Care UK Community Partnerships Limited

Sunningdale

Inspection report

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Ratings

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

Overall summary

We undertook this unannounced inspection on the 3 and 4 December 2014. The last full inspection took place on 9 April 2013 and the registered provider was complaint in all the regulations we assessed. We carried out a responsive inspection on 8 October 2013 in relation to concerns received about cleanliness and infection control. We found the registered provider was complaint with this regulation.

Sunningdale provides nursing, and personal care and support to a maximum of 49 older people who have a range of physical health care needs. Some people have also developed dementia care needs. On the day of the inspection there were 45 people using the service. Sunningdale is situated to the east of the city of Hull, near to public transport facilities and there are local shops within walking distance. The majority of bedrooms are for single occupancy and there are sufficient communal areas, bathrooms and toilets. There is an accessible garden and car parking.

Summary of findings

The service has a registered manager. 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.

We found improvements were required in how medicines were managed to make sure staff had clear directions and people who used the service received their medicines as prescribed. We also found some people who had specific needs did not have an up to date or fully completed risk assessment or care plan to provide staff with guidance in how to meet them. These issues meant the registered provider was not meeting the requirements of the law and you can see what action we told the registered provider to take at the back of the full version of the report.

There was a programme in place to monitor the quality of the service provided to people. We found some areas of this could be improved to make sure any shortfalls in documentation or care were picked up quickly and addressed.

Staff were recruited safely with all checks carried out before they started work. There were enough staff on duty day and night to meet people's assessed needs. Staff completed a range of training courses to help them feel confident when caring for and supporting people. They also received support and supervision from the registered manager and senior staff.

There were policies and procedures to guide staff in how to keep people safe and staff had completed safeguarding training. The environment was safe and equipment used was serviced and checked regularly by staff.

Most people were able to make their own decisions about aspects of their lives and were provided with information so they could choose what they wanted to do. When people were unable to make their own decisions, staff consulted with appropriate people and planned care in the person's best interest.

We found people had their nutritional needs met and menus provided them with choices and alternatives. People told us they enjoyed their meals.

People had access to a range of health and social care professionals for advice and treatment.

People told us they liked living in the service and staff treated them with kindness, dignity and respect. We observed this during the inspection and that staff included people in decisions about their care. There were activities for people to participate in which were organised by specific members of staff.

The registered manager and senior staff made themselves available to speak to people about any concerns or complaints. When complaints were received, these were taken seriously, investigated and a response made to the person who complained.

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.

We found staff didn't always have clear directions about medicines which meant people did not always receive their medicines as prescribed.

People's individual risk assessments were not always completed fully or kept up to date.

Staff received training in how to safeguard vulnerable people from the risk of harm and abuse. They were clear about how they would report any concerns.

New employees were recruited safely and there was enough staff to meet people's needs and maintain their health and wellbeing.

The environment was safe.

Is the service effective?

Requires Improvement

The service was not always effective.

The registered manager and staff had received training in the Mental Capacity Act 2005, however, best practice regarding the application of the Act in assessing capacity required review. Staff were clear about how they gained consent for tasks on a day to cay basis.

The monitoring of health care tasks such as food and fluid intake, wound care and pressure relief was not always completed consistently.

People's nutritional needs were met and they received a balanced diet.

Staff received appropriate training, support and supervision.

The environment had been adapted to meet people's needs.

Is the service caring?

Good

The service was caring.

We observed positive staff interactions with people and saw privacy and dignity were respected.

Staff included people in decisions about their care, listened to them and helped them to make choices.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Some people had needs that were not always written down in assessments and care plans, which meant there was a risk of important care being overlooked.

Summary of findings

There were lots of activities and occupations to participate in and links had been made with the local communities.

People were able to raise concerns and complaints in the belief they would be addressed.

Is the service well-led?

Requires Improvement

The service was not always well led.

Although there was an annual quality monitoring programme in place, we found some audits could be improved to make sure they checked the areas we found as requiring attention during the inspection. Without thorough audits people could be placed at risk of not receiving all the care they need.

