Tarry's Residential Home Limited

Tarrys Residential Home Limited

Inspection report

86-88 Grand Drive
Herne Bay
Kent
CT6 8LL

Tel: 01227367045
Website: www.tarrys-care.co.uk

Date of inspection visit:
05 January 2016
06 January 2016

Date of publication:
08 February 2016

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection was carried out on 5 and 6 January 2016 and was unannounced.

Tarrys Residential Home provides accommodation for up to 19 older people who need support with their personal care, some people are living with dementia. Accommodation is arranged over two floors. A lift is available to assist people to get to the upper floor. The service has 19 single bedrooms with ensuite toilets. There were 16 people living at the service at the time of our inspection.

A registered manager was in post but was not leading the service on a day to day basis, they were also the registered person. The deputy manager was in day to day charge of the service and was supported by the registered manager and the registered manager of another service owned by the provider. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the care and has the legal responsibility for meeting the requirements of the law. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered manager did not provide strong leadership to the staff and did not have oversight of all areas of the service. Staff were not always clear about their roles and responsibilities and did not have a clear vision of the aims of the service.

People were treated with dignity and respect most of the time. For example, staff explained the care and support people would receive before they received it and asked them what they would like staff to do and when.

There were enough staff, who knew people well, to meet their needs at all times. The needs of the people had been considered when deciding how many staff were required on each shift.

Staff recruitment systems were in place and information about staff had been obtained to make sure staff did not pose a risk to people. Disclosure and Barring Service (DBS) criminal records checks had been completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

Staff were not consistently supported to provide good quality care and support. An effective plan was not in place to keep staff skills up to date and some staff had not completed the refresher training they required. Some staff held recognised qualifications in care. Staff met regularly with the deputy manager to discuss their role and practice and any concerns they had.

Staff knew the signs of possible abuse and were confident to raise concerns they had with senior staff or the local authority safeguarding team. Plans to keep people safe in an emergency required reviewing to make sure that they were effective.

People's needs had not been assessed to identify the care they required. Care and support was not planned with people and reviewed to keep them safe. Detailed guidance had not been provided to staff about how to provide people's care. This had a limited impact on the care people received because people's needs were generally known by staff. Staff said that they were not confident that they all provided people's care in the same way.

People got the medicines they needed to keep them safe and well. Action was not always taken when people's health needs changed. People were supported to attend health care appointments and have regular health checks.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards. Applications had been made to the supervisory body where they were necessary.

Consent to care had been obtained from people. People who had capacity were supported to make decisions and choices. Processes were not in operation to assess if people were able to make decisions. Decisions were made in people's best interests when they were not able to make the decision themselves. The requirements of the Mental Capacity Act 2005 (MCA) had not been fully met.

Some people chose not to participate in the activities on offer at the service as they did not like them. Action had not been taken to change the activities when people had told the staff they did not enjoy them.

Possible risks to people had not been consistently identified. Action had not always been taken to keep people as safe as possible, such as assessing their moving and handling needs and providing guidance to staff about how to move people safely.

People told us they liked the food Tarrys. They were offered a balanced diet that met their individual needs, including low sugar diets for people who wanted them. A range of foods were on offer to people each day and they were provided with regular drinks to make sure they were hydrated.

People and their representatives were confident to raise concerns and complaints they had about the service with staff and had received a satisfactory response.

Regular checks on the quality of the service people received had not been completed to make sure that it was to the required standard. Shortfalls had not been identified so they could be addressed to prevent them from happening again. People and their representatives had not all been asked about their experiences of the care to improve the service. Views shared with the provider had not been acted on.

The environment was safe, clean and homely. Maintenance and refurbishment plans were in place. Appropriate equipment was provided to support people to remain independent and keep them safe. Safety checks were completed regularly.

Records kept about the care and support people received were not always accurate. For example, one person's change in mood had not been recorded so it could be monitored.

