

HC-One Limited

Moss View

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 

Summary of findings

Overall summary

This inspection took place on 3 and 4 July 2018 and was unannounced.

Moss View 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. The home is situated in the Huyton area of Liverpool. It provides, residential, nursing and dementia care for up to 78 people and at the time of the inspection there were 71 people living in the home.

A registered manager was 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 service is run. We asked people their views of how the home was managed and feedback was positive.

The environment was not always maintained safely. The home's electrical system had been checked and found to be unsatisfactory and we saw a number of fire doors wedged open.

Risk to people was not always assessed and managed appropriately. Risk assessments had not all been accurately completed to ensure the level of risk people faced was known and actions could be taken to reduce that risk.

Although medicines were stored safely, we found that they were not always managed safely as directions were not always clear and guidance for safe administration was not always followed.

Some applications had been made to deprive people of their liberty lawfully, however the registered manager told us there were a number of applications still to be made. These were completed before the end of the inspection. Not all conditions on the authorisations in place had been met.

Consent was not always gained and recorded in line with the principles of the Mental Capacity Act 2005 (MCA). Not all staff had a good understanding of the MCA and how to record agreements to care when people were unable to provide their consent.

Care plans did not all contain sufficient detail to inform staff of people's needs and how they should be met and did not all reflect the current support being provided to people.

We looked at the systems in place to monitor the quality and safety of the service and found that they were not always effective as they did not identify all of the issues highlighted during the inspection. When areas for improvement were identified, it was not always clear whether actions had been taken to address them.

People told us they felt safe living in Moss View. Staff were aware of safeguarding procedures and how to raise concerns and accidents were recorded and analysed. Feedback received regarding staffing levels was mixed. We saw that staff were busy during the inspection, but were able to meet people's needs. Staff had been recruited safely to ensure they were suitable to work with vulnerable people.

Staff were supported in their roles through induction, supervision and regular training. Staff told us they felt were supported and were able to raise any concerns with the registered manager.

People told us they had enough to eat and that they always had a choice. People were provided with support when needed. Staff were aware of most people's individual dietary requirements.

Some steps had been taken to ensure the environment was suitable for people, though some areas required further refurbishment. The registered manager told us they had plans in place to make the environment more dementia friendly.

People living in the home, their relatives and visiting health professionals told us staff were kind and caring and treated people well. Staff were aware of people's needs and preferences and how they liked to spend their day. We saw staff provide support in ways that protected people's dignity.

People agreed that staff supported them to remain as independent as they could be and records of care showed that staff respected people's decisions.

People's family and friends were able to visit at any time and were made welcome by staff. If people did not have family or friends to support them, details of local advocacy services were available.

Staff worked closely with health professionals to support people at the end of their lives.

A range of activities were available and people told us they enjoyed them. People had choice over how they spent their days.

A system was in place to manage complaints and people were aware of how to raise any issues they had. The registered manager held meetings and issued surveys to gather feedback from people.

A range of policies and procedures were available to guide staff in their role and staff told us they enjoyed working at Moss View.

Ratings from the last inspection were displayed within the home as required.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement ●

The service was not always safe.

The environment was not always maintained safely.

Risk to people was not always assessed and managed appropriately.

Medicines were not always managed safely.

Staff were aware of safeguarding procedures and how to raise concerns. They had been recruited safely and there were enough staff on duty to meet people's needs at the time of the inspection.

Is the service effective?

Requires Improvement ●

The service was not always effective.

Not all required applications had been made to deprive people of their liberty lawfully. Not all conditions on the deprivation of liberty authorisations had been met.

Consent was not always gained and recorded in line with the principles of the Mental Capacity Act 2005 (MCA).

Staff were supported in their roles through induction, supervision and regular training.

People told us they were happy with the meals available.

Is the service caring?

Good ●

The service was caring.

People told us staff were kind and caring and treated them well. We saw staff provide support in ways that protected people's dignity and promoted their independence.

Care files were held securely in locked offices to protect people's confidential information.

People's family and friends were able to visit at any time and were made welcome.

Is the service responsive?

The service was not always responsive.

Care plans did not all contain sufficient detail to inform staff of people's needs and how they should be met and did not all reflect the current support being provided to people.

