staff knew people well and understood how to respond to their individual needs, moods and temperament. Staff supported people to spend time engaging with staff, socialising with others or alone, according to people's needs and preferences. Staff demonstrated the ability to see the world from the person's point of view and offered people appropriate support.

Is the service well-led?

Requires Improvement

The service was not consistently well-led. People were confident their opinions would be listened to and taken into account for

improving the quality of the service. Improvements were needed in transferring staff's knowledge to people's care plans each time they were reviewed, including the actions staff took to minimise risks. Improvements were needed in the guidance and systems available to staff to maintain a risk free environment. Improvements were needed in managing the premises in line with guidance issued by the health and safety executive. Satisfaction surveys were planned to ensure people, relatives and staff had a formal opportunity to make their views known, to make sure improvements focused on what was important to them.

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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.

The inspection took place on 14 and 15 February 2017 and was unannounced. The inspection was undertaken by two inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using, or caring for someone who uses, this type of service.

We reviewed the information we held about the service. We looked at information received from relatives, the local authority commissioners and the statutory notifications the registered manager had sent us. A statutory notification is information about important events, which the provider is required to send to us by law. Commissioners are people who work to find appropriate care and support services, which are paid for by the local authority.

We spoke with seven people and two relatives about what it was like to live at the home. We spoke with seven care staff and both deputy managers about what it was like to work at the home. We spoke with a visiting health professional about how staff supported people to maintain their health. The provider told us that the registered manager had recently retired. We spoke with the provider and the newly appointed manager about their management of the service. We observed care and support being delivered in communal areas and we observed how people were supported at lunchtime.

Most of the people who lived at the home were not able to tell us in detail, about how they were cared for and supported because of their complex needs. However, we used the short observational framework tool (SOFI) to help us assess whether people's needs were appropriately met and to identify if people experienced good standards of care. SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

We reviewed four people's care plans and daily records and four medicines administration records to see how care and treatment was planned and delivered. We checked whether staff were recruited safely, and

trained to deliver care and support appropriate to each person's needs. We reviewed the results of the provider's quality monitoring system to see what actions were taken and planned to improve the quality of the service.

Good

Is the service safe?

Our findings

People and relatives told us they felt safe at the home. One person said they felt safe because, "They treat you well. There's no cruelty here." A relative told us, "I feel [Name] is very safe here. There are always lots of staff around and they are very kind to them. "

The provider took action to minimise risks of abuse, harm or neglect. Staff attended training in safeguarding and protecting people from the risk of abuse. Staff understood the different types of abuse a person may experience and understood their responsibilities to record and report any concerns. Staff understood the provider's whistleblowing policy, which supported them to report any concerns about other staff's practice. Staff told us, "You are here for them (people). I have never seen anything I needed to whistleblow about. I can challenge staff's practice. I can say 'it's wrong'. Abuse can be verbal, or neglect" and "I would report any concerns to a senior. I have no concerns about staff's practice. There is no meanness, no loud voices from staff."

People were supported by regular staff who knew them well and who understood their individual risks. People told us, "The staff help and assist me as my walking isn't too good" and "The staff always offer help when I have a bath, helping me in and out of the bath." People's care plans included an assessment of their needs and abilities. The assessment identified which aspects of their daily lives they could manage independently and which aspects they needed support with. Staff's knowledge of how to support people to minimise risks was evident in their actions and in the explanations they gave to us about how they managed risks. We saw staff were consistent in their actions, so people received the same level and type of support whichever staff supported them. This demonstrated that people received support from a regular group of staff and that staff shared important information between them to minimise risks.

One person told us, "I have never had an accident here, but if I call the staff they do react quickly." Staff kept accident, incident and falls records, which recorded when and where the person was at the time of the incident, whether any injuries were sustained and the action taken to support the person. The deputy manager checked the accident and incident reports to see whether any trends were identifiable. There was no identifiable trend or pattern to accidents in the previous 12 months that required action by the manager or provider to minimise risks of a reoccurrence.

