Aveland Court Care Limited

Aveland Court Care 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?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Aveland Court Care Home (referred to in the report as Aveland Court) is a care home for up to 30 older people. The home is registered with CQC to provide accommodation and care for older people who may be living with dementia, have a physical disability, a sensory impairment or an eating disorder. At the time of the inspection there were 22 people living at the home.

The home is in a residential area of Babbacombe, close to the town of Torquay. The home is close to local amenities and a transport network. Accommodation is provided over two floors, with a passenger lift providing access to the first floor. Bathrooms and toilets have been fitted with aids to support people with impaired mobility. There is an enclosed garden area which is private and not overlooked.

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

This inspection took place on 17 and 18 July 2018 and the first day was unannounced. The home was last inspected in June 2017 when it was rated as 'Requires Improvement'. At that time, we identified three breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014. These related to the safe management of medicines, the environment, record keeping and out of date policies and procedures.

At this inspection, we found improvements had been made to the environment and the home's policies and procedures. However, we identified further improvements were required to the safe management of medicines as well as the quality of assessments, information and guidance provided in people's care records.

The home has a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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.

Some people had not received their medicines as prescribed and their medicine administration records (MARs) were not accurate. We found that three people had not had their medicines on more than one occasion as their medicines had not been dispensed from the blister packs. However, the MARs had been signed indicating each person had received their medicines. There was no indication whether people had refused their medicines or had not been present in the home at the time the medicines were due to be taken. This meant it appeared these people had received their medicines when they had not. We also found the storage arrangements for medicines that required stricter controls did not meet the recommended standard as advised by the Royal Pharmaceutical Society. The registered manager addressed both of these issues immediately following the inspection.

People told us they felt safe living at the home. They described the staff as kind and caring. One person said, "I've got a great team here" and another person said the staff were "great". A relative told us they felt "lucky" to have found Aveland Court and described the staff as "kind and considerate.". Another relative told us their relative was well cared for, but felt some staff were kinder than others. Our observations throughout the two days of the inspection showed staff's' interaction with people was kind and caring.

People were supported by sufficient numbers of safely recruited staff. However, at times we observed people being unsupervised for long periods of time. While people did not show any signs of requiring assistance, we saw one person became distressed and shouted at other people. We have made a recommendation that the registered manager review how staff are deployed during their shift to ensure people have the supervision they require to respond to their needs and protect their safety.

Staff told us about the people they cared for and it was clear they knew people well. They were able to describe to us how they met people's needs and minimised risks to their health, safety and well-being. However, people's care plans and risk assessments did not contain this level of detail and forms used to monitor the care people received had not been fully completed. This meant it was not possible to ascertain from people's care records what their specific care needs were or whether they had received appropriate care to meet their needs and mitigate risks.

Where people lacked capacity to make specific decisions about their care, assessments had not been completed appropriately and best interest decisions had not been recorded. However, throughout our inspection we observed staff seeking people's consent before providing care and respecting people's decisions about how and when they wished to be supported. A relative told us they were fully involved in making decisions about their relations care.

To protect people's belongings and ensure people's rooms were secure, bedroom doors had been fitted with locks. However, some of these locks would not lock open and for those people living with dementia, it had not been assessed whether people consented to their use or had the ability to open the lock and the door handle to leave their room when they wished to do so. This placed people at risk of not being able to leave their room without staff support. Following the inspection, the registered manager confirmed that people's ability to use the bedroom door handle and lock had been reviewed and adjustments had been made for some people.

People told us they enjoyed the food provided at the home. We saw the lunchtime meal on both days of the inspection. These were well presented and people told they always had enough to eat. One person said, "You'd never go hungry with this cook." While staff were aware of people's nutritional needs, care records did not provide sufficient guidance about how to support people who were at risk of not eating or drinking enough to maintain their health.

People received support with their healthcare needs. Records showed people had regular contact with their GP and the community nursing service as well as having optician and dental checks. A visiting health care professional told us people's care needs were well met by competent staff who communicated well and sought advice promptly.

The home organised a number of social activities during the week which people told us they enjoyed. During the second day of the inspection we observed people enjoying musical entertainment. We saw people singing and clapping and one person dancing with a member of staff. One person who participated in the singing told us, "I've had a lovely day."

Staff told us they enjoyed working at the home and they received the training and support they required for their role. Regular staff meetings and supervision sessions provided staff with the opportunity to discuss their work performance and make suggestions for improvements.

