A & I Care Home Ltd

The Meadows Residential 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?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This comprehensive inspection took place on 21 June 2018 and was unannounced.

The last comprehensive inspection took place 13 and 14 September 2016. The service was rated requires improvement in the key question is the service well led? We found one breach of regulation relating to the notifications of incidents because the registered person had failed to notify the Care Quality Commission of a safeguarding concern. We asked the provider to make the necessary improvements by November 2016.

On 15 February 2017, we carried out a follow up inspection to check that improvements to meet legal requirements planned by the provider after our September 2016 inspection had been made. We inspected the service against one of the five questions we ask about services: is the service well led? No risks, concerns or significant improvement were identified in the remaining Key Questions through our ongoing monitoring or during our inspection activity so we did not inspect them. On 15 February 2017, we found the provider was not fully meeting the regulation relating to notifications as they had notified us of seven out of eight incidents.

At this inspection we found the provider had met the regulation regarding notifications but was not fully meeting the regulations for the need for consent, safe care and treatment, good governance and fit and proper persons employed.

The Meadows Residential Care Home 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 Meadows accommodates a maximum of 25 people. At the time of the inspection, 24 people were using the service.

The service is family run. The business owners were part of the management team and were active in overseeing the service. Another family member was the operations manager and there was also 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.

During the inspection we found individual risk assessments were not always completed for areas such as risks related to falls, skin damage and pressure ulcers, malnutrition and moving and handling. Furthermore, window restrictors were not secure, some windows did not have restrictors and there were no risk assessments regarding this. This meant the risks associated with people's care and well-being were not always identified so these could be appropriately mitigated.

Safe recruitment procedures were not always followed to ensure staff were suitable to work with people as gaps in employment that had not been explored, references were not always from the last employers and

details of their criminal records checks at the time they started working at the service were not on file.

The principles of the Mental Capacity Act (2005) were not always followed as mental capacity assessments were not decision specific and we saw examples of relatives signing consent forms for people when they did not have the legal right to do so. Where people were able to make choices and give consent we saw that the provider and staff supported this.

Care plans mostly had appropriate information about people's needs and preferences. However, we found information about their sleeping pattern and the times people liked to get up and go to bed, were not accurately recorded or not recorded at all.

The service had systems in place to monitor, manage and improve service delivery and to improve the care and support provided to people. However, these were not always effective as not all risks had been assessed and mitigated and health and safety checks had not identified the issues with the window restrictors. Additionally, checks carried out on care records had not identified the issues regarding the completeness of these or the way in which some of the consent forms had been completed.

Incident forms recorded the details of the incident and the resulting actions. There were procedures for reporting and investigating allegations of abuse and whistle blowing. Staff we spoke with knew how to respond to safeguarding concerns.

Medicines were managed safely and staff had appropriate training.

The premises were well maintained and there were systems in place to identify any repairs needed. Staff we spoke with understood how to manage infections and wore appropriate protective equipment to reduce the risk of the spread of infection.

People's needs had been assessed prior to moving to the service and care plans included people's likes and dislikes. There were also records of end of life wishes and Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) forms to provide guidance to staff in such events.

Care workers had relevant training, supervision and annual appraisals to develop the necessary skills to support people using the service.

People's dietary and health needs had been assessed and recorded and were met.

People were treated with dignity and respect and we observed care workers communicated with people with care and encouragement.

The provider had a complaints procedure and addressed any complaints appropriately.

People using the service and staff told us the registered manager was available, listened to them and took action where necessary to act on their suggestions or concerns.

The provider received feedback and shared information through team meetings and completed satisfaction surveys.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to the need for consent, safe care and treatment, good governance and fit and proper

persons employed. 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 service was not always safe.

The provider did not ensure risk assessments were always completed for relevant areas such as for the prevention of falls and pressure ulcers. Additionally, some window restrictors were not appropriate and other windows did not have adequate control measures and there were no risk assessments to help protect people from the risk of falling from a height.

The provider did not demonstrate they were always following safe recruitment procedures to ensure staff were suitable to work with people.

Safeguarding and whistle blowing policies were in place and staff knew how to respond to safeguarding concerns.

There were arrangements to ensure medicines were managed appropriately to ensure people received their medicines safely.

The provider had infection control procedures in place which were followed by staff.

Is the service effective?

Requires Improvement

The service was not always effective.

