Angel Care plc

Orchid Care Home

Inspection report

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Ratings

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

Overall summary

Orchid Care Home provides accommodation, nursing and personal care for up to 83 older people. At the time of our inspection there were 78 people living there. The bedrooms are arranged over three floors and all have ensuite bathrooms. There are communal lounges and a dining area on each floor with a central kitchen and laundry. There is also a large communal area on the top floor which is used to screen films and host social occasions.

The home aims to provide people with care and support which derives from 'Namaste Care'. Namaste care attempts to ensure that people are treated in a respectful and dignified manner and are provided with meaningful stimulation.

This inspection took place on 22 and 23 of June 2015 and was unannounced. At a previous inspection which took place in July 2014 we found the provider had not satisfied the legal requirements in the areas of care planning, staff supervisions, appraisals and training. The provider wrote

Summary of findings

to us with an action plan of improvements that would be made. We found on this inspection the provider had taken steps to make some of the necessary improvements.

At the time of our inspection the home had recruited a manager who was in the process of submitting an application to become the 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.

The home manager, deputy manager and staff had knowledge of the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). Deprivation of Liberty Safeguards is where a person can be deprived of their liberties where it is deemed to be in their best interests or for their own safety. Whilst necessary Deprivation of Liberty Safeguards applications had been submitted previously by the provider, the requirements of the Mental Capacity Act were not always followed when assessing people's capacity to make decisions.

We looked at 10 care plans and found that guidance did not always reflect people's current needs and identify how care and support should be provided. This meant that people were at risk of inconsistent care and/or not receiving the care and support they needed.

People and their relatives spoke positively about the care and support they received. They said that if they had any concerns they could speak to either staff or the management team. They said they felt their concerns would be listened to and where required appropriate action taken.

People told us they felt safe living at Orchid Care Home and they were well cared for. Systems were in place to protect people from abuse. Staff knew how to identify if people were at risk of abuse and what actions they needed to take to ensure people were protected.

Staff providing care were familiar with the needs of people they were supporting and we observed that care and support was provided in a person centred way. People were involved in a range of activities within the home and the local community. The provider encouraged people to provide feedback on the services they or their relative received.

People were supported to eat a balanced diet. There were arrangements for people to access specialist diets where required. People told us they could choose what they wanted to eat and if they did not like what was on the menu they could ask for an alternative. There were snacks and drinks available throughout the day during our inspection.

There were clear policies and procedures for the safe handling and administration of medicines. These were followed by nursing staff and this meant people using the service received the correct medicines at the right time of day.

There were effective systems in place to reduce the risk and spread of infection. Staff we spoke with were clear about their responsibility in regard to infection control.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

This service was safe.

There were systems in place to keep people safe from harm. Where required the provider had reported incidents to the appropriate authorities and carried out the necessary investigations.

There were enough staff to meet people's needs. Recruitment procedures ensured people were cared for by suitable staff.

Medicines were well managed and people received their medicines as prescribed.

Is the service effective?

Requires improvement

This service was not always effective.

Whilst the management team and staff had knowledge of the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) the requirements of the Mental Capacity Act were not always followed when assessing people's capacity to make decisions.

People were cared for by staff who had received sufficient training to meet their individual needs. There were arrangements in place to ensure staff received regular supervision and appraisal.

People received sufficient food and drink and their health needs were met.

Is the service caring?

Good

This service was caring.

People received support in a caring and sensitive manner.

People's privacy and dignity was respected by staff.

Staff knew people well and were aware of people's preferences for the way they wished to receive their care and support, their likes and dislikes. Staff supported people to make decisions about their day to day life.

Is the service responsive?

Requires improvement

This service was not always responsive.

Whilst people received a person centred service, people's care and support plans did not always reflect people's current needs and identify how care and support should be provided. This meant that people were at risk of inconsistent care and/or not receiving the care and support they needed.

People and/or their relatives said they were able to speak with staff or the management if they had any concerns or a complaint. They were confident their concerns would be listened to and appropriate action taken.

Summary of findings

People participated in a range of activities and people from the local community were involved with the home.

Is the service well-led?

Good

The service was well-led.

The newly appointed manager was well respected by people using the service, relatives we spoke with and staff.

Staff had a good understanding of the aims and values of the home. Staff were positive about the support they received from management and other colleagues.

Quality monitoring systems were in place and used to further improve the service provided.

Orchid 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.

