Sentimental Care Asher Limited

Asher House

Inspection report

Asher House
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Date of inspection visit:
09 August 2018
10 August 2018

Date of publication:
23 October 2018

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

This comprehensive unannounced inspection was carried out on 9 and 10 August 2018. At the last inspection on 25 September 2015, the service was rated as 'Good'. At this inspection we found the service was in Breach of Regulations 11, 12 and 17 and has been rated as 'Requires improvement'.

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

The service is registered to support up to 20 older people, some of whom may be living with dementia. At the time of our inspection, 14 people were being supported at the service.

Asher House provides accommodation on two floors with access via a stair lift. It is situated in a quiet residential area in Walton on the Naze.

The service required, and did have, 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.

Risk assessments had been completed but we found they were incomplete, confusing and not sufficiently detailed to ensure staff knew how to deal with risks to people appropriately.

Medicines were not administered to people in a safe way. The medicines were handled in a way which did not follow good practice. Appropriate hygiene measures were not used when dispensing and giving medicines to people.

People's capacity to make their own decisions and consent to their care and support was not always assessed and recorded. Systems to protect people's human rights were not always in place.

Staff recruitment systems were in place. However, we found gaps in three staff members employment which needed to be verified to ensure they were safe to work with people at the service.

Staff undertook training in their roles and responsibilities but it was not always effective.

There was an infection control process in place. Despite staff not using protective gloves whilst administering medicines, staff used aprons and gloves and followed processes to minimise the risks from the spread of infection.

There were systems in place to regularly assess and monitor the quality of the service. However, not all areas

of the service were checked and monitored in line with required legislation.

People, relatives, staff and health care professionals spoke positively about the service and the care provided. People and their relatives told us the service was a safe place to live.

Staff had received training in safeguarding adults from abuse and understood their responsibilities and the actions they should take if concerns were identified.

There were sufficient numbers of staff deployed to meet the care and support needs of people.

People had sufficient food and drink and were provided with choices at mealtimes. Where required, people were supported to access health care services to maintain their health and well-being.

People were treated with kindness, compassion and courtesy. Staff knew people well and were sensitive to their needs. People's independence was promoted and people were encouraged to do as much as they could for themselves. People were treated with dignity and respect and staff ensured people's privacy was maintained at all times.

People received a responsive service. The content and design of the care plans had been reviewed. The service was in the process of updating and completing them to make them more person centred which reflected people's current care and support needs.

The involvement and feedback from people and their relatives was actively encouraged. Social and leisure activities were individually tailored to people's needs and people from the community provided entertainment.

Information on how to raise concerns or complaints was available, and people and their relatives were confident any concerns would be listened to and acted upon.
The registered manager was accessible and open and worked in partnership with external agencies.
There was a positive relationship between management, staff, people and their relatives and the values demonstrated by staff were positive.

Further information is in the detailed findings below.

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.

Potential risks to people were not always identified and recorded to keep them safe.

Recruitment procedures were not fully completed for the protection of people who used the service.

The environment was not always kept safe.

People did not receive their medicines safely as infection control measures were not always followed.

There were sufficient numbers of staff deployed to care for people and meet their needs.

Is the service effective?

Requires Improvement

The service was not always effective.

Systems for the protection of people's human rights were not always followed in accordance with the Mental Capacity Act 2005 and associated guidance.

Staff had training but it was not always effective. Staff supervision and support to carry out their role was in place.

People had a choice of meals and drinks which they enjoyed.

People were supported to maintain their health and well-being, including accessing healthcare services when required.

Is the service caring?

Good

The service was caring.

Staff knew people well and were kind, compassionate and respectful, and treated people with dignity and respect.

People were supported to maintain their independence.

Relatives and friends were actively encouraged to visit.

Is the service responsive?

Good

The service was responsive.

Care plans were under review to ensure they were consistently person centred and reflected people's current care and support needs.

There were effective systems in place to deal with concerns and complaints.

The service provided a good quality service to people who were at the end of their life.

Is the service well-led?

Requires Improvement

The service was not always well led.

Quality assurance processes were not sufficiently robust to ensure people received a high quality service.