People, relatives and staff told us they had faith in the registered manager and found them approachable. One relative told us the registered manager communicated well and kept them fully up to date with their relation's care needs. People and relatives said they felt able to raise any concerns they might have about the quality of care with the staff and registered manager but had had no reason to do so. The registered manager told us the home had not received any complaints since the previous inspection.

The registered manager sought feedback from people and their relatives about the quality of the care and support provided at the home and acted upon suggestions for improvements. They were aware of their responsibility to keep CQC up to date with important events affecting the people's well-being.

At this inspection we identified three breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The home was not always safe.

Medicines were not always being managed safely. Some people had not received their medicines as prescribed.

Risks to people's health, safety and well-being were being managed but records did not reflect the action required or being taken by staff to minimise risks.

There were sufficient numbers of staff on duty to meet people's needs. However, staff were not deployed effectively to ensure people received an appropriate level of supervision.

Staff recruitment practices were safe.

Is the service effective?

Requires Improvement

The home was not always effective.

People's consent to receive care and support was sought on a day to day basis. However, capacity assessments for specific decisions relating to care and treatment and best interest decisions had not been properly recorded.

People received appropriate support with nutrition and hydration. However, care records did not demonstrate the support provided to those people at risk of not eating or drinking enough to maintain their health.

People were supported by staff who had a good understanding of their needs and who received training related to their role.

People's healthcare needs were met and staff had a good relationship with healthcare professionals. Advice was sought promptly and followed.

Is the service caring?

Good

The home was caring.

People received support from staff who were kind, caring,

compassionate and friendly.

People's independence as well as their privacy and dignity, were respected and promoted.

Staff respected people's wishes and involved them and their relatives in decisions about how they would prefer to receive care.

Is the service responsive?

Good

The home was responsive.

People received care and support that was responsive to their needs. However, people's care plans did not contain the level of detail necessary to ensure people received consistent care that met their preferences.

People received compassionate end of life care.

Social activities promoted people's engagement with others.

People and relatives were confident any complaints or concerns would be listened to and acted upon.

Is the service well-led?

Requires Improvement

The home was not always well-led.

Care records did not provide sufficient information about people care needs and the actions required by staff to meet those needs. Records used to monitor people's well-being had not been fully completed.

People benefitted from having a registered manager who knew them well and who sought feedback to improve the home.

Staff felt well supported by the registered manager.

Internal audits ensured the home remained safely maintained.

Aveland Court Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was 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 17 and 18 July 2018 and the first day was unannounced. One adult social care inspector undertook the inspection.

Prior to the inspection we requested, and were provided with, a Provider Information Return (PIR) from the provider. The PIR is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. Before the inspection we reviewed information held about the service and notifications of incidents we had received. A notification is information about important events which the service is required to send us by law.

During the morning and afternoon on the first day of the inspection we used the Short Observational Framework Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not speak with us. We met all of the people living in the home, although not everyone could share their views with us. We spoke with two relatives. We also spoke with the registered manager, five members of staff and a visiting health professional. We looked around the home and observed care and support being provided by staff. We looked at the care records for three people living at the service. We looked at three records relating to staff recruitment, the staff duty rota, staff training records and records relating to the running of the home.

Requires Improvement

Is the service safe?

Our findings

At the previous inspection in June 2017, we found the home did not always manage people's medicines safely or maintain complete records relating to people's care.

At this inspection, we found improvements had been made to the management of people's topical creams. However, further improvements were required to ensure medicines were stored safely and administered as prescribed, as well as to the quality of the information in people's care records.

Following the previous inspection, the home had fitted small lockable boxes to the inside of the medicine trolleys to be used for the storage of medicines that required stricter controls. These boxes did not meet the recommended standard as advised by the Royal Pharmaceutical Society. We discussed this with the registered manager who confirmed that an alternative, more suitable, lockable cupboard could be moved to a secure location and be used for the storage of these medicines. Following the inspection, the registered manager confirmed this had been done.

During the inspection we saw staff giving people their medicines. Staff asked people if they were happy to have their medicines and whether they needed any pain relief. Staff stayed with people while they took they medicines. The home used a blister pack dispensing system prepared by the local pharmacy. We checked the packs and found three people had not had their medicines at the prescribed time on more than one occasion; these medicines remained in the blister pack. However, the medicine administration records had been signed indicating each person had received their medicines. There was no indication that people had refused their medicines or had not been present in the home at the time the medicines were due to be taken. This meant it appeared these people had received their medicines when they had not.