The culture of the organisation encouraged openness, inclusion and promoted quality.

The registered manager was supportive of staff and available when required to speak with people and their relatives.

Sunningdale

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 3 and 4 December 2014 and was unannounced.

The inspection was led by an adult social care inspector who was accompanied by a specialist professional advisor (SPA). The SPA had experience of treating people with skin breakdown due to pressure damage.

Before the inspection, the registered provider completed a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. The PIR was received in a timely way and was completed fully. We looked at notifications sent in to us by the registered provider, which gave us information about how incidents and accidents were managed.

We spoke with the local safeguarding team and the local authority contracts and commissioning team about their views of the service. We also received information from four health care professionals who visited the service.

During the inspection we observed how staff interacted with people who used the service. We spoke with six people who used the service and one of their relatives. We spoke with the registered manager, two team leaders, six care support workers, an activity coordinator, the head chef, the administrator and the housekeeper. We also spoke with a podiatrist who was treating one of the people who used the service.

We looked at five care files which belonged to people who used the service. We also looked at other important documentation relating to people who used the service such as sixteen medication administration records (MARs). We looked at how the service used the Mental Capacity Act 2005 to ensure that when people were assessed as lacking capacity to make their own decisions, best interest meetings were held in order to make important decisions on their behalf.

We looked at a selection of documentation relating to the management and running of the service. These included three staff recruitment files, the training record, the staff rota, minutes of meetings with staff and those with people who used the service, quality assurance audits and maintenance of equipment records.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living in the service, there were enough staff to support them and they received their medicines on time. They said, "Yes, I feel safe; I like the door open during the day and I close it at night", "I do, I love it here", "Do I feel safe here? – yes very much. They ask you if you are alright and they tell you they are here if anything is upsetting you", "They check on me during the night", "They come fairly quickly when I ring the bell; it's never very long", "There are no problems with the staff; they come around and see if I'm alright", "I take a lot of tablets but they make sure I take them" and "I have two tablets in the morning and one at night; they're given on time." A relative told us that from their observations they thought there was enough staff on duty. They said, "She's alright in here" and "They take the time to talk to my wife and she likes to talk."

We found some concerns with the management of medicines including general documentation and administration for some people. We found in some instances that people were not receiving their medicines as required. For example, eye drops for one person, eye lubricant for another, weekly prescribed medicine for two people and night sedation for one person. There were also instances when people were prescribed medicine for bowel management but this had not been given. Staff were able to provide some reasons for the omissions but these had not been consistently documented, not followed up with GPs and the medication administration records (MARs) had not been adjusted.

There were protocols in place to guide staff for some medicines used 'when required' but these were not in place for all medicines used in this way. For example, one person was prescribed a pain relief medicine and the MAR indicated they could receive 2.5 to 5mls. There was no frequency indicated on the MAR and staff recorded this was given at 9pm. In discussions with senior care workers, they were clear about the frequency and needs of the person this was prescribed for but it had not been documented. The same person was prescribed anti-inflammatory medicine but staff had become aware of a specific reason not to administer it and had contacted their GP for a review. The medicine had been temporarily stopped but there was no recorded reason why. Some people had multiple MARs which was confusing. For example, one person had six MARs with the same injection prescribed on four of them. Staff reported that each time a person required medicines outside of the usual four-weekly cycle, all the MARs were printed out by the pharmacy and sent to the service each time. This could cause potential errors and was mentioned to the registered manager to address.

These issues were a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the action we have asked the provider to take can be found at the back of this report.

There was a laminated sheet in the medicines file which provided information to staff on what assistance the person required to take their medicines. This included their preference for the type of fluid to take their medicines with and the level of thickener in fluids they needed to aid swallowing. We saw one person's protocol for pain relief described the signs and non-verbal cues the person had to indicate they were in pain.

Staff told us they received training with the supplying pharmacy. This included work booklets and computerised refresher training. Medicines were stored safely and there were systems for ordering repeat prescriptions and returning unused medicines.