The registered manager was visible and open. Positive relationships had been developed with people, relatives and the staff team.

The staff team displayed good qualities and values.

The service worked in partnership with other agencies.

Asher House

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 the 9 and 10 August and was unannounced.

Before the inspection, we reviewed information that we held about the service such as safeguarding information and notifications. Notifications provide information about important events happening in the service that the provider is required to tell us about. We also received feedback from the local authority. We used this information to plan what areas we were going to focus on during our inspection.

The inspection team consisted of one 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. Our expert by experience had experience of supporting relatives who had used this type of service

During the inspection, we engaged with eight people who used the service and eight friends and family. We observed interaction between people and staff supporting them.

We also spoke with the registered manager, deputy manager, five staff, and three health professionals.

We looked at a range of records which related to people's individual care and the management of the service. This included four people's care records and three staff recruitment files. We also looked at a sample of the service's quality assurance, training, supervision, medicine administration and complaints records.

Requires Improvement

Is the service safe?

Our findings

Risks to people's health and safety were not always being fully assessed. In two out of four of the care plans we looked at, some risk assessments had not been completed. Where risk assessments had been undertaken, the recording and action taken to reduce risks was not clear. For example, a risk assessment for one person stated they suffered from anxiety and panic attacks. It then went on to talk about how staff were trained in using the hoist. No further information was available to staff to assist the person in how to deal with their feelings or how to reduce them from happening. It was also recorded that the person used continence aids and had a catheter which was changed by the district nurse. No further information or guidance was provided for staff to know how to deal with the person's continence needs or recognise and manage the risks associated with catheters. For another person, it was recorded that they had a pressure ulcer. When we checked with the registered manager, they told us that the person did not have a pressure ulcer but that they were prone to them and the staff needed to check regularly. We did not see a risk assessment in place as to what action staff should take to mitigate this risk.

The provider did not ensure that the premises kept people safe. We found a fire exit door upstairs in one empty bedroom which went out onto a metal fire escape. It could be opened from the inside but not from the outside. We asked the registered manager why this was accessible without the necessary safety restrictions in place. They told us that the recent fire inspection had not identified this as a risk. Also, that whilst there were two people whose bedrooms were upstairs, they were unlikely to use the door, so it was not a risk to them. After discussion, the registered manager agreed that this was indeed a risk and put in place actions to secure the door with a more suitable alternative security arrangement.

People were not being given their medicines in a safe way. We observed a senior member of staff administering medicines to people at lunchtime. During the dispensing of people's medicines, they did not follow good infection control procedures. Whilst taking a tablet from a packet, it was dropped on the medicine cabinet. The senior staff member picked it up and put it in the dispensing cup. They did not wear gloves or clean their hands with any hand gel. They continued to administer medicines to everyone without following hygienic methods to protect people from infection. Whilst we saw that staff had completed infection control training and had access to personal protective equipment (PPE) such as disposable gloves and aprons, we could not be assured that the infection control policy was being followed throughout the service.t.

Staff did not check that people had taken their medicines as prescribed. One person had received their prescribed medicines at breakfast time. We saw at 12.30pm that the medicines were still in the cup on their table beside their bed. We asked the person if there was a reason they had not taken them. They said that they had forgotten they were there. We made the senior staff member aware that the medicines were on the table and asked about the person's preferences regarding taking their own medicines and if they were time critical as four hours had elapsed since they were given. The senior staff member said, the person did not administer their own medicines and so should have taken them at the time. They added that they should have gone back and checked that they had taken them. We saw that the Medicine Administration Record (MAR) had been signed to say that the medicines had been taken at breakfast time which meant that this

record was incorrect. The staff member checked and confirmed that the person was not at risk from not taking their medicines at the prescribed time. Other people using the service however, could have been at risk, if they had gone into the person's room and taken them.

We looked at the way in which medicines were kept. The room in which the medicine trolley was stored also contained cabinets with additional medicines such as creams, controlled drugs and medicines to be returned to the pharmacy. We looked at the date of an opened bottle of medicine for pain relief and the senior member of staff checked when the person had last taken a dose. This was recorded as February 2018. The expiry date by which the medicine should be used by was 2020. We asked how long the medicine lasted when opened and the senior member of staff was not sure and did not know where to look for this information. The details about its use were on the bottle which stated that it should be used within 90 days of opening. The senior staff member told us they were glad that the person did not require it as they would not have noticed it was out of date. They assured us that this would be returned to the pharmacy and a new prescription ordered.