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

Risks to people's health, safety and wellbeing had been assessed and staff were knowledgeable about people's needs and the risks associated with their health. However, the risk assessments and care plans did not provide this level of information or sufficient guidance for staff to ensure risks were mitigated. For example, one person was at risk from not eating and drinking enough to maintain their health and from developing pressure ulcers. Their care records did not guide staff about how this person's food should be prepared and whether it should be fortified. The records did not indicate how often this person should have their position changed to protect them from pressure damage. Daily monitoring forms to review how much this person ate and drank and when they had their position changed had not been fully completed. This meant it was not possible to ascertain from this person's care records what their specific care needs were or whether they had received appropriate care to meet their needs and mitigate risks.

Another person had support needs in relation to their behaviour towards others. This person's care plans said they could become frustrated and feel that they are not being understood. As a result, this person, at times, shouted at staff and other people living in the home and we saw this during our inspection. However, their care plan did not provide staff with guidance about how to manage these situations.

Failure to provide accurate, complete and contemporaneous care records that provide staff with the information and guidance they require to meet people's needs is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We spoke with staff about these two people's care. They described how they supported the person with nutritional and skin care needs. Staff were able to demonstrate their understanding of good practice. This person had also been provided with pressure relieving equipment. Our observations showed that although staff had not completed the records when they had supported this person to change their position, the person had received regular pressure area care. We saw their position had been changed during the day and they looked comfortable. A visiting healthcare professional also confirmed this person received appropriate care that met their needs. We also observed staff supporting the person with behavioural needs in a calm and sensitive way. This showed us staff understood people's needs and were supporting people in a way that minimised risks to their health, safety and well-being.

Many of the people living at the home were unable to tell us if they thought there were enough staff on duty to meet their needs. Those people who were able to share their experiences with us, told us they received prompt attention from staff when they called for assistance. However, during the inspection, we saw people being left unsupervised for periods of time. On the first day of the inspection during the morning period of our SOFI, people were unsupervised in the lounge room for 50 minutes and in the afternoon for over an hour. While people did not show any signs of requiring assistance, we saw one person, who was living with dementia and was walking to and from the lounge rooms, become distressed and shouted at other people. We also saw this person disrupting the musical entertainment on the second day of our inspection. No staff were present and the musician had to try to resolve the situation.

We discussed the staffing arrangements with the registered manager and reviewed the duty rota. In the mornings, there were four care staff on duty with housekeeping and catering staff. During the afternoons there were four care staff on duty, and overnight, two waking staff. The registered manager told us only one person required the assistance of two staff to meet their care needs, although some people required assistance to stand from their chairs. They felt these numbers of staff were sufficient to meet the needs of the 22 people currently living in the home. Staff also told us there were enough staff and they did not feel rushed when caring for people.

We recommend the home reviews how staff are deployed during their shift to ensure people have the supervision they require to respond to their needs and protect their safety.

Those people who were able to share their views with us told us they felt safe living at Aveland Court. One person told us they felt "very safe" and another said "absolutely". Staff had received safeguarding training in April 2018 and were aware of their responsibilities to report concerns over people's safety and welfare. Staff were recruited safely and underwent pre-employment checks which included obtaining references from previous employers and a Disclosure and Barring check (police check) to ensure they had not previously been barred from working in care.

The home provided a safe for people to keep their money and other valuable items in. Only the registered manager and a senior member of staff had access to the safe. The registered manager kept records of all money received and obtained receipts for all expenditure for each person. We sampled a selection of the money held for people against the records and found these to be accurate.

Infection control practices were safe and the home was found to be clean, tidy and free from offensive odours. Staff had access to gloves and aprons which we saw them use appropriately during the inspecting. All toilets and bathroom had liquid soap and paper hand towels to reduce the risk of cross infection.