We saw people who used the service had individual risk assessments completed for areas such as falls, moving and handling, the use of bed rails, nutrition, choking, swallowing difficulties and skin integrity. The tool used to score risk used codes but it was unclear what these codes meant in practice. Also in some instances we found the tool used to quantify the risk of tissue damage had not been completed correctly. For example one person had a score of one (low risk) for urinary continence but the care plan had contrary information that placed them at high risk. There were also incorrect entries regarding nutrition and weight loss. This could potentially affect the score of risk and the level of care required. There was nowhere to link the two documents together with the care plan to indicate how at risk the person was in developing a pressure ulcer. There was no guideline to indicate how often the risk score should be repeated. We mentioned this to the registered manager to address with nursing and care staff to see how risk documentation could be improved.

The service had policies and procedures in place to guide staff in safeguarding people from the risk of harm and abuse. Via discussions it was clear staff were aware of these procedures. They were able to describe the different types

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Is the service safe?

of abuse and the signs and symptoms that would alert them abuse may have occurred. Most staff had completed training and they knew what to do and who to contact when completing a safeguarding alert; some staff were due for a refresher training course. The registered manager had completed more in-depth training with the local authority and used the local safeguarding matrix tool to guide practice in determining safeguarding risk. They said they would always contact the local safeguarding team for advice and guidance.

We saw staff were recruited in line with good practice. Full employment checks were carried out before new employees could start work. In discussions with staff, they confirmed the recruitment processes. This helped to make sure only suitable staff worked with vulnerable people.

We saw there were sufficient members of staff on duty to support and care for people in ways that maintained their health and welfare. The registered manager used a specific tool to calculate the numbers of staff required. This was based on the dependency levels of people who used the service. In addition to nurses and care workers, there was a range of other staff such as activity coordinators, an administrator, maintenance personnel, cooks and catering assistants, and housekeeping staff. The staff rotas indicated who was on duty each day and night. We saw the service was using agency staff to cover nursing shortages at night. We discussed this with the registered manager who showed us recruitment was underway and until this was completed they used the same agency staff for consistency. There was an on-call arrangement to make sure staff knew which manager to contact out of hours.

We checked the environment to see how the registered manager made sure it was safe for people. The entrance had a coded lock and all exits were linked to an alarm system. There was a contingency plan in place for emergencies such as fire evacuation and all visitors signed in and out when they arrived at the service and when they left. Equipment used in the service was checked and maintained to make sure it was safe and in working order when required. Maintenance personnel were employed to complete health and safety checks and staff within the service reported issues or faults with equipment to them so they could address them quickly. We saw the laundry was accessible to people. The registered manager assured us the maintenance staff would fit a coded lock which could be activated when the laundry was not in use.

Requires Improvement

Is the service effective?

Our findings

People who used the service told us they enjoyed their meals and the staff looked after their health care needs. They said, "I like the food; I don't like butter and if they put in on my bread I won't eat it so they don't", "The food is lovely; they come and ask what you want", "The food here is brilliant; the chef is excellent", "You can have a cooked breakfast, a nice lunch and plenty to eat and drink; I nearly always only want sandwiches for tea but there are choices", "They look after me; they get the doctor and I saw the diabetic nurse the other day" and "If they think you are under the weather, they get the doctor; mine's been here twice to see me." A visitor told us there was a time when their relative was getting upset so they raised this concern with a nurse. They said, "The nurse asked the doctor to attend who prescribed some medication which helped."

People who used the service had various monitoring charts in place to record when specific care was give such as wound care, the application of creams, pressure relief, a check on air-flow mattress settings and food and fluid intake/output. We found these charts were not always completed as fully as required so it was difficult to audit if care had been carried out. We looked at records of wound care for one person who was admitted to the service with a pressure ulcer and other sore areas. The wound care records did not always identify when dressings had been completed and whether any improvement was noted, although at times this had been recorded electronically. It was difficult to audit this care had been given when records were in different places. We mentioned these points to the registered manager to check out and address with staff. The specialist professional advisor felt it would be useful for nurses to have access to a wound care journal to update knowledge and assist in decision-making about the types of dressings required for specific sore areas.