This inspection took place on 22 and 23 June 2015 and was unannounced. Three inspectors carried out this inspection. We carried out this inspection as a follow up from an inspection in July 2014 where we found the provider had not satisfied the legal requirements in the areas of care planning, staff supervisions, appraisals and training. They wrote to us with an action plan of improvements that would be made.

Before we visited we looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification. Before the inspection, we did not ask the provider to complete a Provider Information Return (PIR) as the inspection was carried out in order to follow up on the previous inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We used a number of different methods to help us understand the experiences of people who use the service. This included talking to people and their relatives, looking at documents that related to people's care and support and the management of the service. We reviewed a range of records which included 10 care and support plans, staff training records, staff duty rosters, staff personnel files, policies and procedures and quality monitoring documents. We looked around the premises and observed care practices throughout the day.

During our inspection we observed how staff supported and interacted with people who use the service. We spoke with 16 people and eight visitors about their views on the quality of the care and support being provided. During our inspection we spoke with the home manager, the deputy manager, four nurses, 13 care workers including night staff, an activities coordinator, housekeeping staff, and the chef. We arrived early on the second day of our inspection to speak with night staff. We also spoke with two visiting health professionals and a training provider.

Good

Is the service safe?

Our findings

People and their relatives told us they or their relative felt safe and supported living at Orchid Care Home. Comments included "I didn't feel safe living at home but I do here. When I first came, there was so much bad press about care homes, but I do feel safe here" and "I don't have any worries, I'm very happy." Visitors we spoke with told us they had no concerns regarding people's safety.

Staff had received training in keeping people safe. Staff told us what they would do if they thought a person was being abused or at risk of harm. They were confident any concerns would be listened to and any actions required taken by the manager. Staff were aware of safeguarding policies and procedures. The manager told us they would respond accordingly to any allegations of abuse and report their concerns to the appropriate authorities, for example the local authority safeguarding team. The manager told us that they would also seek advice and guidance as appropriate if they were unsure whether a situation warranted a safeguarding alert.

People were protected from the risk of being cared for by unsuitable staff. There were safe recruitment and selection processes in place to protect people receiving a service. All staff were subject to a formal interview in line with the provider's recruitment policy. Records we looked at confirmed this. We looked at six staff files to ensure the appropriate checks had been carried out before staff worked with people. This included seeking references from previous employers relating to the person's past work performance. Records showed that references had been obtained and a check made with the Disclosure and Barring Service (DBS) before new staff started working. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with vulnerable adults.

Staff told us staffing levels had improved and they felt there was sufficient staff to provide the care and support people needed. The manager told us there was a nurse and five carers on every floor during the day and a nurse and two carers on every floor during the night. We looked at the home's rota which indicated there was a consistent level of staff each day and night. We observed these staffing ratios were met during our inspection.

People's medicines were managed so that they received them safely. We observed part of two medication rounds on separate days. Both of the nurses demonstrated they knew people well and were knowledgeable about the medicines they were administering and the reasons why. Time specific medicines were administered at the correct time and there were clear notifications for staff within the medication administration records (MAR) to highlight when a medicine was time critical. This included medicines used to treat Parkinson's disease.

The nurses were patient and caring when assisting people with medicines. They did not rush the person, helped them to sit up when needed, ensured they had a drink to hand and waited to ensure medicines had been swallowed before signing the MAR chart. People who had been prescribed pain relief on an as needed basis were asked if they had any pain, and if they wanted pain relief. Cardiac medicines were administered safely and the nurse checked the person's pulse before giving them their tablets. One person asked the nurse why they were constipated as it was not normal for them, and the nurse explained it was a side effect of another of the tablets they were receiving.

Where people had been prescribed medicines to control anxiety or behaviour, staff had documented the dose and time given on the MAR chart. These entries reflected the content of the behaviour charts within the person's care plan. Staff had tried various distraction techniques before administering medicines which showed the person's behaviour was not being controlled unnecessarily.

All medicines were stored safely and in locked cupboards or trolleys. The medicine fridges were also locked and the temperature control log was up to date. Medicines stored in the fridges such as eye drops had been dated and signed to indicate when they had been opened in line with the manufacturer's guidance. Topical creams and lotions were signed for by the staff who applied them. The nurses showed us how they checked these had been applied before signing the MAR charts. Medicines that were no longer required were disposed of safely and in line with the provider's procedure.