The service was not following its policy and procedures for medicine management despite being updated in June 2018 along with refresher medicines administration training for senior staff being undertaken. Staff had all signed to say they had read it.

This is a breach of Regulation 12 (1)(2)(a)(b)(d)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The recruitment records showed that most of the necessary information to keep people safe had been obtained such as references, identification and a Disclosure and Barring Service (DBS) check to make sure staff were suitable to work with people. However, in all three staff files we looked at, we saw gaps where their employment history had not been accounted for. The registered manager told us that they would request for this to be updated by the staff members and confirmed after the inspection that this was in progress.

People were supported by a consistent staff team and rotas were planned to ensure there were enough staff to meet people's care and support needs. The rota included the registered manager who worked shifts during the week. The registered manager carried out an assessment of people's dependency levels to ensure there were always enough staff to meet the individual needs of people living at Asher House. During our inspection, we observed staffing levels were sufficient and people were being supported in a timely way. Staff confirmed to us they did not feel rushed or task focussed as management always ensured there were enough staff.

Despite some of the findings from the inspection, people told us they felt safe living at Asher House and had confidence in the staff to care for them in a professional and compassionate manner. One person said, "Yes, I feel safe here." A family member told us, "I'm very content with [name of relative] being here, I know it's safe for them."

People were protected from the risk of abuse. Staff had received training in safeguarding adults, demonstrated an understanding of safeguarding procedures and when to apply them. Staff were confident any concerns would be listened to and actioned appropriately by the registered manager. One staff member said, "I would definitely be able to talk to the manager about any concerns I had about anyone, people or other staff." Another said, "We keep an eye on everyone, any little thing or change in them we would talk about and do something about. That's how we work."

The risk assessments which had been completed correctly, showed that, where any risks had been identified, management plans had been put in place to minimise these. We saw that staff had a good knowledge of people's needs and identified risks, including eating and drinking, mobility and falls.

People had personal emergency evacuation plans so that they could be safely evacuated from the premises in the event of an emergency. Records showed that staff were trained in fire awareness and tests were carried out regularly. The Red Bag Scheme was in place. This enabled people's notes, medicines and a change of clothing to be put together to go with them to hospital so that they could be transferred quickly and without delay. Appropriate monitoring and maintenance of the premises and equipment was on-going. There were up to date safety certificates in place,

There were systems in place to ensure food was clearly labelled with the date of opening so it could be used or disposed of within safe timeframes. Staff had received food hygiene training and the kitchen was well maintained. They had also received a five-star food hygiene rating.

Systems were in place to record and monitor incidents and accidents. These were monitored by the registered manager who told us that they would take prompt action to ensure they wouldn't happen again. Any lessons learned from incidents and accidents would be shared and discussed with the staff team to improve the quality and safety of the service. The registered manager was able to give us an example of lessons learnt and improvements made.

Requires Improvement

Is the service effective?

Our findings

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Where people had been deprived of their liberty, the registered manager had made appropriate applications to the local authority. Two applications had been made in 2016 and had been followed up regularly by the registered manager as there was a delay in getting these processed with the local authority. We were informed shortly after the inspection that a DoLS had been authorised for one person. A notification to CQC was yet to be received. Some people had family who were authorised to act on their behalf through a Lasting Power of Attorney (LPA). However, for other people, it was unclear from their records who they would like to represent their views and support decision making if they were unable to do so independently.

We discussed with the registered manager people's level of capacity to make day to day or significant decisions as well as those people whose capacity fluctuated, or changed unexpectedly. They told us about people who did not have capacity to make particular decisions. However, no MCA assessments had been completed in these cases so that people's rights and choices were considered. As some people were new to the service, the registered manager told us they would review this process so that records showed the correct procedure was in place to support people legally.