The provider did not always act in accordance with the requirements of the Mental Capacity Act (2005) regarding consent to care.

People's needs were assessed prior to their move to the home which helped to ensure the provider only supported people whose needs they could meet.

Staff were supported to develop professionally through, training, supervision and appraisals.

People's dietary and health needs had been assessed and recorded.

Is the service caring?

Good

The service was caring.

People using the service were treated kindly and with respect.

Care plans identified people's needs and preferences and provided staff with some guidelines to care for people in a way that met people's needs.

Care workers supported people to have choice around day to day decisions.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans included some of people's preferences and guidance on how to support them. However, care plans did not always accurately reflect
the care they needed and their preferences, such as their sleeping patterns and the time they liked to get up in the morning. Care plans were reviewed monthly but there were no indications people or their relatives were always involved in the review of the care plans.

The service had a complaints procedure and people knew how to make a complaint if they wished to.

People had their advanced wishes for end of life care recorded so staff were aware of these and were prepared to meet these if they developed.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider had data management and audit systems in place to monitor the quality of the care provided. However, these were not always effective as they did not identify the concerns raised at the inspection.

People and staff were able to approach the registered manager to discuss any aspects of their work or care and felt supported.

People using the service and staff had the opportunity to provide feedback to improve service delivery.

The Meadows Residential 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 is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 21 June 2018 and was unannounced. We brought the date forward because we had received information of concern regarding the service. The inspection was carried out by two inspectors.

Prior to the inspection, we looked at the information we held on the service including notifications of significant events and safeguarding. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about. We contacted the local authority's safeguarding team to gather further information about their views of the service.

During the inspection we spoke with seven people using the service, two relatives, five care workers, one catering worker, two domestic staff, one healthcare professional, the operations manager, the provider's representatives and the registered manager. We viewed the care records of five people using the service and three care workers files that included recruitment, supervision and appraisal records. We looked at training records for all care workers. We also looked at medicines management for people who used the service and records relating to the management of the service including service checks and audits.

Requires Improvement

Is the service safe?

Our findings

During the inspection, we found the provider did not always have robust arrangements to ensure that risks associated with people's care and well-being had been identified, monitored and managed to ensure they were safe. Individual risk assessments were not completed, for risks related to falls, skin damage and pressure ulcers, malnutrition and moving and handling. For example, where people were at risk of developing pressure ulcers, the correct pressure relieving equipment was in place and records showed people were re-positioned regularly, but a risk assessment was not carried out in the first instance to determine the level of risks so the appropriate measures could be put in place to mitigate the risk of developing a pressure ulcer. Similarly, whilst there was a care plan for manual handling, there were no detailed manual handling risk assessments to fully assess the task to be completed and the level of risk involved, the environment where the task was to be completed, the individuals completing the task and the actual nature of the task. There was therefore risks that people were not being adequately protected against risks associated with the delivery of care. After we discussed this with the provider, they emailed us appropriate risk assessments that they planned to complete immediately.

The provider carried out health and safety checks of the premises and checked for maintenance issues. We noted that there were roof windows in a number of bedrooms on the second floor that could be fully opened to enable a person to reach the roof. There were no risk assessments and measures to mitigate the risk of falling from a height in relation to these windows. There were also windows with restrictors that could be disabled by pressing two catches so that the windows could be fully opened. We did not see any risk assessments in regards to this. The Health and Safety Executive in its guidance, 'Falls from windows or balconies in health and social care', states "Window restrictors should: ….be robustly secured using tamper-proof fittings so they cannot be removed or disengaged using readily accessible implements or key." This therefore meant that people were not being adequately protected from the risk of falling from height. The provider arranged to fit appropriate restrictors on all windows when we pointed this to them.

The above were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the personnel files for the three most recently recruited care workers. They all had completed application forms and a number of recruitment checks which included criminal records checks, employment references, proof of identity and of the right to work in the UK. However, the work history for two of the care workers were not complete. There were gaps in employment that had not been explored and recorded by the provider. Whilst the staff had references, these were not always from the last employers. All three applicants had character references when they had previous employers that the provider could have contacted to obtain references from. There were no records to show that the provider had made attempts to contact previous employers and that the character references were as a last resort.