The home was safely maintained. Records of equipment servicing and regular checks to ensure it remained in safe working order were undertaken. For example, the fire safety system had been serviced in April 2018 and was checked every week to ensure it remained fully functional. People were protected from environmental risks. The hot water temperature to the sinks in people's bedrooms and to the toilets and bathrooms was controlled to reduce the risk of scalds, radiators were covered and windows above ground level had restricted openings.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the home was working within the principles of the MCA. The majority of people living at Aveland Court were living with dementia and as such had limited mental capacity to make decisions about their care and support. Information in people's care plans was at times contradictory. There was no clear indication of how living with dementia affected people's day to day lives and their ability to make decisions about their care. For example, in one person's care file, their ability make decisions was described as "[Name] may lack capacity due to dementia. [Name's] diagnosis is likely to remain unchanged and is a long-term condition." However, another section of the care plan stated, "[Name] is likely to regain capacity so any decisions regarding consent to care and treatment can be delayed until then." Where capacity assessments had been undertaken, these were not decision specific. For example, one person's capacity assessment had been undertaken for "Making complex decisions or choices in her life." Another person's assessment had been undertaken for decisions about their living arrangements and having treatment for a serious health condition, rather than individual assessments for each of these decisions.

The registered manager confirmed that all the people currently living at Aveland Court would be unsafe to leave the home unescorted. To protect people's safety, the home had keypad locks on the external doors and some internal doors. They also used monitoring equipment such as door alarms and sensor mats to alert staff to people's movements. Although one relative told us they had been fully consulted over the use of this equipment, no capacity assessments or best interest decisions had been recorded to ensure these were the least restrictive option and in people's best interests. The registered manager confirmed applications had been made to the local authority to authorise the restrictions placed on people from leaving the home unescorted. Due to the high volume of applications received by the local authority, all but one of these had yet to be authorised.

To protect people's belongings and ensure people's rooms were secure, bedroom doors had been fitted with locks. However, some of these locks would not lock open and for those people living with dementia, it had not been assessed whether people could consent to these or had the ability to open the lock and the door handle at the same time. This placed people at risk of not being able to leave their room without staff support.

Failure to assess people's capacity to make decisions about their care and treatment and to record best

interest decisions is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Following the inspection, the registered manager confirmed that people's ability to use the bedroom door handle and lock had been reviewed and adjustments had been made for some people.

Our observations showed that people were able to make choices about what they did in their day to day lives. For example, people chose when they went to bed and got up, where and with whom they spent time and their choice of food. The registered manager and staff told us that staff sought people's consent when providing care and support. We saw staff asking people for their consent, such as to receive their medicine and to be supported with their personal care. For example, on the first day of the inspection, one person declined support with their personal care and staff respected this. They repeatedly asked them throughout the morning and when the person consented, they supported them appropriately. The person was not rushed or pressurised to receive support and, when ready, was happy to receive assistance. This demonstrated staff respected people's decisions.

People told us they enjoyed the food provided at the home. We saw the lunchtime meal on both days of the inspection. These were well presented and people told they always had enough to eat. One person said, "You'd never go hungry with this cook" and another said, "I need new clothes, I've put weight on since I've been here." One main meal was provided and alternatives were available should people not wish to have this. A vegetarian option was available each day.

Records showed people's weight was monitored monthly. Of the three care files we looked at, two people had lost weight over the past six to 12 months. We discussed this with the registered manager and staff. They described how they had involved people's GP and people were provided with fortified foods such as meals calorically enhanced with butter and cream. One person was also more active after they had moved into the home than when they were living in their own home. However, the care plans for these two people, did not indicate the action that had been taken to address this.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People received support with their healthcare needs. Records showed people had regular contact with their GP and the community nursing service. People were also supported to have optician and dental checks as well as attend hospital appointments. The healthcare professional we spoke with, confirmed people received good support with their healthcare needs. They said the staff informed them promptly if people needed to be seen by the GP or community nurses. They said staff were knowledgeable about people's needs and followed the advice given.

Staff told us, and records showed, staff received the training and supervision they required for their role. The home maintained a record of the training staff had undertaken and when updates were due. Staff had received training in care topics such as dementia care as well as health and safety topics such as safe moving and handling. The registered manager met with each member of staff every two months to discuss their work performance, seek their feedback and review their training and development needs.

At our previous inspection in June 2017 we found the home was not always being maintained to a satisfactory level. At this inspection we found improvements had been made. Repair work and redecoration had been carried out. Maintenance issues were recorded and a member of staff checked these regularly and undertook simple repairs. For more complex maintenance work, the home employed maintenance staff.

In June 2017, we had also made a recommendation for the home to take into account good practice guidance regarding signage to support people with dementia to orientate themselves around the home. We saw appropriate signs had been placed around the home, indicating where the toilets, bathrooms, lounge rooms and dining rooms were and some people's doors had photographs of the person on them to assist people to identify their room.