Staff worked closely with health professionals to support people at the end of their lives.

A range of activities were available to people.

A system was in place to manage complaints and people were aware of how to raise any issues they had.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Systems in place to monitor the quality and safety of the service were not always effective.

A range of policies and procedures were available to guide staff in their role and staff told us they enjoyed working at Moss View.

Systems were in place to gather feedback from people living in the home and their relatives.

Ratings from the last inspection were displayed within the home as required.

Requires Improvement ●

Moss View

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 July 2018 and was unannounced. The inspection team included an adult social care inspector, an assistant inspector 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 care service.

Before our inspection we reviewed the information we held about the service. This included the statutory notifications sent to us by the provider about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We also contacted the commissioners of the service to gain their views.

We used all of this information to plan how the inspection should be conducted.

During the inspection we spoke with the registered manager, area director, a visiting manager, 16 people living in the home, four relatives, a visiting health professional, regional training and development managers, hospitality specialist, three members of the care staff, an administrator and an activities coordinator.

We looked at the care files of eight people receiving support from the service, four staff recruitment files, medicine administration charts and other records relevant to the quality monitoring of the service. We also observed the delivery of care at various points during the inspection.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Is the service safe?

Our findings

We looked at how the environment was maintained. Prior to the inspection we had received concerns from Merseyside Fire Service about fire safety procedures. We could see that most of the recommended improvements had been completed. We found that external contracts were in place in areas such as gas, fire safety equipment and lifting equipment. The electrical system had been checked in April 2018 and was found to be unsatisfactory. We saw that a contractor had been arranged to complete the necessary works and these were due to commence later in the month.

When we looked around the home we saw a number of fire doors that were wedged open. This meant that they would not close in the event of a fire. The registered manager told us the automatic closure devices needed repairing and we saw that these were fixed by the end of the second day of the inspection. We also observed a store cupboard with chemicals stored within it that was unlocked. The lock was broken and this meant that vulnerable people had access to the chemicals that could cause them harm. We raised this with the registered manager and the lock was fixed during the inspection.

We looked at how risk to people was managed. Care plans showed that risk assessments had been completed in areas such as malnutrition, skin integrity, falls and risks relating to choking. We found however, that these assessments had not all been completed accurately. For example, one person's file included a risk in relation to pressure sores. The person's body mass index had been inaccurately recorded on this and their nutritional risk was not reflected. The choking risk assessment did not reflect the person's needs in relation to the support required to eat and drink, or their cognitive impairment. This meant that the risks had not been accurately assessed.

When risks were identified, we saw that it was not always clear if actions had been taken in a timely way to reduce the risk. For instance, one person's malnutrition risk assessment showed that they had lost weight each time they had been weighed since November 2017, however, a referral to the dietician for advice was not made until May 2018. At the time of the inspection the person had not been assessed by the dietician and care plans did not provide information as to how the ongoing risk was being managed. Staff we spoke with were aware of the person's dietary needs and told us their meals were fortified whilst waiting further advice from the dietician. On the second day of inspection, a member of the management team informed us that a new protocol had been created to advise staff when to make referrals to the dietician and what to do to minimise risk whilst waiting for the review.

We looked at how medicines were managed and found that they were stored securely in locked clinic rooms. Staff had completed training and had their competency assessed to ensure they could administer medicines safely. A policy was also in place to help guide staff in their practice. We found however, that medicines were not always managed safely. For example, one person's medicine administration chart (MAR) showed that they had a medicine administered through a patch on their skin. The directions stated not to use the same area of skin for 14 days, however staff were recording only two areas where the patch was applied. This meant the patch was applied to the same area every two days. This meant that the medicine was not administered as it had been prescribed.

Another person's MAR chart advised a medication to be administered "As directed." A staff member explained how they had decided this should be administered every three days, however the MAR charts showed it had been administered every four days. They agreed to contact the GP and obtain clear instructions as to how often the medicines should be administered and we saw that this request had been made by the end of the inspection.

When medication was prescribed as and when required (PRN), we found that there was not always protocols in place to ensure all staff were aware of the signs to indicate when the person required the medicine.