Criminal records checks were carried out. For two care workers their records showed that they started work prior to the date of the result of the criminal records check on file. The operations manager explained that the care workers were offered employment on sight of a criminal records check but these were not copied

and they had to request for a new certificate for the checks which was after the care workers had started work. Further to our discussion with them, they agreed to improve their recruitment process to address the areas of concern identified during the inspection.

The above were a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People living in the home told us they felt safe and one relative said, "[Person] is very safe here." There were systems in place to help safeguard people from abuse. Safeguarding policies and the whistleblowing policy were up to date. Care workers we spoke with had undertaken relevant training, were able to identify the types of abuse and knew how to respond to concerns. One care worker said, "If I have a concern I go to a senior and if nothing is done I go to the manager and then CQC and Ealing." We saw signs in communal areas of the home describing what safeguarding is and the reporting process.

The local authority told us that they did not have any outstanding safeguarding issues. The provider raised safeguarding alerts appropriately with the local authority, notified CQC and completed a brief analysis as part of their logging system. We saw evidence of investigations, outcomes and actions taken to prevent a reoccurrence, for example, one carer worker undertook re-training to improve their practice as part of the outcome of an incident.

The provider recorded incidents and accidents appropriately and included the circumstances of the incident and a plan to prevent reoccurrence. Where required, we saw behavioural reporting plans that noted how the situation could be prevented and reminded staff to update the care plan. We looked at the audit for incidents and accidents in May 2018 and saw the provider had recorded 'lessons learnt' and what steps they had taken to prevent reoccurrence. This meant the provider could see patterns and take preventative action.

The provider had checks in place to ensure the environment was safe including a monthly health and safety check. Regular checks of the fire alarm and fire safety equipment were undertaken. A comprehensive fire risk assessment was in place which showed there was a good provision of fire safety equipment. All staff undertook annual fire training and fire drills to ensure they knew what to do in the event of a fire. People using the service had personal emergency evacuation plans which provided guidelines on how to evacuate them safely in an emergency.

Notwithstanding some of the findings in regards to the premises as described above, these were well maintained and there were systems in place to identify any repairs needed and action was taken to complete these in a reasonable timescale. There were safety and maintenance certificates in place to show that equipment such as the hoists and the lift were being appropriately serviced and maintained. Contracts were in place with specialist companies to service and maintain certain equipment such as the central heating and the laundry systems. Records showed gas, and electrical equipment was regularly tested and serviced.

There were sufficient numbers of staff deployed with the right skills to meet people's needs. A care worker told us, "Definitely enough staff. No agency" and a relative said "Yes, there is enough staff." A health care professional said, "They have time for everyone. They make time. They treat them like a relative."

Medicines were managed safely. Only staff who had been assessed as competent administered medicines. We looked at a sample of medicines administration records (MARs) and saw that these were all signed appropriately when medicines were administered. A record was made of when medicines were received

from the chemist in the home although this was not always signed by the member of staff who checked these. The registered manager said they would review this.

We checked some medicines which were in their original packaging and noted that the quantity in stock tallied with the records. Medicines were stored securely in a locked medicines trolley which was anchored to a wall when not in use. There was also a medicine cabinet to store controlled drugs where these were prescribed.

There were measures in place for the control and prevention of infection and care workers received appropriate training in infection control. They told us, "We wear gloves, use disposable spoons for medicines and use hand gels" and "We use gloves, wash hands often, use antibacterial spray and aprons." All visitors had access to hand sanitising gel when they arrived at reception. There was a housekeeping team to ensure all areas of the service were clean. There was at least one housekeeper daily. The two members of the housekeeping team we spoke with confirmed they had received training to enable them to work safely and they had all the necessary equipment to fulfil their roles. The laundry was secure, well equipped, clean and organised. Systems were in place to ensure laundry was segregated and managed safely. There were arrangements for the safe management of waste. This was appropriately segregated and stored in appropriate bins. All chemicals used for cleaning or laundering were stored in a locked cabinet in the laundry room, which was accessible to the housekeepers. This helped to reduce people's contact with dangerous chemicals.