People told us there were enough staff to support them, which made them feel safe. People said, "There always seems to be plenty of staff around." Staff told us they felt there were enough staff on duty to keep people safe and to meet their needs. Staff told us they had enough time to support everyone, they were not stressed or rushed and there was always good cover and support. One member of staff said, "People do need all five of us all the time. There are enough staff" and "We have time to chat with people, plus there is always seven of us, plus cooks and a housekeeper" and "The deputies cover seven days a week between them." The deputy manager told us they only needed two staff at night because everyone who lived at the home slept well. The deputy and manager had recently undertaken an unannounced visit to the home at night, to check staff's practice. This had reassured them there were enough staff on duty at night to meet people's needs safely.

The staff recruitment files we looked at did not demonstrate consistency with the provider's recruitment process. We had discussed this previously with the provider at an inspection at their other home. Since that discussion, the manager had re-instated the recruitment process and defined the standards for the supporting documentation with a checklist. The process, supporting documentation and checklist, matched the requirements for safe recruitment as described within the regulations. This ensured no staff could start working at the home until all appropriate checks of their suitability had been made and recorded and any issues identified had been effectively risk assessed and managed. Records showed a current staff recruitment was progressing in line with the revised process and in accordance with the regulations.

People told us they received the medicines they needed when they needed them, particularly pain relief medicine. People thought their medicines were managed and administered effectively and safely. People said, "Staff always give me my medication" and "They stand with me until I've taken it. They like to make sure I take it." Staff received training in medicines administration. Medicines were delivered by the pharmacy in 'bio dose' pots, that is, all the medicines a person required at the same time of day in one sealed pot.

The pots were contained in trays, colour coded for the time of day and included a photo of the person, a list of medicines in each sealed pot and the purpose of the medicine. A member of staff told us if any medicines were stopped by the GP, they sent the whole tray back to the pharmacy, who amended the contents and returned the tray the same day. Warnings about possible reactions with other medicines, foods or drinks were printed on the tray labels. Where we saw a known reaction was not printed on the label for one tray, staff phoned the pharmacy straight away to ask them to include this information in future.

The pharmacy supplied a separate medicine administration record (MAR) for each person. Staff signed the MARs to record when people had been given their prescribed medicines, or used an agreed code to explain why the medicine had not been given. A member of staff told us they would contact the person's GP if they consistently declined to take their medicines. Medicines that were declined were put into a dated envelope and returned to the pharmacy.

For people who regularly declined their medicines, their GP had agreed they could be given covertly in their best interests, that is, without their knowledge mixed in food or drink. The staff had not obtained separate advice from the pharmacist about the suitability of giving specific medicines mixed into particular food or drinks, because the pharmacy belonged to the GP's practice. During our inspection, a member of staff contacted the pharmacy immediately to check that their current practice would not interfere with the effectiveness of the medicines they administered covertly.

For medicines that were described for a short time, staff put a line through the record and the date the final medicine was administered. Staff told us most people were able to say if they wanted pain relief medicines, and they monitored people's body language and facial expression to assess whether they were experiencing any pain. To minimise risks related to medicines, the manager had decided not to keep grapefruit or grapefruit juice in the home as a matter of course, because it is known to interrupt the effectiveness of several medicines. Staff told us they would obtain grapefruit only if a person asked for it, and it would be set aside in their name.

The provider had minimised risks related to essential supplies and equipment, by contracting with specialist suppliers to test, service and maintain essential supplies and equipment. Records showed, for example, that the water, gas and electrical supplies and installations had been tested and serviced in the previous quarter, and that the lift and hoists were regularly serviced.

The provider took action to minimise risks in the event of an emergency. Staff had all attended training to

give them the skills and confidence to respond to and deal with emergencies, such as health and safety, first aid and fire safety awareness. Staff practiced how they should respond in regular fire drills. Staff were able to explain where the fire exits were and the actions they would take in the event of a fire. A plan of the building and people's personal emergency evacuation plans were available in the fire safety folder just inside the front door. The deputy manager kept the evacuation plans up to date as people moved into and out of the home. The provider told us the local fire protection service had scheduled an inspection visit for later this month.