None of the people using the service administered their own medicines. One person with diabetes monitored their own blood sugar and informed staff of the result. They then administered their own insulin with staff supervision. The nurse told us "It's important for them to be as independent as possible, so we just watch to check they do it properly".

Good

Is the service safe?

We observed the nurse explaining to the person why their blood sugar may have been higher than usual during the past few days. This showed us their knowledge about the medicines they were giving and the possible interactions.

Staff told us there were "regular" medicines audits undertaken by the manager or deputy manager and that the results of these audits were shared with staff in order to improve compliance against standards.

The home had a policy in place to promote good infection control. There were processes in place to maintain standards of cleanliness and hygiene in the home. For example, there was a cleaning schedule which was completed by housekeeping staff to ensure that all areas of the home were appropriately cleaned. Staff used coloured coded mops and clothes for different areas of the home to ensure cross contamination was minimised. We looked at a number of individual bedrooms and these were clean and well maintained.

People told us their rooms were cleaned every day. Comments included "My room is lovely and clean, they come in every day to do it" and "I have a lovely room, it's always clean and tidy."

We were told by staff that they had access to personal protective equipment (PPE) such as disposable gloves and aprons. Staff we spoke with were knowledgeable about the home's infection control processes and described how they implemented it in practice. For example how they handled and transported soiled laundry. Training records reflected that staff had received training on infection control. This ensured staff followed the home's infection control procedures.

Requires improvement

Is the service effective?

Our findings

CQC is required by law to monitor the application of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The Mental Capacity Act 2005 sets out what must be done to make sure that the rights of people who may lack mental capacity to make decisions are protected, including when balancing autonomy and protection in relation to consent or refusal of care or treatment. This includes decisions about depriving people of their liberty so that they get the care and treatment they need where there is no less restrictive way of achieving this.

DoLS require providers to submit applications to a 'Supervisory Body', the appropriate local authority, for authority to do so. Whilst all necessary Deprivation of Liberty Safeguards applications had been submitted previously by the provider to the appropriate local authority, we found on this inspection that the requirements of the Mental Capacity Act were not always followed when assessing people's capacity to make decisions.

We looked at 10 people's care records and found records of assessments of capacity were not appropriately completed for some people deemed to lack capacity to decide on their care and treatment. The assessments that were in place, did not meet the requirements of the MCA Code of Practice in terms of due process and the quality of recording. For example there was an assessment in place which asked various questions about people's memory capability and ability to make decisions. Some of these had not been fully completed. They also did not include information on what decisions people were able to make about their daily living. The assessments did not conclude if the person had capacity or not.

Where it was suggested that people could not retain information in these assessments there was no evidence of how this conclusion had been reached. For example, how the information had been given to the person and what had then been done to check if they had retained the information.

There were cognitive assessments in place but it was not clear if they were linked to the capacity assessments. Some of the assessments we reviewed had conflicting information. For example one person's assessment stated they could orientate themselves to the date and time. The conclusion of the assessment then stated the person needed support and encouragement to orientate themselves with the date and time. Again these assessments did not identify if people were able to make any decisions or choices about daily living.

People who use the service were not protected against the risks associated with inadequate mental capacity assessments. The registered person had not acted in accordance with the Mental Capacity Act 2005 when assessing people's capacity to consent to care and treatment. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff understood how to gain consent to care and treatment. Staff gave good examples of how they achieved this; for example one staff member told us "I always offer people choice and if they don't want to join in an activity than I respect their wishes." Another said "For those people who are not able to talk to me I will still ask permission before doing anything. I take in to account their body language or if they use sign language." Staff said they offered people choices about when they preferred to get up and when they went to bed. People using the service confirmed this.

We observed the lunchtime meal on all three floors on the first day of our inspection. People were arriving in the dining areas from 12.30pm onwards. Some people chose to have their meal in their room or in the communal lounge area. However on the day of our inspection the food trollies did not arrive till after 1pm. We had previously been informed that lunch was at 12.30pm. People's choices of food were then served to them. This was done from a list of people's pre-chosen meals which meant people sitting together were not served their meals at the same time. Some people did not receive their lunch until after 1.30pm. The process of giving out lunches and supporting those people who required it was slow and uncoordinated.

Staff were friendly, respectful and told people the plates were hot, yet no one was informed of what the meal was that was placed in front of them. We saw one member of staff bending over a person rather than sitting alongside them when helping them with their food. On another occasion, one person asked what the food was they were being assisted with, and the member of staff did not know.