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 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 services and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

Where people were able to make choices and give consent we saw that the provider and staff supported this. One person was able to consent to their care and told us "I have seen my care plan when I first came into the home". In cases where people could not give consent, mental capacity assessments were in place. These were however not always decision specific. For example, where people had bed rails there was no specific mental capacity assessment about the use of bed rails. There was also no evidence that a best interests decision had been carried out

In some cases, relatives had signed consent forms when they did not have the legal authority to do so. Some relatives were named as having Lasting Power of Attorney for property and financial affairs but were signing consent forms for people about care matters. A person can make care decisions on behalf of another person if they are nominated as a Power of Attorney for care and welfare. A lasting power of attorney (LPA) is a legal document that lets a person (the 'donor') appoint one or more people (known as 'attorneys') to help them make decisions or to make decisions on their behalf.

The above was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager kept a record where they had made applications for authorisations to deprive people of their liberty under DoLS. They confirmed that where necessary they had applied for new applications and had been reminding the local authorities to assess the people for whom she had made applications.

Care workers we spoke with had completed MCA training and understood about being able to make choices. Their comments included, "People with dementia might not be able to take decisions so help them out with a best interests decision", "In the morning ask them what they would like to wear and show them different clothes" and "We always ask what they would like to wear, eat and drink. They have dementia but that doesn't mean they don't have choices."

People's needs were assessed prior to moving to the home. We saw pre-admission assessment forms that recorded people's mobility, diet, continence, their history of falls, a brief social history, if moving and handling was required and any other potential risks. People using the service had mainly been placed by

local authorities which also provided background information and assessments as part of the provider's assessment process to ensure the service could meet the needs of the people. The assessment covered various aspects of people's needs. Once admitted the provider prepared care plans for people but a full and detailed assessment of people's initial needs was not on record. For example, there was no information about people's sleeping patterns, elimination needs and the support they needed, and level of independence with meeting their own needs. Where people's needs had changed, there was a record made in the progress notes or evaluation notes and new care plans were prepared. There was however no record of an updated needs assessments to reflect the changes based on a cycle of assess, plan, implement and evaluate. We discussed this with the registered manager who said she would look into this matter.

All staff had completed relevant courses as identified by the provider which helped to provide staff with the skills and knowledge required to deliver effective care. This included equality and diversity, manual handling, food safety, fire safety, privacy and dignity and safeguarding. There was additional training that staff could complete face to face or through e-learning. Staff completed an induction that included training and shadowing and had started to complete the Care Certificate. The Care Certificate is a nationally recognised set of standards that gives staff an introduction to their roles and responsibilities within a care setting. Staff also underwent probationary interviews at monthly intervals before they were confirmed in post. Once in post all staff received quarterly supervision and annual appraisals. One relative said, "Oh yes they have skills. I have been here when staff have meetings or training. It's a stable staff team." A care worker told us, "I do supervision with [registered manager] once a month. If there is a small problem it's a way of bringing the problem out in the open to resolve without bad feelings. It's a way of me finding out what I am doing."

Care workers told us they worked well together to meet the needs of the people using the service. Comments included, "We have a team handover at 2pm and one with night staff. We write down concerns with daily and hourly checks", "Any changes are given in the handover and we have to sign and read the communication book" and "The team here is really good. Everyone gets on and is happy. No major problems."

People's care records had information about their healthcare needs and showed that they were referred to various healthcare professionals according to their needs. For example, we noted that they were seen by the optician, speech and language therapist and their GP. Where this was the case appropriate records were made about the outcome of these appointments. A healthcare professional told us. "They absolutely follow through on advice. Any problems they call us. Carers ask questions and we sit with the manager to make a care plan."

Overall the premises were appropriately maintained and in a good state of repair and decoration. We noted that people's bedrooms were appropriately furnished according to their choices. People could bring items to make their rooms more personalised. One relative said that their family member had their own pictures which made their room looked homely. The home was suitable for the people living there. It was accessible to wheelchair users and had a lift so people could move between floors easily. There were also various areas that people could use if they did not want to sit in the main communal areas and engage in their own activities.

Good

Is the service caring?

Our findings

People were treated with care and kindness. People using the service told us they liked living at The Meadows "very much", "Staff are very nice. They handle people with dementia sympathetically", "Not too bad here" and "There's some nice staff." Relatives said, "My [family members] are always immaculately dressed" and "I'm very pleased with the service. I think it is more like a family and the residents are treated like family." Comments from relatives in satisfaction questionnaires included, "Staff are always friendly and approachable, "My [relative] is very happy here. The staff are amazing and go above and beyond to help us," and "The staff know everyone by name. Very polite." A healthcare professional commented, "Sometimes I'm here for an hour. It's very pleasant. Everybody smiling. Staff love their job and it makes a difference."