In two care plans we noted that both people used bed rails. We discussed those people's individual requirements with the registered manager. One person had requested to have them in place and had capacity to make that decision. We did not see any documentation regarding the consideration of any risks to them or their consent to have their wishes met so that staff were clear about the decisions made. Another person, who did not have capacity to decide if they wanted bedrails or not and if they did was it safe for them to have them. It was recorded in their care plan that they needed, "Bed rails when in bed", and, "I like the bed rails up." This had been signed by the registered manager. No risk assessment, mental capacity or best interest assessment had been completed for this person to ensure the safe and legal use of bed rails. When we asked how the registered manager knew that they liked the bed rails up, they told us that this information had come from the care plan at the previous service.

Although the use of bedrails is intended to keep people safe, if a person has capacity a record of the consultation regarding the use of bedrails should be held. However, if the person lacks capacity a 'best interest' decision should be taken. Wherever possible, the best interest decision should involve relatives, other relevant health and social care professionals and staff. It is important staff are clear on the reasons as to why the restriction is in place, and there should be evidence that other options had been considered as part of the best interest decision.

Staff were not always aware of how certain actions could deprive people of their liberty. For example, they told us people were free to leave at all times and they would unlock the front door for them. However, there were some people who would need to be supervised outside so they would need to have someone with

them. They wouldn't let them go alone as they would be unsafe.

This is a breach of Regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care and support needs were assessed and monitored in line with current guidance and legislation. There had been four people who had currently transferred from another service with limited information about their needs.

The registered manager told us that an initial assessment had taken place to ensure the service was appropriate to meet people's needs and expectations. The staff were getting to know them with information and support from their families being recorded and followed to create an effective care plan.

Staff told us they had received appropriate training and guidance to enable them to perform their role and meet people's care and support needs. A programme of face to face and online training was in place. Staff were required to complete the provider's mandatory training such as moving and handling, health and safety, safeguarding people from harm, Mental Capacity Act 2005 and fire awareness. They also had the opportunity to undertake additional training, such as diabetes care and dementia care.

The knowledge of some staff needed updating and we spoke with the registered manager about this. They told us they would look at the medicine administration and infection control procedures to ensure all staff were competent in these tasks.

An induction process was in place when they started work at the service which included shadowing experienced members of staff, an orientation of the building, fire safety and emergency procedures and getting to know people. One staff member said, "I was nervous at first but got to know people quickly as everyone is so friendly. I never worried about asking silly questions as the staff were always helpful."

Staff spoke positively about working at the service. They told us they felt supported in their roles and received supervision. They said the registered manager as approachable and available for support and guidance at any time as well as working with them providing direct care. Records showed, staff had received supervision, observations of their practice and annual appraisals.

People were supported to drink and eat enough and maintain a balanced diet. The daily menu was displayed on blackboards so people could see what was on offer each day. People's care plans recorded their dietary needs and preferences. Snacks and drinks were available throughout the day and night.

We observed the meal time experience. Staff sat with people, talking with them whilst supporting them to have their meals at a relaxed pace. People could choose where they wanted to eat, for example, in their own rooms or in the main lounge, and staff respected this.

People and their relatives were complimentary about the food. One person told us, "The food's good here, well pretty good anyway, and there is a lot of choice if you don't like what's offered. The chef comes around in the mornings and asks what we would like. They are nice and we have a chat." Another person said, "I like the food here. Today it's Sausage, egg and mash for lunch, my favourite." Family members said, "I have my lunch with [name of relative] when I come in, and I always enjoy it. It's a good lunch for £3," and, "The food is always lovely, can't fault it." We spoke with the cook who told us about people's eating habits, likes and dislikes and specialist dietary needs. They said, "I go around to each person every morning to discuss what they want to eat. I note down lunch and tea options. My policy is to make sure everyone gets what they

want. I order all the food in, it's sourced locally and all freshly prepared."

People were supported to access healthcare professionals and services, such as GPs, the district nursing team, opticians and chiropodists. One person said, "I'm waiting to see the optician with some new glasses. They were here three weeks ago to test me". Later in the day the optician arrived with two new sets of glasses for the person. Another person said, "I've just got back out of hospital, and I'm seeing the physio regularly. I'm hoping the staff help me get mobile again. I'm doing all the exercises, and can move everything now." One family member told us, "I'm taking [relative] to the dentist today as they have lost their teeth."