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

Feedback received regarding staffing levels was mixed. People's comments included, "When you call for help, it does not take too long at all", "Some days are better than others, but mostly staff are doing their best to look after so many of us, it must be hard on them" and "Responding to buzzers is very variable, staff may be busy with another patient, but I am not concerned at all, because I know they will come to me before long." Relatives told us, "Staff work together very well, everybody, even the unit manager mucks in, there is less agency now" and "They could do with more staff, more so they can focus on accompanying residents into the new garden, so it can be used more often." A visiting health professional told us they felt more staff were required due to the layout of the building. Staff told us, "I think you have never got enough staff. We do have a lot of staff in the morning" and "Staffing levels can be a bit of a struggle in the afternoon. We have more night staff now, that has made a difference." During the inspection we heard that call bells answered in a timely way and saw that staff were busy, but available to support people when they required it.

Most people we spoke with told us they felt safe living in Moss View. Their comments included, "Let's put it this way, I am in no fear of anyone doing me harm", "I have no issue with staff, they are brilliant, they keep me safe" and "Staff are always checking if you are ok." Relatives we spoke with agreed and told us, "The home has done a brilliant job with [relative], I know she is safe, I have peace of mind" and "We could not ensure [relatives] safety at home but here they do."

We spoke with staff about adult safeguarding, what constitutes abuse and how to report concerns. Staff were aware of the safeguarding procedures and how to raise any issues. One staff member told us, "Safeguarding to me is reporting any concerns about the way people are being treated. It is your duty of care to protect people. I would alert my line manager. If I had to take it further, I would go to the manager, then 'HC-One', then CQC." A copy of the local authorities safeguarding policy was available and we found that appropriate safeguarding referrals had been made to the local authority for investigation. The registered manager had a system in place to oversee all safeguarding incidents and this helped to ensure that appropriate actions were taken. We saw that accidents were also recorded and appropriate actions taken to reduce the risk of recurrence.

Staff said they understood the concept of whistle blowing and we saw that a poster was on display within the home that included telephone numbers. Whistleblowing is where staff can raise concerns either inside or outside the organisation without fear of reprisals. An equality and diversity policy was also in place which helped protect people from discrimination. This helped to raise staff awareness and ensure that people were not discriminated against regardless of their age, sex, disability, gender reassignment, marital status, race, religion or belief or pregnancy, as required under the Equality Act 2010.

We looked at how staff were recruited within the home. We looked at four personnel files and evidence of

application forms, photographic identification, appropriate references and Disclosure and Barring Service (DBS) checks were in place. DBS checks consist of a check on people's criminal record and a check to see if they have been placed on a list for people who are barred from working with vulnerable adults. This assists employers to make safer decisions about the recruitment of staff.

We saw that staff wore gloves and aprons when supporting people or serving meals. This helped to prevent the spread of infections. Bathrooms also contained liquid soap and paper towels in line with infection control guidance. We saw however, that some pieces of equipment, such as hoists, were visibly dirty. We raised this with the registered manager who arranged for all equipment to be cleaned and added this to the system of regular checks in place. We saw that equipment had been cleaned by the end of the inspection.

Is the service effective?

Our findings

We looked to see if the service was working within the legal framework of the 2005 Mental Capacity Act (MCA). 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 make 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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw that five authorisations were in place and other applications had been to the local authority. The registered manager told us there were more applications that they needed to make, but had not been made. We discussed the need for these to be made as soon as possible and the registered manager confirmed they had been submitted by the end of the inspection.

A system was in place to monitor when applications had been made, when the authorisations were due to expire and whether there were any conditions attached to the authorisation. We found however, that these conditions were not always known or met. For instance, one person's authorisation included a condition for the person's needs to be reviewed in May 2018, to establish if the agreed restrictions were still required to maintain the person's safety. However, there was no evidence this had been completed and the registered manager confirmed it had not taken place. Not all staff we spoke with were aware who had a DoLS authorisation in place.

None of the care files we viewed contained any consent to people living in the home or receiving the care and treatment planned for them. We found through discussions that not all staff had a good understanding of the MCA and how to record agreements to care when people were unable to provide their consent due to cognitive impairment. We saw that when applications had been made to deprive people of their liberty, there was not always a mental capacity assessment completed to establish if they were able to make this decision themselves.

We raised these concerns with the registered manager and the regional training and development manager visited the home during the inspection and explained they would create a specific training course for staff to cover the areas of concern identified. This training was arranged before the end of the inspection.