Good

Is the service caring?

Our findings

Those people who were able to share their experiences with us told us they were supported by kind and caring staff. One person said, "I've got a great team here" and another person said the staff were "great". A relative told us they felt "lucky" to have found Aveland Court and described the staff as "kind and considerate". Another relative told us their relative was well cared for, but felt some staff were kinder than others.

Although there were times during the inspection when we saw people were unsupervised, we also saw evidence of kind and caring interactions between staff and people. It was clear staff knew people well and had developed close relationships. We heard staff talking to people about their likes and preferences well as sharing jokes. At times there was much laughter and conversation. For example, one member of staff was reminiscing with one person about television advertisements and sang a theme song of an advert. The person smiled and joined in, saying they remembered.

We heard another person telling staff they felt "a bit fed up". Staff spent time with this person, listening to them and having a pleasant conversation. Afterwards the person told us, "I love it here." We observed staff to be patient and kind towards one person who had become distressed. The staff spoke quietly to the person, asked them what was upsetting them and spent time with them until they were settled. For one person being cared for in their room due to their frail health, staff had placed meaningful items and photographs around their bed which they knew were important to the person. For example, they had several teddy bears to hold and pictures of family members had been placed on the wall for them to look at.

Staff told us how much they enjoyed working at the home. Many staff had worked at the home for several years. One said, "I love it here" and another said the staff treat people as if they were their own parents. Staff were aware of people's spiritual, religious and cultural needs and respected these.

People's care plans contained information about their past social history, such as their earlier adult life, their family and their employment. Staff said they used this information to engage with people. They told us they supported people to remain as independent as possible and to do as much for themselves as they were able. However, people's care plans did not describe what people were able to do for themselves and how staff should offer support in a way that encouraged them to do as much for themselves as possible. The registered manager gave assurances this information would be added as they would be reviewing each person's care plan following this inspection.

People's privacy and dignity were respected and promoted. We saw staff knocking on people's doors before entering and supporting people's discreetly with their personal care and toileting needs.

People were supported to maintain contact with friends and family. A visitor told us they could visit at any time and were always made welcome. A member of staff said the home valued people's relatives and saw them as part of the home's "family".

Good

Is the service responsive?

Our findings

People received care and support that was responsive to their needs. Those people who were able to share their experiences with us, told us they felt well cared for. One person said, "I've got everything I need. You only have to ask and it's done for you." Another person said, "Everything's really good for me." Staff told us the routines in the home were flexible and people could get up and go to bed when they wished. We saw people being supported throughout the morning with their personal care and being offered breakfast either in their room before they got dressed or afterwards when they were in the dining room.

Each person had a care plan that identified their care needs. The plans identified specific needs in relation to a variety of care topics such as personal hygiene, continence care, nutritional and hydration and mobility needs. Staff told us about the people living in the home and it was clear they knew their likes, dislikes and preferences. However, we found the care plans did not contain the level of detail described to us by staff. This meant that staff new to the home and unfamiliar with people's care needs would be reliant on the home's care staff to inform them of people's care needs. The care records would not provide them with the information they needed care for people in a safe and consistent way. For example, one person's care plan stated they required "full assistance" with personal care tasks as well as with getting dressed. Other than the use of equipment needed to support them to have a bath, the care plan did not describe how staff should provide support.

Another person's care plan described them as "unable to assist with dressing herself and will require total assistance, she also experiences discomfort whilst dressing." However, there was no information or guidance for staff about how to assist the person in a way that would lessen their discomfort, or whether staff should offer pain relief prior to assisting this person with their personal care and with dressing. We observed this person's care throughout the two days of the inspection. Each day staff were attentive to their needs and the person looked comfortable and did not show any signs of discomfort or distress.

Care plans had been reviewed regularly, with the person they related to and with their relatives but this had not identified the lack of guidance and information.

We discussed the lack of detail in people's care plans with the registered manager and they gave assurances all the plans would be reviewed immediately following the inspection.

Aveland Court was able to care for people at the end of their lives. Where known, people's care wishes for their end of life care were recorded in their care plans. Staff were supported by the community nursing team to meet people's increased care needs at these times. The home had received a number of thank you cards from relatives expressing their thanks for the care provided to their relations. Two recent cards thanked staff for their "devotion and love" and for the "kindness and compassion" shown to the person and their families.