We saw people who used the service had access to a range of health care professionals for advice and treatment. Records showed these included GPs, district nurses, specialist nurses, occupational therapists, dieticians, speech and language therapists, physiotherapists, opticians and podiatrists. We spoke with four health professionals who visited the service. They told us nursing staff were busy and there had been occasions in the past when they did not always plan for visits and did not always have full knowledge of care decisions and people's needs to hand. The health professionals felt this had improved in recent months. They said, "Subsequent calls to the home have been dealt with efficiently and thoroughly by the nurse resulting in a much better impression of the care provided. From these conversations advice is now being followed in full and the client's care is appropriate to meet her needs." Other comments included, "The risk assessments need to be updated as and when the client's needs change." When asked if staff kept the health professionals informed of changes, two stated this was an area that could be improved. Another health professional was concerned they had to frequently remind staff about specific instructions. A district nurse who visited people who required residential, instead of nursing care said, "I feel senior carers have a strong knowledge base" and "Staff follow instructions to the best of their ability."

The Care Quality Commission is required by law to monitor the use of Deprivation of Liberty Safeguards (DoLS). DoLS are applied for when people who use the service lack capacity and the care they require to keep them safe amounts to continuous supervision and control. There were no people subject to a DoLS at the time of this inspection. The registered manager and deputy manager were aware of their responsibilities in relation to DoLS and were up to date with recent changes in legislation.

Training records showed that most staff had completed training in the Mental Capacity Act 2005 (MCA) and DoLS. We saw when a person was admitted to the service, staff completed an automatic assessment to check their general capacity, although some of these forms were incomplete. This was contrary to best practice, as in line with MCA, people are assumed to have capacity to make their own decisions unless assessed otherwise for specific decisions at a specific point in time. We spoke with the registered manager about this and they assured us this practice would be addressed and MCA guidance revisited. We saw best interest meetings were held for some people when a care decision was required and they had been assessed as lacking capacity to make the decision independently. These meetings included relatives and health professionals.

We saw some people had a 'do not attempt cardiopulmonary resuscitation' (DNACPR) form in their care file. It was unclear if there was a review process set up to make sure these remained valid. The registered manager

Is the service effective?

told us they would speak with people who used the service, GPs and relatives to check out the DNACPR forms. We received information following the inspection to confirm this had been done.

Staff were clear about how they gained consent from people on a day to day basis prior to carrying out care and support tasks. They said, "We ask people what they want to wear, check what toiletries they use and we'll show people choices and ask them what they think" and "It's part of our training to give choice; if they want to remain in bed or have a bed bath instead of a shower, that's fine." This showed us that staff helped people to make their own decisions.

There were means of communicating important information between the registered manager, staff, relatives and people who used the service. Staff completed handovers at each shift changeover and there were communication diaries. The registered manager told us they completed a walk round each day to check there were no concerns and to speak with people. Staff told us they contacted relatives to keep them informed of issues that affected people who used the service.

We found people's nutritional needs were met and they received treatment from dieticians when required. Nutritional risk assessments were completed and people's weight was monitored in line with this. Each person had a care plan which provided guidance to staff, such as how much support the person required, their likes and dislikes, where they preferred to sit to eat their meal and how often their weight was to be monitored. We saw one person had nutritional and swallowing needs and had been treated by a speech and language therapist. Although specific information was not reflected in the care plan, there were details of the diet and texture of food required in the person's bedroom. Staff demonstrated an awareness of the person's needs and said it was always handed over to any new staff or agency staff. The chef was also fully aware of this person's needs.

We observed the lunchtime experience for people and found this was calm and relaxed with appropriate support given to people as required. The meal served was well-presented with attention to portion size to meet people's nutritional needs and preferences.

Staff had access to training which covered those areas considered mandatory by the registered provider and those which were specific to the needs of people who lived in the service. We saw training started during an induction phase for new employees when they completed workbooks which tested their competence in certain areas. These were linked to Skills for Care common induction standards (CIS) and provided new staff with an introduction into care practices and expectations. A member of staff described the induction process, "I was shown around, shadowed staff on shifts, had a mentor and filled in a brown booklet (CIS)."