Requires improvement

Is the service effective?

A choice of drinks was available and consistently topped up for people. Staff told us if people changed their mind about their previous choice of food, they could have the alternative or something else.

People had access to food and drink throughout the day and staff supported them when required. People told us they enjoyed the food provided by the home. Comments included, “The food is very good, there is always something I like” and “There’s always plenty to eat, I have no complaints.”

We spoke with the chef who told us they received information from staff about people’s dietary requirements. People were asked about their menu preferences each month and if they wanted any new meals adding to the menu. People had access to specialist diets such as pureed and soft food where required.

People had nutritional assessments within their care plans and their weight was monitored regularly. When required, action was taken to address weight loss. For example, one plan showed that a person had lost weight during the past few months. Staff had documented when they had begun to provide food supplements. When the person continued to lose weight, advice had been sought from a dietician and this was also documented.

Staff had regular contact with visiting health professionals to ensure people were able to access specialist advice and treatment as required. The home contacted relevant health professionals including GPs, district nurses and chiropodists if they had concerns over people’s health needs. Records showed that people had regular access to healthcare professionals and attended regular appointments about their health needs. We spoke with two visiting health professionals during our inspection. Both were enthusiastic about the service and both said staff kept them well informed and updated on people’s health and wellbeing. Comments included “The staff are very switched on here and know people really well” and “We work as a team with the staff.”

At our last inspection the provider did not meet the legal requirements for supporting workers. They wrote to us with an action plan of improvements that would be made. We found on this inspection, the provider had taken steps to make the necessary improvements.

Staff were aware of their roles and responsibilities. Staff told us they received the core training required by the provider, such as safeguarding, infection control, manual handling and health and safety. Training records confirmed this. New staff undertook a probationary period in which they completed an induction. The induction included completing core training, familiarising themselves with the service's policies and procedures and shadowing more experienced staff members.

Regular meetings were held between staff and their line manager. These meetings were used to discuss staff member's work progress, training and development opportunities and other matters relating to the provision of care for people living in the home. The meetings also gave staff the opportunity to discuss any difficulties or concerns they had. Staff said they felt supported by both the home manager and deputy home manager. They said they could approach them at any time to seek guidance and support.

Good

Is the service caring?

Our findings

All of the people we spoke with were happy with staff members and the care and support they received. Comments included "Staff are very nice", "I get spoilt rotten here", "I've always been happy here, everyone is very friendly and they always say this is your home" and "The manager is good, I can talk to her." One person told us that a staff member sung to them which they enjoyed. Visitors spoke positively about the care provided. One relative told us "I am happy with the way staff treat them, staff are lovely."

During our inspection we heard and observed laughter and people looked happy. They were relaxed with the staff who were supporting them smiling and in some instances sharing jokes. The atmosphere was calm and unhurried. Staff were not rushing and we saw them taking the time to talk to people.

Staff were polite and respectful when talking with people. Staff made eye contact with people and crouched or sat down to speak to them at their level. Staff involved people in their care, talking to them about what was happening at all times and asking what they would like to do, such as going to the toilet or returning to their room. We observed staff asking people what they wanted to do during the day and asking them for consent before doing anything. People were given choices about what they would like to eat and drink. People also chose where they would like to spend their time within the home. We saw that people moved freely around the home choosing to sit in the communal areas, their room or outside in the garden.

People told us they felt their privacy and dignity was maintained. Comments included "The staff always knock before coming in" and "They are very good even when they wash me, they keep me covered up". Staff knew how to maintain people's dignity and we saw this in practise. Staff encouraged people to be independent but also provided support when required. For example, one person was wheeling themselves along the corridor and a member of staff asked them if they wanted to be pushed or if they preferred to wheel themselves.

On the second day of our inspection we arrived at 7am so that we could speak with night staff. We saw that those people who were early risers were up and dressed. Some people chose to remain in their rooms whilst others were sat in the communal lounges. Some people were already eating their breakfast whilst other people had chosen to just have a cup of tea or coffee. We heard staff knock gently on people's bedroom doors before entering and ask if people required any support. Other people were still asleep. Staff said it was people's choice about when they got up. They said some people liked to get up early whilst others preferred to 'lie-in'.