During our inspection visit an alarm sounded when one person inadvertently removed the cover of the alarm in the hallway. Staff all gathered in the hall in accordance with the policy and procedures. The fire marshal checked the fire panel in the hall, but it did not identify the danger and safe zones, because it was not an actual fire alarm. The alarm was triggered because a person had removed the protective cover, so it did not sound across the whole building, only at the front door. The provider responded immediately. They came to the home to replace the small pin that the person had pulled out of the cover to ensure the alarm was reset and working correctly.

Good

Is the service effective?

Our findings

People told us the staff were effective because they understood their needs and offered them the support they needed, when they needed it. People told us, "The staff seem to be well trained in what they are doing. They are always ready to support you" and "The staff are very good they look after me when I need them."

Staff told us they felt well prepared to start work because they completed an induction programme. A senior member of care staff told us, "I can induct staff now. I show them the fire exits, the policies and procedures, the care plans and explain people's needs. The policies and procedures support our practice." Staff told us they had training when they started working at the home and refresher training, which improved their practice. A member of staff told us, "I had dementia training. People with dementia don't understand the impact of their behaviour. I take my time, they need time. I don't rush. We have a chit chat."

The manager kept a list of the training staff attended to make sure it was appropriate to their role and responsibilities. Although some staff had achieved nationally recognised qualifications in health and social care, no staff had taken Care certificate training. The Care certificate is a nationally agreed set of fifteen standards that health and social care workers follow in their daily working life. It was launched in April 2015 and providers regulated by the CQC are expected to ensure that the standards of the Care Certificate are covered in their induction of new staff.

The manager told us they had signed up to the Skills for Care national minimum data sets and had negotiated with a training provider for Care Certificate training. They told us, "This will link into our internal induction training programme. The supplier has highlighted gaps in our current training provision and will deliver training to fill the gaps as refresher training to current staff and will supply specialist training when needed. They will input all current staff data and set up a rolling programme of training that acknowledges qualifications already achieved by individual staff."

Staff were supported by the management team, because they had regular opportunities to meet with the manager at team meetings and one-to-one meetings with the deputy manager. End-of-year performance appraisal meetings were scheduled between the staff and the manager.

The Mental Capacity Act 2005 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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards.

The manager understood their obligations under the Act and had applied to the Supervisory body for the legal authority to deprive people of their liberty. This was because the home operated a 'locked door' policy. People who did not understand the risks of harm did not go out independently. One person who

understood the risks of harm told us staff usually went out with them, because they were at risk of falling. Sometimes they were able to go to the local shops independently, "If the staff think I'm okay (health wise)." At the time of our inspection visit, the manager was waiting for the local supervisory body's approval of the applications they had submitted.

Staff had been trained in The Mental Capacity Act 2005 and understood and acted in accordance with the principles of the Act. A member of staff told us, "You should assume capacity unless otherwise stated. People can make everyday choices" and "There is a fine line between encouraging and forcing. Some people are reluctant and need time to make a decision." We saw staff encouraged people to make everyday decisions. Another member of staff said, "People make their own decisions. [Name] did not want to come down today. [Name] said, 'I'm not ready, I want to lie down'. A bit later they did want to come downstairs. It feels rewarding to be able to help when they want it."

People told us they made their own decisions about their daily lives. People told us, "I really don't feel restricted at all", "They never force you to do anything they just try to encourage you" and "I go to bed when I get tired, but I don't feel any restriction at all. They do come and check on me when I'm in bed to make sure I'm ok."

Staff consulted with people's families or healthcare professionals to make sure complex decisions were made in a person's best interests. For example, for two people who were sharing a room, staff had discussed the idea with each person, with one person's family and with the other person's advocate. All parties had agreed this was an appropriate decision, because both people were known to have made friends, chose to spend time together and 'looked out for' each other. This was a more complicated decision than, for example, deciding what to wear, because it had an impact on each person's privacy. Staff told us both people had agreed to share a room when it was suggested and the decision was supported by their relation and advocate.