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

Staff we spoke with told us they were well supported in their roles. They completed an induction when they commenced in post and records showed that all staff had received a formal supervision recently. Staff told us they got to talk about what was important to them during these meetings. Staff also told us they had a mentor. A mentor is someone who helps a colleague to learn and develop professionally.

Records showed that training was available to staff to support them in their role. We saw that most staff had completed training in areas such as care planning, moving and handling, nutrition and hydration, dementia, person centred care, fire safety, dignity, mental capacity and DoLS and falls awareness. This helped to ensure that staff had the necessary knowledge and skills to meet people's needs. During the inspection we observed staff supporting people to transfer using equipment and we saw that this the equipment was used appropriately.

The home had also recently introduced a nursing assistant role, to support registered general nurses and provided these staff members with additional training in preparation for this. One staff member told us, "The training I had was interesting, it made what I knew more formal. We were trained in medications, ordering and giving them. We also trained in writing care plans, 'daily living and well-being', communication with families and doing simple wound dressings under supervision."

Care plans were in place to inform staff of people's needs and how they should be met and included any equipment that people required to ensure they received safe and effective care. We saw that people had access to hoists, wheelchairs, specialist mattresses, bath hoists and raised toilet seats. Staff in the home also had access to relevant legislation and best practice guidance, to enable them to provide the most effective care to people.

Staff worked with other health care professionals to maintain people's health and wellbeing. The care files we looked at showed people received advice, care and treatment from relevant health and social care professionals, such as the GP, mental health team, community matron, optician, district nurse, dietician and speech and language therapist. Care plans also showed that people's health was monitored regularly, such as their weight, blood pressure and temperature. People living in the home told us staff arranged appropriate health advice when it was needed. Their comments included, "If I need a doctor, I ask staff", "When I was not feeling well, staff called the doctor for me, I got new medication" and "I get a GP when I request one." Relatives we spoke with told us they were kept up to date with any changes in their family members health and wellbeing.

We joined people for lunch on the first day of the inspection. We saw that people could choose where to have their meals and staff offered a choice of meals. There were at least six different meals served due to people's preferences. When people required support to eat their meals, we saw that this was provided in a dignified way and people were not rushed. People told us they had enough to eat and were happy with the food available to them. Their comments included, "It could be better but mostly the food is delicious", "I don't go hungry, there's is always plenty of choice, "Whatever I fancy, staff give me" and "Someone comes in my room every day to ask what I want to eat, if I don't like it, they change it." Snacks and cold drinks were available throughout the day in the lounges.

Staff were aware of most people's individual dietary requirements, however not all staff were able to accurately describe how people required their drinks to be thickened if they had a swallowing difficulty. Specialist diets were catered for and these included, diabetic, fortified and pureed diets, as well as nutrition administered through a percutaneous gastrostomy tube (through a tube directly into the stomach). When there was a concern about people's intake, diet charts were maintained to monitor what they ate and drank.

We looked to see if the environment was suitable to meet people's needs. Corridors were wide with handrails for people to use. One lounge had recently been refurbished which provided a large, bright space for people to socialise or watch television. Other areas of the home however, were tired looking and required some attention. The registered manager told us they hoped to refurbish more areas of the home in the near future.

One unit within the home supported people living with dementia. Some steps had been taken to ensure the environment helped people to remain safe and orientated, such as the use of pictorial signs for commonly used areas, such as the bathroom. A new seating area had been created in the garden but this was not currently in use. We saw that a number of clocks were on display within the unit, but they all showed different times. This could be confusing for people. The registered manager told us they had plans in place to make the environment more dementia friendly.

Is the service caring?

Our findings

People living in the home told us staff were kind and caring and treated them well. Their comments included, "[Staff] are very supportive", "I am happy to be here, staff are fantastic", "We are treated very well", "[Staff] are simply fantastic" and "Staff are very respectful, very considerate." Relatives we spoke with agreed and told us, "Staff are brilliant, they treat everyone like family" and "Standards of care are very good." A visiting health professional told us "Staff seem genuine and caring."