We heard staff talking to people in a kind voice and taking the time to explain things to them. For example, when a care worker supported a person up from the breakfast table, they explained what they were doing, asked if that was okay and explained why it was good for them to walk [rather than use a wheelchair]. Staff offered choices to people such as what breakfast they wanted and how they wanted their cereals and if they wanted to use a clothes protector. Staff were attentive to people's needs. We observed one person was not eating their lunch, a care worker checked with the person why they were not eating and immediately brought them a different meal which they said they were much happier with.

Where people were able to they were supported to be independent and to do as much as possible for themselves such as to take part in their personal hygiene. We saw people who were able to, walk in various areas of the home independently and freely and choosing where they sat in the dining room, conservatory or lounge area. People could stay in their rooms, have a lie in or come down to the main communal areas according to their wishes.

Care workers told us they tried to involve people in decision making and give them choices. A relative said, "Sometimes if [person] does not want to get up, staff will come back. They are not forced to go to bed at a set time." Care workers comments included, "When residents come to the home, they're asked when they would like to get up and go to bed. We do try to let them get up when they're ready. If we go into a room and they are not ready, we cannot force them to get up. The majority are quite early risers. If they are asleep, we pull the door shut and go back and check on them again later."

Care plans contained some information about people's preferences and included any cultural or religious needs. Care workers we spoke with said that they were aware of meeting people's religious dietary needs and joining in cultural celebrations such as St Patricks day, Eid and Diwali.

We observed during our inspection that all people were appropriately dressed and appeared well cared for. A relative said, "My [family members] are always immaculately dressed" and this was further confirmed by the relatives giving feedback in satisfaction questionnaires. Care plans indicated if people would like personal care support from a male or female carer. One care worker said, "Make them comfortable. Talk to them while showering so it's not a big thing. Let them have a choice of shower gels. Make sure they're covered. They all have habits, likes and dislikes."

The staff welcomed relatives when they visited and supported them to maintain contact with their family members. One relative said, "I was very impressed. I can come and visit when I want to."

Requires Improvement

Is the service responsive?

Our findings

People using the service had care plans that were reviewed monthly with records made. Whilst people and their relatives were involved when the care plans were drawn up, we did not see that people or their relatives were involved in the reviews of the care plans. Relatives however told us and feedback in the satisfaction questionnaires indicated that they were kept informed of changes in people's needs and these were discussed with them.

Care plans addressed people's needs and overall contained instructions for staff to care for people. On the day of our inspection we visited the home at 6.15am and we saw that there were six people up in the lounge. We saw that two people were busy talking with each other, one person was reading the newspapers, one walking in the lounge and down the corridor, another was sleeping in their chair and the last one was dozing intermittently in their chair. Staff explained that these people were up early because they liked or wanted to get up early, and this included the person sleeping and the one dozing, as they would call staff to get them up. We looked at people's care records to confirm their sleeping patterns and that staff were caring for them according to their care plans in relation to night time care. We noted that the care plans did not always accurately reflect people's sleeping patterns. For example, two people's care plans said they went to bed at 8pm but staff said they prefer to go to bed at 6pm. There was no time identified in the care plans when people wanted to get up or the correct time when they went to bed. This meant care plans were not always accurately reflecting people's wishes and preferences. We discussed this with the registered manager and they agreed that they would update the care plans to reflect people's sleeping patterns.

People were satisfied with the activities they received and with the support they received to be kept stimulated. The provider employed an activities coordinator who arranged the activities in the home. On the day of the inspection we observed people playing with balloons, singing and listening to culturally relevant music. At other times we observed people reading books or newspapers or talking among themselves. People were smiling and seemed to be enjoying each other's company and there was a relaxed atmosphere in the home.

Feedback from people was positive about the activities provided and people could join in or opt out according to their wishes. One person told us, "I enjoy watching TV and I have been on outings. I like going to the park." Other people we spoke with confirmed they also enjoyed the activities on offer and were able to go out to the park when the weather was nice. The activity co-ordinator was conscious of personalising activities. For one person she used an iPad to reminisce so they could look up the village the person grew up in or find their home country's sports. A musician came in weekly for an hour. During this time, the co-ordinator took another person for a walk with a dog as the person did not like the music but did like dogs.