People told us they enjoyed the activities provided by the home. During the second day of the inspection we observed people enjoying musical entertainment. We saw people singing and clapping and one person dancing with a member of staff. One person who participated in the singing told us, "I've had a lovely day."

People said the home organised musical entertainment three times a week, one of which was with exercises. At other times staff encouraged people to join in with quizzes and ball games. One person said they liked to watch a particular television programme every day and staff made sure the television was turned to the right channel. People were also supported to go out of the home to local places of interest. Two people told us how much they had enjoyed a recent trip to the local shopping centre. The home had an enclosed garden with a pleasant patio area and people told us they enjoyed sitting outside.

For those people who did not choose to, or were unable, to be involved in these group activities, records did not identify whether they received staff attention other than when being assisted with their personal care. For example, one person's care plan said, 'It's possible that she is only aware of the current moment, so providing gentle stimulation and companionship that she can enjoy will improve the quality of her life.' However, this person's daily care notes for the week before the inspection did not show that staff had spent any time with them other than when being assisted with care related tasks. The registered manager said this was a recording oversight as staff often spent time with this person sitting next to them and holding their hands and talking to them.

All providers of NHS and publicly funded adult social care must follow the Accessible Information Standard. The Accessible Information Standard applies to people who have information or communication needs relating to a disability, impairment or sensory loss. CQC have committed to look at the Accessible Information Standard at inspections of all services from 1 November 2017. Care plans identified people's communication needs and provided staff with guidance about how to communicate effectively with them. For some people staff were guided to be observant of body language and facial expression as some people had limited verbal communication.

People and relatives told us they felt able to raise any concerns they might have about the quality of care with the staff and registered manager but had had no reason to do so. People were provided with a copy of the home's complaints procedure and we saw this was available in people's bedrooms. The registered manager told us the home had not received any complaints since the previous inspection.

Requires Improvement

Is the service well-led?

Our findings

The home had a registered manager in post. 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 home is run. People, relatives and staff told us they had faith in the registered manager and found them approachable. A member of staff described the registered manager as "great". One relative told us the registered manager communicated well and kept them fully up to date with their relation's care needs.

At the previous inspection in June 2017, we found some of the home's care records were not being well maintained and the home's policies and procedures were out of date. At this inspection, we found some improvements had been made. The policies and procedures had been updated and the registered manager had a timescale of reviewing and updating these throughout the year. However, we found improvements were still required with the quality of information held in people's care files and with the use of records to monitor people's well-being.

This is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The registered manager was supported by a senior member of staff who took on management responsibilities two days a week as well as a team of senior staff who managed each shift. Staff were aware of their responsibilities and roles. Staff told us the communication between themselves, the senior staff and the registered manager was very good. Handover meetings between shifts and communication books ensured important information about people's care needs was shared within the staff team. Regular staff meetings allowed the registered manager and staff to discuss issues related to the running of the home and to share ideas about improvements. The registered manager and senior staff provided out of hours 'on-call' support for staff to ensure they always had a senior member of staff to seek advice from.

The registered manager used a variety of ways to seek feedback from people and their relatives about the quality of the care and support provided at the home. They met informally with people, assessing their satisfaction through conversation and observations, they met with relatives when they visited the home and they used surveys. The most recent surveys from March and May 2018 showed a high level of satisfaction with the home. People and relatives were invited to meet with the registered manager every month to discuss events in the home and to make suggestions.

The registered manager undertook regular audits of the environment to ensure the home was well maintained and safe. The registered manager also kept records of any accidents occurring in the home to monitor people's well-being. An accident form was completed by care staff at the time of the incident and reviewed by the registered manager. Individual records were maintained to allow the registered manager to assess the type and nature of any accidents and whether there was an increase which might indicate a change in people's health or abilities.

The registered manager said they were well supported by the registered providers. They met with them every three months and had discussions over the telephone every day. The registered manager kept up to date with developments in the care profession by attending meetings with other care providers and accessing the local authority's and CQC websites. They were aware of their responsibility to keep CQC up to date with important events affecting the people's well-being.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider has failed to ensure capacity assessments and best interest decisions were recorded in adherence with the Mental Capacity Act 2005 code of practice. 11(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure the proper and safe management of people's medicines. 12(2)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure the home maintain accurate, complete and contemporaneous records in relation to people's care and treatment. 17(2)(c)