Training records were held electronically and enabled the registered manager to track the staff team's progress and to follow up when staff required refresher training. The training was completed in a variety of ways such as e-learning, with a facilitator and with work books. Staff spoken with confirmed they had enough training to help them look after the people who used the service. They said, "It's mainly e-learning but we have some face to face training such as fire, moving and handling, medicines, and MCA and DoLS", "I've completed training in activities for people and every four months the activity co-ordinators from other homes get together to share ideas", "We get letters reminding us when training is due" and "Yes, there is enough training." Nurses told us they completed clinical training such as tissue viability, wound care, taking blood, catheterisation and verification of death (only nurses who have completed this training are able to verify that, after checking vital signs, a person has died).

Staff told us they received formal supervision meetings and felt supported by the registered manager and deputy manager. There was a structure of supervision with the registered manager, nurses and senior care workers involved in the process. Staff said, "There is always someone to back you up" and "Management is open, approachable and supportive."

Good

Is the service caring?

Our findings

People who used the service were complimentary about the staff who supported them. They said staff promoted their privacy and treated them with dignity and respect. Comments included, “The staff and everything here is first class”, “They work hard and are kind to me”, “The staff are nice; I stay in bed all day if I want to”, “The staff are very good; they always tell me to ring the bell if I need them”, “It’s a home from home here”, “The staff are lovely”, “They are all nice girls”, “I have a key to lock my door if needed” and “When I first came in, all I wanted to do was die but I’ve met friendly people in here. I’ve come out of that now and I’m the strongest I’ve ever been.” A relative told us they felt involved and when asked if they thought staff were kind and caring, they said, “Yes, when I’m here and if there is anything she wants, they sort it” and “After she had been here for a while, the doctor had to see her and I was asked if I wanted to come in.”

We observed positive interactions between staff and people who used the service. Staff were polite, provided explanations prior to tasks, gave people time to respond to questions and encouraged independence during these interactions. For example, at lunchtime staff asked people if they wanted to pour gravy themselves on their meal or if they wanted assistance to do this. During lunch staff checked out if people needed assistance and if they had eaten sufficient amounts. There was a key worker system, which enabled staff to get to know people and their relatives. It was clear staff had developed friendly but professional relationships with the people they cared for. The atmosphere in the home was calm, relaxed and unhurried.

Via discussions with staff it was clear they knew how to promote privacy, dignity, choice and independence. They said, “We try to encourage people, you know if they want to wash their own hands and face; we ask them to try and see what they can do for themselves”, “We close curtains and doors and always knock on doors” and “We have a sign to use when personal care it taking place in bedrooms.” Staff demonstrated a caring approach to people who used the service and each other. One member of staff said, “One service user is new and they are a bit lost and frightened. We talk to them, make them feel safe, reassure them and hold their hand.” Another member of staff was overheard supporting a colleague when they dropped a tin of coffee which spilt over the floor.

Care records reminded staff of the importance of privacy, dignity and respect. The records seen showed us people were involved in decisions about their care. For example staff had written, “Give the option to choose the clothes they want to wear” and “Wishes to be independent and will use the nurse call when requires assistance.”

There were privacy locks on bedroom and bathroom doors and each person had a lockable facility to store personal items. Staff respected confidentiality and closed the office door when sensitive phone calls where required and when care issues were discussed.

There was information in reception about advocacy, what people could expect from the service, menus, activities, staff photographs, advice leaflets and the results of customer satisfaction survey, although this was out of date. People were involved in aspects of their care. For example, care plan review meetings, as well as general service user meetings, were held to obtain people’s views about the service. The new chef told us about a meeting held at which people requested gravy boats and sauce bottles to be placed on dining tables. We saw during lunch this request had been listened to and acted upon. People had also requested burger and chips on the menu, a wider variety of fresh fruit and a second choice to the roast dinner on Sundays. The new chef was aware of these requests and was taking action to address them.

Requires Improvement

Is the service responsive?