Care records showed staff worked in partnership with health and social care professionals to ensure people received effective care and support. People were assisted with healthcare appointments and put into practice advice and support required. We received complimentary feedback from the healthcare professionals about the service. One healthcare professional said, "Whenever I have been here, its friendly, the staff know people's needs and know we are coming." Another said, "The staff follow our advice and support people to be as independent as possible. I have seen people shine after a little while living here."

Staff gained people's consent prior to care tasks being carried out. Throughout our inspection, we observed people being given choices by staff, seeking their permission and explaining the care to be given. For example, "Can I give you your tablets now [name of person], is that oaky?" and, "Shall I check if your batteries are working as I think you can't hear me properly. Can I take them out and replace them for you?"

Asher House is a two-storey building in a residential street with garden access, communal lounge and dining room. Access into the garden was a little uninviting, as the most direct route was through the laundry. The main entrance was up three steps with a wheelchair accessible entrance around the side of the property. The doors to people's bedrooms had a number with no other identifying features such as a photograph of them or their name. The registered manager told us this was in the pipeline to discuss with people. The bedrooms were personalised and decorated with personal effects, furnished and adapted to meet their individual needs and preferences.

The registered manager told us that the lounge and dining room had been refurbished recently, with new carpets and furniture and further work on other areas of the service was needed and planned. We observed that the lighting in the hallway both up and downstairs was dim and the paintwork in need of some care and attention. The registered manager told us after the inspection that the provider had received quotes to refurbish the front of the service to make it more accessible and welcoming and to add a key pad to the front door to make accessing it easier for people who used the service, their visitors and staff.

Good

Is the service caring?

Our findings

People and their relatives told us how kind, friendly and caring the staff were. One person said, "I am settling in and they are helping me to get sorted with everything. They couldn't be kinder." Another said, "Lovely staff, lovely people and don't forget the cleaner too, everyone does their bit to make it a nice place." One family member told us, "We all think this is a lovely place for [relative] and they really look after him well here. All the staff know him, and they have a laugh together." Another family member said, "We come all the time, and always welcomed, offered drinks and we know [name of relative] is very happy here. To be honest, I couldn't imagine them anywhere else."

The service had a person-centred culture. People were relaxed in the company of staff and it was clear, from our observations, positive relationships had been made. Staff knew the needs of people and their backgrounds and personalities. One staff member said, "People here are like my extended family, I care for them like I care for my own." People and their family were involved in planning their care and had as much choice and control as possible over their care arrangements.

People were treated with dignity and respect. During our inspection, we observed staff being caring and kind in their approach to people and being sensitive to each person's individual needs. Staff addressed people by their preferred names, spoke to people in a polite and respectful manner and engaged with them in a friendly and companionable way. Staff were not rushed or task orientated, and it was clear the needs and well-being of people were of primary importance. People felt they mattered and were listened to. The atmosphere within the service was calm and pleasant. One family member told us, "It's very nice for [relative] here. It's always friendly and there are lots of things for them to do. We felt it was a nice small home when we came for the first visit, and it hasn't let us down. The manager is nice and friendly and always comes and talks with us."

People's independence was promoted. Staff recognised the importance of encouraging and enabling people to do as much as they could for themselves. One person told us "The staff are helping me to do my exercises with the aim that I could eventually sit in my chair. Another said, "I am happy just doing my own thing and try and get up and do things myself. If I can't and ask for help, it's always forthcoming without complaint." One staff member said, "It's great when people make progress especially after coming out of hospital and we can get them back to being well." This approach showed people were supported to have as much independence and control in their lives as possible.

People's privacy was respected. Staff knocked on people's doors before entering and told us how they protected people's dignity when giving personal care by making sure doors were closed, covering people appropriately and explaining what they were doing as they went along.

People's ways of communicating were recorded so that staff were aware of their individual needs. Guidance for staff included, "Please speak slowly and make eye contact with me," and, "[Person's name] will close their eyes when they have had enough to eat."