It was clear through discussions that staff knew the people they were supporting well, including their preferences. Care plans provided information regarding how people liked to spend their day and what was important to them. We asked staff how they supported people as individuals with their own diverse needs, for example religion, race, gender, sexual orientation, age or disability. A staff member told us, "We have different religious services on offer. People can attend holy communion for example. But we have also worked with Baptist churches." Staff also mentioned that a vicar came into the home regularly. There was also an equality and diversity policy available which raised staff awareness and helped to ensure that support was provided in line with the Equality Act.

During the inspection we saw that people's dignity and privacy was respected by staff. For instance, we observed staff knocking on doors before entering and personal care was provided in private areas with doors closed. We spent some time in a lounge observing interactions between staff and people living in the home and heard staff speak warmly to people and in a way that they could understand. Staff told us they were very aware of people's dignity and one staff member said, "I treat people the way I want to be treated. We are not carrying out personal care in front of others and we always encourage independence." Care files were held securely in locked offices. This meant that people's confidential information was only accessible to those people who needed to see it.

People agreed that staff supported them to remain as independent as they could be. One person told us they were unable to do as much for themselves anymore, but said, "I like it when staff give me a chance to use what I got." Another person told us, "Staff always encourage me to do whatever I still can do." Care plans we looked at reminded staff to encourage people's independence and to ensure people were offered choices. One person's care plan reflected that they chose to spend most of their time in bed and another person's care file explained that despite professional advice, they chose not to eat a specialised diet. Risks regarding this had been assessed and discussed with the person. This showed that people's views and decisions were respected by staff.

When people moved in to the home, they were provided with a service user guide and other relevant information regarding the home and what could be expected when living in Moss View. Notice boards around the home provided information on activities available, menus, advocacy services and local church services. This showed that people were given information and explanations regarding the service to enable them to be involved and make decisions.

When people required support to make decisions and did not have friends or family to assist them, local

advocacy services were contacted. An advocate is a person that helps an individual to express their views and wishes, and help them stand up for their rights. At the time of the inspection there were people receiving support from advocates.

We looked to see how people were involved in the development or review of their care plans. Not all people we spoke with remembered seeing their care file, but did tell us care was discussed with them and that they were happy with the support they received. People told us, "I was in a meeting with my doctor recently and [family member] was there as well", "I can't remember [about care planning] but I think my daughter is involved in all that sort of thing" and "My children take care of all that." Relatives agreed that they were involved in people's care and kept up to date. Their comments included, "I attended a review meeting for my [relative], staff will let you know well in advance", "We always have meetings, staff let us know in advance", "I attend all my [relative's] care reviews" and "If I ask staff to see my [relative's] care plans, they will let me."

We found that people were supported by staff to communicate their needs. Care files included a communication plan so that staff were aware of how people communicated most effectively. Regular optician appointments were arranged for people with visual impairment and the registered manager told us they had access to large print policies and could order information in braille should this be required. They also planned to order menus in picture format to help people who were unable to verbalise their choice or preference.

We saw friends and relatives visiting throughout the inspection and all those we spoke with told us they could visit at any time and were always made welcome. There were no restrictions on visiting and people were encouraged people to maintain relationships they had built in the community before moving into the home. This helped people to maintain relationships that were important to people and prevent isolation.

Is the service responsive?

Our findings

We looked at people's care files and saw that they included care plans in areas such as communication, personal care, mobility, eating and drinking, medicines, continence, activities and skin integrity. The plans included information regarding people's care preferences and had been reviewed regularly. However, we found that they did not all contain sufficient detail to inform staff of people's needs and how they should be met. For instance, we viewed the plan for a person who required oxygen and the care plan did not inform staff how many hours per day this was required, or at what rate of flow. Staff we spoke with were aware of how this should be administered. Another person had a diagnosed breathing condition and had received treatment at hospital recently due to this. However, there was no plan of care in place regarding their breathing difficulties or how these were managed. A third person had diabetes and this was not reflected in their eating and drinking care plan, although they did receive an appropriate diet. Staff were aware of people's needs and we saw that they were receiving the care they required, but care plans required updating to ensure all staff had access to up to date information regarding people's needs.

Care plans did not all reflect the current support being provided to people. For instance, one person's care file indicated that they had been provided with a specialist mattress to help prevent pressure sores developing. However, this information was not recorded within their skin integrity plan.