Our findings

People who used the service told us they received the care they required to meet their needs. They also told us they were able to raise concerns in the knowledge they would be dealt with. Comments included, "The nurses are nice, I would tell them (of any concerns)", "I would tell the manager but I've never had to go with any complaints", "I would tell one of the girls and they would sort it (complaint) out", "I'm able to carry on my social life with my family and friends; I enjoy painting and listening to Hull City (football team) on the radio", "We play games like bingo and we have singers", "I prefer to keep myself to myself; if there's anything going on in the lounges, the carers come and tell me" and "I stop up late watching TV and prefer my own room; I like my own comfy recliner chair." One person told us they would like more activities and would like to get out more.

We saw each person who used the service had received assessments, risk assessments and had a care plan which included preferences and a list of likes and dislikes. The information was held electronically and staff typed in the care they provided several times a day. The information could be printed off at any time to discuss with people who used the service, their relatives and visiting health professionals. Mostly the documents provided good information to staff on how the person preferred to be cared for but we found some areas of need had not been included in care plans and some information conflicted with others. For example, one person's daily notes referred to the use of a suction machine to help clear their airway but this was not included in the care plan. Two people had behaviours which could be challenging to others but staff did not have clear directions in how to support them when this occurred. One person required a specific arrangement of pillows to support their legs when in bed, which was devised by a physiotherapist, but this information was not readily available in their care plan. One person had specific pressure area care needs but had differing guidance about repositioning. One person had conflicting types of barrier cream to use on their skin in the care plan and on their topical medicines chart. We found this had the potential to be confusing for staff. This meant there had been a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the action we have asked the provider to take can be found at the back of this report.

We found there was lots of information about people's individual needs but this was spread out in different places and on different charts. We found there was no 'one page profile' about the person, what was important to them and how staff should care for them, which would provide staff with this information 'at a glance'. The registered manager told us this was a planned activity for January 2015. Despite the fact it was time-consuming locating some care information and some information was missing from care plans, we felt nursing and care staff knew the needs of the people they cared for.

Bedrooms were personalised and people were able to bring in items from home to make them feel familiar and comfortable. There was a lounge and dining room on each floor and a quiet room on the ground floor. There was also a hair salon on the first floor.

The service employed two activity co-ordinators and made sure at least one of them was on duty each day, seven days a week. The activity co-ordinator told us they visited new people to check out their main interests or they sought information from relatives. The information was included in individual plans. The notice board indicated a range of activities such as craft work, flower arranging, quizzes, bingo, games and reminiscence work with people who were living with dementia. Twice a month an entertainer visited the service to sing and play music to people. Some links had been made with the local community, for example church services were held in the home and choirs from local schools visited two to three times a year. The activity co-ordinator said, "Some people have newspapers and magazines delivered which stimulates topical discussions", "We do a full room visit every day to talk to people, ask if they are ok and if they've enjoyed their breakfast and see if they want to join in anything", "We take people out for a walk or to sit in the garden" and "We do activities with some service users in their bedrooms such as nail care or games." They said some relatives joined in the bingo sessions at the weekends and assisted people to play and enjoy the game.

The service had a complaints policy and procedure. This was on display in the service and included a flow chart to guide staff. Those staff spoken with told us any formal complaints were dealt with by the registered manager but

Requires Improvement

Is the service responsive?

they sorted out niggles on a daily basis. The registered manager maintained a complaints and compliments file. The records showed us complaints were taken seriously, investigated and resolved where possible.

Requires Improvement

Is the service well-led?

Our findings

People who used the service knew who the registered manager was which showed us they made themselves available and visible in the service. At the time of the inspection the service had a manager who had been registered with the Care Quality Commission since November 2011.

Although there was an internal quality monitoring system in place which consisted of audits and surveys we found the checks were not always effective. There were instances when some checks had not picked up the shortfalls which we found during the inspection and we felt these areas required more attention. For example, with risk assessments, care plans, monitoring charts and medicines management. Without thorough audits people could be placed at risk of not receiving all the care they need. We also found an investigation had not been completed into why a person developed a sore heel. These issues were discussed with the registered manager and they have assured us they would be addressed.