People were encouraged to maintain relationships with friends and families. The registered manager said visitors were welcome at any time and many family members chose to eat lunch or dinner together either at the service or went out into town.

The registered manager told us that no one was using advocacy services at this time but they would support people to access advocacy if required. An advocate supports a person to have an independent voice and enables them to express their views when they are unable to do so for themselves.

The provider had considered the way in which people's information was collected and stored. We saw this was kept confidential and in line with current legislation.

Good

Is the service responsive?

Our findings

Prior to people moving into the service, a pre-assessment was undertaken to identify people's health, personal care and social support needs to ensure these could be met by the service. Information from the pre-assessment process, for example, provided by the local authority, was used to develop people's care plans. The registered manager told us that four people had transferred from another service in the past two months as it was closing. Therefore, the assessment of their needs was still being undertaken to get to know them and how they could be supported.

People contributed to the planning of their care. Care plans were person centred and identified people's personal care needs and how these were to be met. For example, their mobility and use of equipment, risk of falls and pressure care, nutrition, communication, social activities, and end of life care wishes. We discussed with the registered manager the way in which care plans had been put together. For example, rather than knowing about the person first, we saw a body map, incident form, details about pressure care and mattress settings, daily notes, and medical history was placed at the front of people's care records. This did not show respect for how the person was described. They told us they were currently reviewing the style and content of the care plans and would ensure information about the person's history was collected and recorded and placed at the front of the care plan together with a photograph of them.

Some of the daily notes, whilst informative about the care provided to the person, were written in a task orientated rather than person centred way. The registered manager advised us that they would discuss this at a staff meeting and remind staff about writing in a way which was person centred and respectful.

People's care plans were regularly reviewed and, should a person's needs change, these were discussed at staff shift handover meetings and the care plan updated. People's likes, dislikes and preferences were recorded to meet their individual needs such as, "I like Disney movies and 60's music," and, "I like chocolate, sweets and cakes and not spicy food," and, "I like tea with one sugar and I like socialising with my family." People's sensory needs and oral health care were assessed, considered and acted upon. One person was getting used to using hearing aids which was proving difficult for them. Staff were very encouraging and supportive saying, "Try them this morning and then when you have a rest you can take them out." Staff also spoke to each other about checking that the right switch was on at the right level for them. Information relating to people's characteristics were mostly recorded such as their gender, age, marital status, ethnicity and religion. However, people's sexual orientation was not asked.

From April 2016, all organisations which provide NHS or adult social care are legally required to follow the Accessible Information Standard (AIS). AIS aims to make sure that people who have a disability, impairment or sensory loss are provided with information they can easily read and understand so they can communicate effectively. People's care plans recorded any sensory and communication needs. The registered manager confirmed to us they would always ensure appropriate formats would be sourced if required so that people were informed.

People enjoyed a range of social and leisure activities. These were provided by the staff who spent time with

individuals concentrating on what they wanted to do as well as providing some group activities such as exercises, quizzes and sing alongs. The hairdresser visited weekly and musical entertainment was provided monthly by visiting singers. Outings included visits to the sea front, garden centres and many people went out with family and friends to family events. We saw in the daily notes how people had spent their time. The day of our inspection, an outside company set up rails in the lounge with a range of clothes for people to try and buy. This provided people with an opportunity to socialise and to do some 'shopping'. People told us they were included in planning events at the service like the recent Care Home Open Day and garden party which they had enjoyed. One person told us, "I don't get out much but there's a planned trip to the garden centre in a couple of weeks, so I'm looking forward to that." Another person said, "I prefer to keep myself to myself, the other residents here are not my sort of people. The staff come in very regularly and see me with a drink, and I'm alright here with my TV and books."

People's and relatives' involvement and feedback on the service was encouraged. Meetings of people who used the service and their families were held and feedback recorded such as, being offered sherry or Baileys, having the company of staff and involvement in the planning of events. At the meeting held in July 2018, new people had been introduced to everyone.

Records showed questionnaires were undertaken to gain people's and relatives' views. We saw responses to the surveys in 2017 which had been very positive. It said, staff respected their rooms, they felt listened to, staff treated them as equals and good food day and night. Suggestions put forward had also been actioned such as staff to involve people in the household chores like laying the tables and more involvement in looking at care plans.