During our inspection, we saw the two people chose to spend time together, but the discussion and agreement had not been documented to clearly evidence that people had been supported to make the decision by appropriate representatives. A deputy manager told us, "That is an oversight. It should be in the 'resting and sleeping' (care) plan. The care plans have not been updated (effectively) since they started sharing." After our inspection the manager sent us a copy of their mental capacity assessment framework and best interests decision making guidance. They had shared this guidance with the deputy manager, to ensure best interests decisions were recorded in accordance with the principles of the Act in future.

People told us the food was good. They said they liked the meals and always had a choice. People told us, "The food is very good here", "There is always plenty to eat" and "We always have plenty to drink, lots of tea and coffee and they always offer you a biscuit. I am very satisfied with the food."

Meals were delivered to the home by a specialist catering supplier and included a range of meals to meet people's dietary requirements, such as diabetic, milk-free, vegetarian and gluten free foods. The cook used a special oven to heat meals according to the supplier's guidance. A member of staff told us, "People and staff did joint tasting sessions to try the meals and the deputy manager chooses the menu according to people's preferences. The suppliers deliver promptly and we can try new recipes as they become available."

A relative told us their relation was supported to maintain a good diet because they were served 'soft' meals in accordance with their needs. People's food likes, dislikes, how they liked hot drinks and any allergies were recorded in a folder in the kitchen. For example, for people who were on medicines that could be ineffective if mixed with some foods, there was a list of the items they should not eat or drink.

On both days of our inspection visit, we saw there was a choice of main meals. Most people sat at the dining table and were able to eat independently. Staff assisted people to sit closer to the tables and offered aprons and meal choices verbally, patiently and repeated the choices several times until the person came to a decision. A member of staff showed us a picture book of meals and said, "The supplier provides picture menus which we would re-introduce if people did not understand our words."

We saw one person's meal was served in the consistency explained in their care plan and in accordance with the speech and language therapist's advice. One person needed assistance to eat, and staff sat next to them encouraging them verbally. We heard staff say, "Hello, I'm here. Are you ready?" The person did not open their eyes, but responded to staff's voice and opened their mouth. Records showed the person had put on weight, which demonstrated staff's actions in supporting the person to maintain a balanced diet were effective.

Staff monitored and recorded whether people ate well. We heard staff shared information at handover about people's moods, appetites, behaviour and whether they had taken their medicines. Staff commented about anything unusual about the person, with a reminder to the incoming staff to 'keep an eye on [Name]'. Everyone was regularly weighed, which enabled staff to identify those people at risk of poor nutrition. For those people identified as 'at risk', staff asked their GP to visit and for the GP to refer the person to specialist services, such as a dietician. A member of staff told us, "We monitor appetites and call the GP if their appetite changes. We know people well and can see changes just by the way they hold themselves. [Name] was not their usual self, so we called the GP who diagnosed a chest infection and prescribed antibiotics. They will arrange an x-ray for [Name]."

People told us they were supported to maintain their health and a relative told us they were happy with their relation's healthcare. People told us, "If you need to see a doctor they call one in to see you" and "The staff know me very well here. I see the optician and chiropodist. They come in when necessary." A visiting healthcare professional told us they had no concerns about the care people received and said staff were supportive when people needed nursing treatment by visiting healthcare professionals. They told us, "The staff are really nice girls here." Records showed people were supported to access healthcare specialists, such as opticians, dieticians and district nurses, when needed.

Good

Is the service caring?

Our findings

People told us staff were kind and caring. People said, "All the staff are very kind", "They try to keep you happy and do what they can for you" and "You need to be considerate and compassionate in this job and most of them are." Relatives told us, "Staff are very kind to [Name]" and "They all love [Name] and are always saying they want to take [Name home with them. They are lovely."