The service had a complaints procedure which was also available in the service user handbook. People we spoke with had never made a complaint but said they would speak with staff if they had concerns. A relative told us, "I have never made a complaint but I would speak to [operations manager]. I can approach them at any time with concerns." Complaints were managed appropriately and included an investigation and lessons learned. Complaints were logged with a brief analysis and where required progressed to a

safeguarding alert.

We saw that each person had detailed instructions in their care plan about their preferences and wishes for end of life care. The forms were completed with people or their relatives and were detailed. These included information about what spiritual support people would want at the end of their life and down to the planning of their funeral if they had thought about it. Do not attempt cardio-pulmonary resuscitation forms were also completed where indicated with the GP signing these as required to make sure people were not resuscitated against their will or where the outcome might not be positive for the person.

Requires Improvement

Is the service well-led?

Our findings

The provider had quality assurance systems and carried out a range of checks at various frequencies. However, these had not identified the concerns we found at this inspection so the provider could make the necessary improvements.

The provider's quality systems had failed to identify that assessments were not addressing the risks that people faced whilst living at the home. Risks to multiple aspects of care had not been assessed and mitigated. The provider's health and safety checks had not identified the issues with the window restrictors or the lack of these on the roof windows. We also found that the checks carried out on care records had not identified the issues regarding the completeness of records as they did not contain information about the times people went to bed or got up. The quality checks had also not picked up issues about the appropriateness of the way some of the consent forms had been completed.

For the above reasons we concluded that the provider's quality assurance processes were not always effective and that there was a breach of Regulation 17 of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had weekly, two monthly and quarterly audits. These looked at specific areas of the service and were repeated according to the relevant frequency. Appropriate records were maintained about the checks. For example, the bi-monthly audits included looking at various areas of the service including people's bedrooms and their state of decoration, the décor, the environment, the furniture in communal areas and in people's bedrooms, the laundry, kitchen and medicines management.

There were a number of ways for the provider to get feedback from people and their relatives about the quality of service provided in the home. There were two monthly 'community meeting' where people and their relatives could ask questions about the service and offer suggestions. We also saw that there had been a number of satisfaction questionnaires that people had completed. Copies of the responses of the latest survey were sent to us. The satisfaction questionnaires were positive about the service people were receiving.

People and relatives could also approach the provider and registered manager to give feedback about their experiences of care. We observed during the inspection that the provider's representatives were on the premises. They were very involved in the operation of the care home and knew the people using the service and relatives well. They were approachable and available to people and their relatives and also to healthcare professionals when they visited. Feedback from relatives in questionnaires always described them as approachable, caring and contactable when required. Staff therefore had good role models to follow in terms of how the values of the organisation were demonstrated.

All staff we spoke with said the providers were approachable and supportive. Comments included, "I would speak to [registered manager or operations manager] if I had a concern. They're very good. Available 24/7. There is always someone", "There is a good relationship between staff and the manager. Never feel under

pressure" and "[Registered manger] listens and there is an open-door policy in the office. Here five days a week." Many staff had worked at the service for many years and feedback from people and relatives praised the ability of the provider to retain their staff. There were staff meetings arranged and the last one was in March 2018. Minutes were available for staff to be aware of what was discussed.

The registered manager informed the Care Quality Commission of notifiable incidents as required. The registered manager and operations manager kept up to date with good practice through newsletters from the local authority, CQC and Skills for Care. They also attended the local authority's provider forum and received minutes from it.

We saw evidence the provider worked positively with a number of other professionals including the speech and language therapist, optician, tissue viability nurse and social services. A health care professional told us, "I look forward to coming here. The environment is pleasant. They are so helpful to me. For example a person had dementia and they understood his needs well and are very helpful from managers to carers."

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 registered person did not have suitable arrangements to demonstrate that they always sought consent for care and treatment from the relevant person and they always acted in accordance with the Mental Capacity Act 2005 where a person did not have the mental capacity to make an informed decision. Regulation 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 registered person had not always assessed the risks to the safety of service users so these could be appropriately mitigated. Regulation 12 (1) (2) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not have effective systems to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. Regulation 17 (1) (2) (a)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed

The registered person did not demonstrate that safe recruitment procedures were always followed so that only suitable persons were employed to work at the service.

Regulation 19(1)