There were systems and processes in place to manage complaints. Information on the service's complaints process was clearly displayed and contained in the service user guide. Records showed there had been one complaint which had been dealt with appropriately.

People's preferences relating to their end of life care were recorded in their care plans. We saw that people had Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders in place so that their wishes were clear to visiting professionals. People's funeral arrangements had been discussed with them where appropriate and recorded as to their wishes, such as if they wanted to be cremated and who the funeral directors were. Staff had received training and had provided end of life care to people using the service. Support was available to families who could visit any time. Compliments and thank you's had been received from family members and one read, "We always felt totally confident in the ability of staff to fully provide for [relative's] needs." No one at the service was currently receiving palliative care but it was available should any require it.

Requires Improvement

Is the service well-led?

Our findings

The service was not always well led. Systems and processes were not always operated effectively to ensure people received high quality care. Whilst the registered manager was working to continuously improve the quality of the service, the governance framework, quality assurance processes and record keeping were not robust and did not always provide adequate information to assess, monitor, mitigate analyse and improve care practices.

The registered manager spent a percentage of their time as a staff member caring for people on the rota. Whilst this gave them an opportunity to observe staff performance, the time they spent to assess and monitor the quality of the service people received was insufficient to ensure people received a high-quality service. The registered manager felt that their time allocation needed to be reviewed so that adequate time was given to focus on areas for improvement. They would discuss this with the provider.

The role and responsibilities of the management team were not clearly defined in terms of providing management support to the registered manager. We discussed how certain tasks could be undertaken by senior staff so that they supported the registered manager more effectively, such as undertaking audits and keeping up to date with current good practice.

Quality assurance processes, auditing and record keeping were not robust or accurate. At this inspection, we saw staff recruitment files were incomplete with lack of records relating to their employment. Lack of risk assessments to ensure people were safe had not been completed or audited and inconsistency in the approach to people's mental capacity did not assure us that the registered manager was following guidance and good practice. Medicine administration and infection control competency checks, which did not follow the provider's policy and procedures, were not being well managed as audits were not picking up bad practice. The provider undertook a quality control visit in 2017 but we did not see an improvement or action plan which the registered manager was working towards.

This is a breach of Regulation 17 (1)(2)(a)(b)(c)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service required, and did have, a registered manager. The registered manager promoted a positive and open culture and demonstrated their commitment to providing homely care for people. They were part of 'My Home Life' which is a UK-wide initiative that promotes quality of life and delivers positive change in care homes for older people.

A range of health and safety audits had been undertaken alongside supervision and appraisals of staff. The training programme had been reviewed so that it was easy to see at a glance when training was due to be refreshed. Team meetings offered staff opportunity to share their views and these were recorded.

Staff told us how supported they felt by the senior staff and registered manager and enjoyed working at the service. They were respected, encouraged, and felt able, to share their views and put forward any

suggestions. One staff member said, "I can go to any of them and know they will help me with anything." Another said, "All the staff are great and the manager includes me in everything." A third said, I've been here a long time, and I really feel part of a team. I like the manager and deputy manager and they are nice to work with and very supportive. It's a nice home."

We received complimentary feedback from health and social care professionals. They spoke positively about the service, the staff and the way the service was friendly and efficient.

The registered manager told us they researched the NHS, Care Quality Commission (CQC) and Skills for Care websites and were registered with the Information Commissioners Office regarding people's information rights. They networked with other care home providers (for example using their equipment for moving and handling training) and subscribed to health and social care publications. The registered manager told us they shared information and learning with the staff team and that they were supported by the Provider who visited the service on a regular basis.

Services that provide health and social care to people are required to inform the CQC of important events that happen in the service. The registered manager was aware of their responsibilities and had systems in place to report appropriately to CQC about reportable events. They also understood their responsibilities under duty of candour, which places a duty on staff, the registered manager and the registered provider to act in an open way when people came to harm.

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 People's capacity was not assessed or recorded.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people's health and wellbeing were not being assessed and recorded. The environment was not always kept safe. Staff training and knowledge was not always effectively used.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance processes were not sufficiently robust to ensure people received a good service.