Staff told us they liked working at the home, because they enjoyed supporting people. Staff told us, "You are here for them" and "You get totally involved in their lives, especially by doing long days." Staff understood it was the 'small things' that made a difference to people's emotional wellbeing. Staff told us, "They are lovely. They need the best of care" and "When they go to bed, I like to tuck them in. [Name] likes their shoes facing a certain way and loves to have a kiss goodnight."

We saw staff were thoughtful in their interaction with people. People responded positively to staff because they spoke in soft voices and used people's names. Staff maintained eye contact when talking with people, by crouching down beside their chair and looking directly at them. One person we sat beside pointed out a member of staff to us and said, "She's lovely she is. She is such a lovely person, so kind."

Staff were enabled to deliver care and support that met people's needs by reading a short 'profile', which was in the front of each person's care plan. The profile explained the person's health and any medical conditions, and how these conditions might affect the person's mood and behaviour. The profile described the signs of agitation the person might display, and how staff should best support the person. Staff demonstrated a clear understanding of how to support people's emotional wellbeing, through their actions and in their verbal descriptions of the actions they took to support people.

Staff understood people's preferences for engaging with staff, for spending time alone and for engaging with other people who lived at the home. One person told us, "They try to encourage you to be independent. They are very attentive most of the time." Staff were interested in hearing people's life stories and to share their interests. A member of staff told us, "[Name] loves playing cards. They taught me a new card game, suits and sets." Staff's willingness to learn from people made their relationships more equal.

People were supported to maintain their dignity and staff respected their privacy. People's hair, clothes and nails were clean and manicured. One person told us, "I have my hair done here every week I enjoy that." They told us a member of care staff came in at weekends, especially to give people a pampering manicure session. Staff understood that supporting people to maintain their appearance promoted their dignity and self-esteem. A member of staff told us, "I have seen their photos in their lovely clothes. I help them keep up their appearance. I help them to maintain their pride in their appearance."

Staff did not disturb people unnecessarily if they chose to spend time in their own room. When staff did go to people's rooms, they knocked first and called out to let them know who was at the door, before entering.

Two bedrooms at the home were used by two people sharing the room. One of the shared rooms had a

privacy curtain, which could be pulled across to divide the room and enabled staff to support people with personal care privately. The other room did not have a privacy curtain, but staff told us they always used the adjacent bathroom to deliver personal care. The provider told us this was an oversight and the room should have a privacy curtain. The provider assured us they would arrange for this to be put in place immediately. After our inspection visit, they confirmed by email that this had been done.

Good

Is the service responsive?

Our findings

People and relatives told us staff were responsive to their needs. People told us, "They always offer to assist me", "When you call the staff to get you something they are quite good" and "If I ask for something they always help if they can. They give me my pain relief tablets when I need them."

We saw staff understood people's individual needs and abilities and offered appropriate support at the right time. Staff respected people's right to choose how and where they spent their time. We saw people spent time in different places within the home on the different days of our inspection. Staff told us that people spent time according to their individual mood on the day. One member of staff told us, "[Name] will socialise when they want to. [Name] doesn't always want to come out of their room. They have their own television in their room" and "[Name] stayed in their pyjamas one day and chose their best jacket another day."

People told us staff encouraged them to socialise and to maintain their interests in life. One person said, "The staff speak to you here and try to involve you in things. They never ignore you, they always have something to say or get you to sing and dance. They do their best I think." Another person told us, "My hobby is singing and staff encourage me to sing-a-long." We heard this person singing throughout our inspection visit, and saw the person, and other people, took pleasure in singing. The person told us, "I have enjoyed music and singing since I was a little girl and every month they have the local church and choir come here. I just love it. "

Staff told us they had tried to encourage people to use another separate lounge to allow them more space for their individual interests, but people had declined and seemed to prefer to spend their time in the main lounge. We saw some people were engaged in playing cards with staff at the table while other people watched television in the space off to one side. During the afternoon, staff put on music and danced with people and encouraged others to join in. Those people who declined to dance showed pleasure in watching the others. One person said, "They are patient and try to spend time entertaining us."