Some checks had been effective such as activities, training, laundry and the environment. Where shortfalls were identified action plans were produced. The registered manager completed a monthly return on a clinical governance system. This included areas such as infection control, weight monitoring, the number of pressure ulcers, safeguarding referrals, notifications to CQC, the number of deaths that occurred in the service and whether these were reported to the coroner. They also completed unannounced management visits at weekends and at night, and carried out spot checks of kitchen practices. The chef described the actions they had taken to make sure the service was up to date with new food legislation. This included notifying people of the ingredients in meals which had the potential to cause allergic reactions.

There was a tool used to report on areas such as the 'lived experience' for people who used the service, how they were involved in decisions, personalised care, staffing numbers, staff training and documentation. The registered manager told us this audit was usually completed by a registered manager from another service in the company. We checked the record for July 2014 and saw shortfalls had been identified and an action plan produced which was signed off by the area manager when completed.

The registered manager notified relevant agencies such as care management teams and continuing healthcare teams when incidents or accidents occurred and they involved the people they commissioned a service for. They also contacted CQC and the local safeguarding team to report incidents which affected the safety and welfare of people.

We spoke with the registered manager and staff team about the culture of the organisation. The registered manager showed us the registered provider's 'values, vision and customer promise – our home, your home' statement which was on display in the service. This focussed on quality, including people and responding to feedback. In discussions with staff and in records written about people we saw staff strived to meet this statement. The registered manager said, "We have an open culture; it's important to get to know staff and have good communication so if staff feel they have concerns they can come to me." There were several ways staff could raise concerns such as discussions with the registered manager and area manager, a company helpline, via human resources and whistle blowing policies and procedures. These means of feedback showed us the registered provider felt it was important for staff to have a range of avenues to raise concerns.

There was a staff reward ceremony taking place on the evening of the inspection day with 'edible and fun' prizes. Although there was a light-hearted edge to the ceremony, the registered manager said staff were recognised for their hard work and dedication. People who used the service, relatives and staff were invited, tables were set out for wine and nibbles and staff were dressed up for the evening. We spoke with a person who used the service the next day and they said, "Last night I went to the awards ceremony and really enjoyed it; all the girls were dressed up." There were other schemes to reward staff such as, 'care shopping reward scheme' where staff received discounts at certain stores and 'Gem Awards'. This was an internal award where staff could nominate each other for doing something special and they received a voucher.

The registered provider was part of a large company and registered managers had the opportunity to meet up with their peers to share information and what has worked well in other services. The registered manager told us they recently attended an internal conference to prepare them for Care Quality Commission (CQC) inspections and they had signed up to receive National Institute for Health and Clinical Excellence (NICE) guidelines. They were to look at

Requires Improvement

Is the service well-led?

how these guidelines could improve practice and documentation. An activity coordinator told us they met up with colleagues every four months to share ideas and check out what activities and occupations had worked well for people.

We saw there was a range of internal staff meetings, which included heads of departments, care staff and catering staff. The manager told us some of the meetings were not well attended and they would be re-thinking how this could be improved. There were meetings for people who used the service and for their relatives. We saw issues discussed at meetings were acted upon and information provided to people.

Surveys were completed for people who used the service, relatives and staff. Action plans were produced for areas that required improvement. The staff survey 'over to you' was due to be sent out in December 2014. The action plan devised from the 2013 survey indicated what the service does well, what could be improved and what required further investigation. The area manager checked on the progress of action plans during their visits.

In September 2014, the service had been assessed by the local authority contracts and commissioning team. This audit looked at areas such as staff training, recruitment and selection, complaints and safeguarding. The report stated the service had met the outcomes and no recommendations were made.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines How the regulation was not being met: People who used the service were not protected against the risks associated with the management of medicines. People did not always receive their medicines as prescribed. Regulation 13

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records How the regulation was not being met: People who used the service were not protected against the risks of receiving inappropriate care arising from a lack of proper information about them. Risk assessments and care plans did not contain full and up to date information to guide staff in meeting people's needs. Regulation 20 (1) (a)