We saw that care plans had regular reviews. These asked for the involvement and views of the person and their family. We found that reviews of care plans did not always lead to new or rewritten care plans. At times important information was noted in the review section at the back of a care plan, rather than in the main care plan. This meant that information at times was contradictory and not clear.

This meant that there was a risk staff would not have access to up to date information regarding people's needs and how they should be met. We raised these concerns with the registered manager and the care plans were updated straight away.

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

Some of the care files we viewed contained advanced care plans, which described what support people wanted to receive at the end of their lives and where they wanted to receive it. Staff told us they worked closely with the district nurses when people were reaching the end of their life, to ensure the support they provided was appropriate. This showed that discussions regarding people's end of life wishes had been held and staff would be able to meet people's needs and preferences when the time came.

Staff told us they were kept informed of any changes in people's needs through daily handovers and reading care plans. Handover sheets were updated during the inspection to include information that was essential for staff to be aware of, to safely support people. We saw that care plans included pre-admission assessments. This helped to ensure that staff were aware of people's needs and that they could be met effectively from the day they moved into the home.

We spoke to the registered manager about activities available to people, as surveys showed this was an area that people would like to see improved. The registered manager told us that two activity coordinators were in post and they were in the process of recruiting a third. There was a minibus available but this was only used to take people to appointments and not for days out.

We saw that an activity schedule had been created and included singing, crafts, games, films and themed events. External entertainers visited the home regularly. There was a record player and vinyl records available in the quiet lounge for people to enjoy and a dog visited each week for pet therapy. They visited during the inspection and we saw people responded to the dog in a positive way; smiling, petting the dog and giving her treats and they were much more engaged than they had been before the dog's arrival. We also observed a musical quiz, pampering, pampering, painting plant pots and a singalong.

We asked people their views on activities and their comments included, "I enjoying my music activities", "[Activity coordinator] got me to watch my favourite concert on a big screen", "I do crosswords but I love a bit of a laugh, we are all friends in here", "I like to sit outside in the garden, it's only small, we are not allowed to go into the bigger garden, we have to go through the kitchen and it is always locked", "I like to go out shopping with staff", "I don't go out much, don't want to, what good does going out achieve, if you got everything you need in here?", "I like staying in my room, the girls come in, we have a laugh, they bring me cross words, I watch a bit of telly, I don't feel isolated" and "I don't go anywhere, as I get older it is a struggle even to get into my chair, but staff are very good, they sit with you, we have a laugh, play games, they bring their tablet and we google places of interest." Relatives told us, "my wife loves singalong, she comes alive" and "There is always something going on."

People told us they had choice in how they spent their time during the day, where they ate their meals, or whether they wanted to participate in activities. Staff we spoke with agreed and told us people always had choice, such as when to get up or got to bed and when they had a bath or shower and that these choices were always respected. A relative told us, "My [relative] prefers to be attended to by male staff and the manager made sure it happened."

Technology was in use within the home to help ensure people received effective care in a timely way. For instance, we saw that call bells were available to ensure people could call for staff if they needed help. A virtual nurse system was also used to enable staff to access healthcare advice via a computer 24 hours per day. Sensor mats were also in place for some people who were at risk of falls. These helped to ensure people received timely care and helped them to remain safe as staff were alerted when they got up.

A complaints procedure was on display within the home and the registered manager maintained a log of any complaints received. Those we reviewed showed that they had been investigated and responded to appropriately. People we spoke with told us they knew how to raise any concerns and would be comfortable raising them with staff. People told us, "I would definitely tell someone if I was not happy", "If I have got concerns I ask for the manager" and "When I need things straightening out, I tell my [relative], they will sort it out." Relatives were also aware how to raise any concerns they had and told us, "I never complain, I am outspoken, I speak it the way I see it, I am all that my [relative] has, if I don't speak up for [relative], no one will", "There is always someone around, it makes it easy in the event you are concerned about something", "I won't be afraid to say something if I see something going wrong with [relative] or with someone else. If they don't listen I will go higher" and "The manager is always available."

Is the service well-led?

Our findings

We looked at the systems in place to monitor the quality and safety of the service. The provider employed a team of quality assurance personnel to undertake checks within the service. These resulted in recommendations being made on how the service could be improved. The registered manager told us these recommendations were added to the service's action plan so that they could be monitored by the management team and head office.