People told us they were supported to maintain individual as well as group activities. One person told us staff supported them to go to the local barbers and sometimes took them out to have a drink. The person said, "They are always ready to put themselves out, but it's all about time really. They are happy to do it when they have the time." The deputy manager told us they had just recruited an activities coordinator to work two weekdays and one weekend day, which meant they would be able to provide more person-centred activities and more variety in group activities.

People's religious and cultural preferences were identified and they were supported to maintain their traditional practices. One person told us they were happy because, "The priest comes in to me once a month to hear my confession and for me to receive Holy Communion." Staff told us the provider often brought a meal from their home in for one person, because they shared the same cultural background and taste in food. Another person told us staff were happy to collect a takeaway meal for them, when they felt like 'having a treat'.

Relatives told us the staff were, "Very good with visitors" and "They always make you welcome." They told us they could visit when they liked and were encouraged to continue supporting their relations, as if they were in their own home. One person told us, "My [relative] comes to see me (and) quite often changes my bed covers. The staff welcome that." It was valuable to the person that their relative was able to 'make a fuss' of them and staff had responded appropriately to that need.

People's care plans were regularly reviewed, but changes in how people were supported and cared for were not always documented in their care plans. Staff knew about changes in people's needs and abilities through handover and regular conversation with the manager and they adapted their practice to meet people's changed needs. The manager and deputy manager told us there were plans in place to improve how changes in people's needs were recorded, which would include staff's knowledge and practice, by introducing changes in how care plans were written.

The provider had not received any formal complaints about the service. People and relatives told us they had not made any complaints because the staff were, "Very good" and they had, "No problems at all." Everyone we spoke with was confident any complaints would be responded to appropriately. People told us, "I know the management. I would speak to [Name] if I had a problem. They are very good" and "If I did have a problem, I would speak to the manager. I can't remember their name but I know who they are."

Requires Improvement

Is the service well-led?

Our findings

People told us they felt that the deputy manager and staff listened to them and thought they would respond to their suggestions about anything that would improve their experience of the service. One person told us, "I have only been in the home for a few weeks but I have been happy here with no complaints." Another person told us, "I feel the staff act very promptly." The person told us they had decided, on the day of our inspection, to, "Ask the management for my own (room) key." They were only worried about the possibility of losing the key.

We found the deputy managers did listen and respond to people's suggestions. When we spoke with a deputy manager after the inspection, they told us they had already arranged for staff to go into town with the person to get a new key cut. They told us they would keep a copy in the staff office, in case the person lost or misplaced their key.

There were plans in place to invite feedback from people and relatives on a more formal basis. The manager showed us the survey they planned to conduct at the end of February. This included an easy read and picture survey for people who lived at the home. The questions reflected the questions we ask about services, based on the fundamental standards of care, which showed that the manager understood the purpose of the regulations. The manager told us, "The satisfaction survey for people and relatives will be available this month, with copies in the hallway and posted to relatives. I plan to analyse the results by the end of March (2017)."

People felt the home was well-managed, because they were familiar with the two home (deputy) managers who had day-to-day responsibility for the home. People told us, "The management seem good here, they organise things for us. I think they do a good job really" and "If anything is going on, they do tell us and let us know."

The provider told us the registered manager had retired in December 2016, but had not yet deregistered. The new manager had submitted an application in February 2017, to become the registered manager. The manager and deputies understood their delegated responsibility to inform us of important events at the service through the statutory notifications system. We had not received all the notifications they had sent to us, but a deputy manager was able to show us copies of the emails they had sent. We advised them to check they always received an automatic reply from us, with an enquiry reference number, to make sure the information they shared was received by us.

The provider understood and had complied with the legal requirement to display the latest CQC rating at the entrance to the home and on the website, with a link to the report on CQC's website.

Staff told us they felt well supported because, "The deputy manager is a strong leader. We have no issues here. I feel okay with how it is run." Staff said they felt supported in their practice by the deputy mangers and could share any concerns. A member of staff said, "I feel supported. I am still learning. We can talk about our

feelings at work." The manager planned to invite all staff to appraise their own skills and interests and to identify the support they needed to improve their skills and develop their careers at their annual performance appraisal meetings, which were scheduled for February 2017.