One person who had finished being supported to get dressed was confused about where they should go. Staff reassured the person and gave them the choice of remaining in their room or joining some of the other people in the lounge area. Staff then supported the person to the lounge where they had chosen to go.

Staff appeared to genuinely care about people and spoke about the people they were caring for as individuals. Although the care plans did not always contain much personal information about people, the majority of staff knew about people and their personal histories. Comments from staff included "I love it here. I really know the people and I am able to provide continuity of care, so I can see if people's needs change" and "I love getting to know people, that's why it's a good place to work".

People's bedrooms were personalised and contained pictures, ornaments and the things each person wanted in their bedroom. People told us they could spend time in their room if they did not want to join other people in the communal areas. One person told us they liked to sit at the end of one of the corridors where they could watch the activity going on outside. They said they had a friend within the home who would also join them in this area. Seating had been made available and turned towards the window so they could see out. The person said "I like sitting here, I can see what's going on."

People's relatives said they had been involved with care planning. One person said "I do have a care plan, and one of the girls came to my room and wrote it with my input. I think we're going to review it soon". Another relative said they had been able to discuss the care and support their family member needed with nurses who "took on board what I was saying". They explained this made them feel comfortable with raising any future concerns or suggestions they may have.

People were supported at the end of their life to have a comfortable, dignified and pain free death. Staff referred

Good

Is the service caring?

people for hospice care, input or advice when needed and hospice staff confirmed this with us. One person who required hospice input had a care plan in place for staff to ensure their end of life needs were met. Staff said they sought specialist advice and training when needed and we saw this in practise.

Requires improvement

Is the service responsive?

Our findings

At our last inspection the provider did not meet the legal requirements in the areas of care planning. They wrote to us with an action plan of improvements that would be made. We found on this inspection the provider had taken steps to make some of the necessary improvements.

We looked at 10 people's care and support plans. Whilst we found that care focused on the needs of the individual, not all care plans had been updated to include information about the care and support required. For example, one person's personal care plan stated that they could use the toilet during the day and wore incontinence aids during the night. However, their continence plan stated that they were doubly incontinent and wore aids both day and night. Similarly, the skin integrity management plan stated the person required the use of a handling belt when transferring. However, the moving and handling assessment concluded the person needed to be hoisted using a sling. This meant that the person may be at risk of receiving incorrect care if staff were following different care plans.

Another person using the service who displayed anxiety throughout our inspection did not have a comprehensive care plan in place. Although the plan stated the person sometimes went into the garden through the fire exit door unattended by staff, and the risk of danger to the person had been identified, there was no clear guidance for staff on how they should care for the person. The plan stated 'Staff should supervise when outside', despite previously stating the person often went out unsupervised. There was no guidance for staff on other distraction techniques they could use or how to help alleviate the person's anxiety. Although staff told us how they helped to reduce the person's anxiety and fears, this had not been documented. The conflicting information that was available and the lack of in-depth guidance meant there was a risk that people's needs were not always being met consistently.

There were people using the service who sometimes demonstrated behaviour that might be upsetting to others. Staff told us how they supported this when it happened and what they did to diffuse potential conflict situations. However, the care plans did not contain information that was easy to follow. For example, one section of the plan we looked at described the type of behaviour one person might display. Within the 'Anxiety' section of the plan, some of the language used by staff was inappropriate. The information did not tell staff how they could relieve the person's anxiety. However, later in the care plan, under the "Communication" section, there was much more information, including informing staff to "listen, reassure, provide privacy, allow them to talk". The two plans were linked in their context, but this had not been documented. The plan was not easy to navigate and this meant it was difficult for staff to locate the information they required, in order to meet the person's needs.

Food and fluid charts that were in place to record people's daily intake were completed and up to date. However, there were no targets set for people's intake so staff were not able to accurately assess whether they needed to encourage people to eat or drink more than they had. Food intake was documented as a percentage of the meal eaten. It did not state what the meal was, or what size portion had been provided. The quality of the information documented on these charts was limited.

Some of the handwriting in care plans and daily notes were undecipherable. Care staff said they did not have time to always read the care plans, although they did demonstrate a good understanding of people's needs. Daily preferences, my lifestyle and my life history sections within plans were not always completed. This meant that people's personal choices might not be taken into consideration and that people may not always receive person centred care.