We saw that audits were completed in areas such as accidents, medicines, care plans, catering and health and safety. We found however, that these audits did not highlight the issues that we identified during the inspection, such as those relating to medicines, the environment, consent and care plans. This led us to question the effectiveness of the audits.

When issues had been identified in the audits, we saw that actions had not always been taken to address them. For instance, one person's care file audit showed that their resident profile required completion and body maps updating. There was no action plan to identify these issues or show if they had been completed. Another person's care file audit identified that the use of oxygen should be added to a specific care plan. We checked this care plan and saw that the action had not been completed. The care plan audit prompted staff to review the do not attempt resuscitation order if one was in place. One person did have this in place and the care plan audit had been completed with the review date of the order. However, the audit failed to identify that the order had not been signed by a GP and was therefore not lawful. The registered manager arranged for the order to be signed by a GP by the end of the inspection and completed an audit of all other DNAR orders to ensure they were lawful.

This meant that systems in place to monitor the quality and safety of the service were not effective and it would be difficult to maintain oversight of the required improvements and know if they had been actioned.

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

The home had a registered manager in post. We asked people their views of how the home was managed and feedback was positive. People told us, "The general manager is approachable; the unit manager is on hand and is always helping staff, it's nice to see that happening", "I spoke to the manager; he seems like a good one", "The manager seems to be doing a good job, I think it is getting better and better" and "There is a chap [manager], he came to see me, he is not bad, very nice."

Staff told us they felt well supported by the registered manager. One staff member said, "[Registered manager] is doing ok. If I have any queries, he will help. He will listen and I feel listened to." Most staff told us they had attended staff meetings and were able to share their views during these meetings. There were also daily 'flash' meetings that included the head of each department. This enabled any key pieces of information to be discussed and actions agreed. It enabled the registered manager to be kept informed of the day to day practices within the homes and any concerns could be addressed quickly.

We asked staff to describe the culture of the service, what it was like to work at the home. Staff told us they enjoyed working in the home and that they all worked well together as a team. One staff member told us, "It is a friendly service, not 'cliquey'. It is 'manager-run' and team-run. We all want to provide the best care we can." Staff were aware of the responsibilities of their roles and the general aims of the service.

A range of policies and procedures were available to guide staff in their role. A whistleblowing policy was also in place which staff were aware of and told us they would not hesitate to raise their concerns. Having a whistle blowing policy helps to promote an open culture within the home.

We asked people living in the home what the atmosphere was like. They told us, "I would rather be here than anywhere else, my family loves the place, it is good for me", "the atmosphere is good, we get along well with each other", "the staff is very nice here, they make this home credible, it is the best place" and "the place is homely." Relatives agreed and told us, "The atmosphere is good, my [relative] likes it here", "This is the best place for my [relative], he is looked after well, the atmosphere is brilliant!" and "Regular staff deserve a medal, they make the atmosphere."

Systems were in place to gather feedback from people living in the home and their relatives. This included quality assurance surveys and resident and relative meetings, although not all people we spoke with could remember attending any meetings.

The registered manager had notified the Care Quality Commission (CQC) of most events and incidents that had occurred in the home in accordance with our statutory requirements.

Ratings from the last inspection were displayed within the home as required. The provider's website also reflected the current rating of the service. From April 2015 it is a legal requirement for providers to display their CQC rating. The ratings are designed to improve transparency by providing people who use services, and the public, with a clear statement about the quality and safety of care provided. The ratings tell the public whether a service is outstanding, good, requires improvement or inadequate.

The registered manager told us they had been making links with the local community, such as arranging visits from local school children, accepting student nurses on placement in the home and people undertaking community service had assisted with developing the new garden area. The home also had good working relationships with other healthcare professionals.

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
Treatment of disease, disorder or injury	Consent was not always sought in line with the principle of the Mental Capacity Act 2005. Deprivation of Liberty Safeguards applications were not all made in a timely way and conditions on authorisations were not all met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Risk to people was not always managed appropriately. Medicines were not always managed safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Care plans did not all contain sufficient, up to date information regarding people's needs. Systems in place to monitor the quality and safety of the service were not effective.