The manager's plan for continuous quality improvement included coaching and mentoring the two deputy managers, and supporting them both to obtain a recognised qualification in leadership and management in health and social care. One of the deputies told us, "The training is really good. I have done level five (of a nationally recognised qualification in health and social care)." All the staff we spoke with described a shared view of their purpose, that is, that people were at the heart of the service. Staff told us, "We are here for them (people)", "I really enjoy it, the people, the atmosphere and the staff. I like the care I have to give" and "It feels rewarding to be able to help when they want it."

Some improvements were required in the leadership of the service. The manager told us they had planned to spend more time at the home to introduce updated systems, procedures and guidance to ensure a person centred approach, but had needed instead to respond to issues that had arisen at the other home they were responsible for. We found some current practice at the home was long established custom and practice and was not focused on the individual person's needs. For example, night staff were checking every person every two hours throughout the night, whether they slept well or not, which disturbed some people's sleep. A deputy manager told us they would they would review each person's individual risks to make sure people were only checked every two hours at night if it was proportionate to their individual risk assessment.

The manager told us they had already identified that people's care plans were not accurately updated with new information. They told us they had planned to review and update everyone's care plan as a priority, but had been delayed by the need to respond to issues at the other home. There was no obvious impact on people who received the service, because they were supported by the same regular staff group knew them well. But it did mean that information about people's needs and abilities was not up to date and could be misleading.

Improvements were needed in the guidance and systems available to staff to maintain a risk free environment. The provider had followed a previously agreed process for reporting and completing maintenance issues at the home. Although one member of staff thought they had a maintenance request book in place, another member of staff told us this had 'dropped out of use'. Maintenance requests were not recorded at the home, so the manager was not able to make sure maintenance requests were prioritised according to risk and was not able to check they were completed in a timely manner. A deputy told us they had already reported a broken window sill that we saw during our visit and 'expected' the maintenance person to repair it 'soon'. The broken window sill was partially repaired on the second day of inspection. The deputy manager was expecting some additional work to the window sill to ensure it would not be damaged by a bed again.

The deputy manager told us they understood the system for reporting issues, was a phone call to the provider followed by a job-inspection visit by the maintenance person. The maintenance person then prioritised work, dependent on obtaining the required materials and in agreement with the provider. The deputy told us this method did not always match their own assessment of risk to people's health, safety and welfare. They told us, "Small repairs and things like light bulbs are replaced promptly, but I don't always know when bigger items are scheduled for repair or refurbishment. I will re-introduce the maintenance book to make sure all maintenance issues are recorded and dated, so we can chase up if not responded to in an appropriate time-frame. We could do with our own on-site maintenance man to make sure we keep up to date with repairs and refurbishments."

Staff were not given clear instructions about their responsibility to identify and report maintenance issues or about the frequency of testing fixtures and fittings. During our inspection, we found several call bells were not working, the hand dryer in a toilet was not working, two curtains were hanging down and there was an unexplained screw sticking out of a window surround. Staff told us, "We check call bells, but not to a regular schedule. We are planning to implement a schedule of regular checks" and "It is our duty to say when things are wrong, but we would benefit from pro-active maintenance." The manager told us, "I planned to implement the management walk-around checklist, which includes day to day maintenance checks, before now, but have not had time. I will share it with the deputy now, so they can start implementing it." On the second day of our inspection, the call bells were working, because the provider had fixed them overnight.

Improvements were needed in managing the premises in line with guidance issued by the health and safety executive. The provider had not followed their own health and safety policy, to ensure the measures they implemented to minimise risks to people's safety met the latest standards as set out by the health and safety executive's guidance. Window restrictors were in place to the recommended width of opening, but the restrictors were not 'tamper proof'. The provider told us they would start changing the restrictors to the recommended type on a rolling programme, starting with the rooms of those people who were identified as most at risk of tampering with the restrictors.