We found that the registered person had not designed care and treatment to reflect people's preferences and ensure that support plans reflected people's care and support needs because accurate and appropriate records were not maintained. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had access to a number of activities and interests organised by the activity co-ordinators. This included events and entertainment, or time spent with people on an individual basis. An activity co-ordinator told us that although a programme was available, activities were flexible depending on how people were feeling and what they wanted to do. Activities included ballroom dancing, card games, arts and crafts and musical entertainment. There were links with the local school whereby children came in each month to sit and read to the people living in the home. People told us they were given the opportunity to to join in with activities but it was their choice whether

Requires improvement

Is the service responsive?

they did so. Records of activities people had taken part in where recorded. However whilst it stated the activity, information on whether the person had enjoyed the experience was limited. Within daily notes, there was detail of the activity and comments such as 'Enjoyed' or 'Declined'. There was no detail of what exactly the person had enjoyed, how they knew this, why they had declined or if anything else had been offered.

People and visitors told us they knew how to make a complaint, but nobody we spoke with had ever felt the need to do so. A copy of the provider's complaints procedure was on display in the reception area for people to see. A relative told us they had been able to raise concerns and felt listened to. They said actions had been taken to resolve their issues. Other comments included "If I have an issue I know I can speak to the manager" and "I have no complaints, I'm very happy here."

Good

Is the service well-led?

Our findings

There was a newly appointed home manager in post who had submitted an application to become the registered manager. People and their relatives spoke positively about the management team. They said they saw them often and felt comfortable speaking with them. Staff told us the manager was approachable, valued their opinions and made them feel part of a team. They said they could easily raise any concerns with the manager and were confident issues would be addressed appropriately. Staff told us they felt supported in their role and did not have any concerns. One visiting professional said "The new manager has made a huge difference here. I'm always made to feel welcome".

Staff spoke highly of the support provided by the whole staff team. They told us they worked well as a team and supported each other. Several staff members told us the manager had an open door policy and was visible around the home. They knew what they were accountable for and how to carry out their role. Staff told us about staff meetings they had attended. There was a head of departments meeting every morning where information was shared. We observed a meeting on the second day of our inspection. Each area of the home such as housekeeping, nursing and kitchen was discussed and any issues documented. The manager asked if there had been any concerns or complaints raised that she needed to be aware of. They said complaints or concerns that were not raised formally would be logged at these meetings and any actions noted. This meant that issues could be dealt with informally before they escalated.

Staff demonstrated a good understanding of what the service was trying to achieve for people. They told us their role was to treat people as individuals, support people with choice and promote their independence. However, not all staff were aware that the home aims to provide people with care and support which derives from 'Namaste Care', as described by the manager.

People and their family were regularly involved with the service and their feedback was sought by the provider and the home manager. Relative and resident meetings were held periodically throughout the year. One person said they had attended a recent relative's and residents meeting with the manager. There were copies of the minutes available for people to read outside of the dining room.

The provider had systems in place to monitor the quality of the service and to help inform and plan improvements. The manager completed audits including infection control, medicines, maintenance and health and safety. The findings of these audits, formed part of the home's over all action plans. Where audits had identified issues, actions to resolve these had been included on the action plan and timescales identified.

Whilst there were shortfalls in people's care and support plans this had been identified by the new manager and included on their action plan. They showed the new paperwork they were currently implementing.

Staff members' training was monitored by the home manager to make sure their knowledge and skills were up to date. There was a training record of when staff had received training and when they should receive refresher training. Staff told us they received the correct training to assist them to carry out their roles.

The home manager and deputy manager attended the local health centre where a monthly 'Topic surgery' was held. Each month a different topic was covered by guest speakers. Topics had included dementia care and diabetes. This gave managers the opportunity to keep up to date with best practice and changing care practices for older people.

The management operated an on call system to enable staff to seek advice in an emergency. This showed leadership advice was present 24 hours a day to manage and address any concerns raised. There was also a contingency plan in place to cover emergencies such as loss of utilities, fire or insufficient staffing. There were emergency fire protocols in place. A fire evacuation assessment had been completed on each person which identified their mobility requirements in the event of a fire. For example if they needed a wheelchair or could leave the building independently.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent People who use the service were not protected against the risks associated with inadequate mental capacity assessments. The registered person had not acted in accordance with the Mental Capacity Act 2005 when assessing people's capacity to consent to care and treatment. (1) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care We found that the registered person had not designed care and treatment to reflect people's preferences and ensure that support plans reflected people's care and support needs because accurate and appropriate records were not maintained. (3) (b) (d)