We found 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 this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Some risks to people had not been assessed and guidance had not been given to staff about how to keep people safe all the time.

Staff knew how to keep people safe if they were at risk of abuse.

There were enough staff who knew people well, to provide the support people needed at all times.

Guidance had not been given to staff about giving people 'when required' medicines or creams. Other medicines were given to people when they needed them.

The service was clean.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff did not always follow the Mental Capacity Act (2005) and people's capacity to make particular decisions had not been assessed. Decisions were made in people's best interests by people who knew them well.

A plan was in place to make sure that staff completed all the training they required but gaps in their knowledge and skills had not been prioritised.

People received food and drinks they liked to help keep them as healthy as possible.

Action had not always been taken when people's health needs had changed. People were supported to have regular health checks and attend healthcare appointments.

Is the service caring?

Good

The service was caring.

People said the staff were kind and caring to them.

Information about people's life history and their background was recorded. Some staff knew about specific details of people's lives but this was not always recorded.

People were given privacy and were treated with dignity and respect.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Regular assessments had not been completed to identify changes in people's needs.

People's care plans did not contain guidance to staff about how to provide people's care. Staff were not confident they all provided people's care in the same way.

People were not involved in the running of the service. They told us they chose not to take part in the activities as they were not interested in them.

Action had been taken to resolve people's concerns to their satisfaction.

Is the service well-led?

Requires Improvement

The service was not well-led.

The registered manager was also the registered provider. They were not managing the service on a day to day basis. They were advertising the manager's post at the time of our inspection.

Staff were not clear about their roles and responsibilities.

Checks on the quality of the service were not completed regularly. Some people and their relatives had shared their experiences of the service but these had not been acted on.

Records about people and the care they received were not always accurate and up to date.

Tarrys Residential Home Limited

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 5 and 6 January 2015 and was unannounced. The inspection team consisted of two inspectors.

Before the inspection we reviewed the Provider Information Record (PIR) and previous inspection reports. The PIR 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 also looked at notifications we had received from the registered manager. Notifications are information we receive from the service when significant events happen, like a death or a serious injury.

During our inspection we spoke with people living at Tarrys Residential Home, the registered manager, staff and people's relatives. We visited people's bedrooms, with their permission; we looked at care records and associated risk assessments for four people. We looked at management records including staff recruitment, training and support records, health and safety checks for the building, and staff meeting minutes. We observed the support provided to people. We looked at medicines records and observed people receiving their medicines.

We last inspected Tarrys Residential Home in November 2013. At that time we found that the registered provider and manager were complying with the regulations.

Requires Improvement

Is the service safe?

Our findings

People and their relatives told us they felt safe at Tarrys. One person said, "I feel safe here and think the staff are very nice". One person's relative told us, "Mum is kept safe and well cared for".

People received care, when they needed it, from staff who knew them well. Consideration had been given to people's needs and preferred routines when deciding how many staff to deploy at different times of the day. One person told us, "The girls [care staff] are very good. I can rely on them and they are there when I need them". Housekeeping and catering staff were employed and care staff were free to concentrate on providing the care and support people needed.

Staff shifts were planned in advance. Cover for staff sickness and holidays was provided by other staff members in the team. An on call system was in place and management cover was provided at the weekends and in the evenings, so staff had support when they needed it. The staff team was consistent and staff turnover was low.
A call bell system was fitted in peoples' bedrooms and communal areas. People used the bells to call staff during our inspection and staff responded quickly. Staff were present in communal areas with people.

There were policies and processes in place to keep people safe, these were known and understood by staff. Staff had completed safeguarding training and knew the signs of possible abuse. They were confident to raise safeguarding concerns or 'whistle blow' to relevant people, such as the manager or the local authority safeguarding team.

Risks to people had been not been assessed consistently. A process to assess people's moving and handling needs was in place but had not been used at the service. Guidance had not been given to staff about how to move people safely. We observed that on most occasions staff moved people safely. However, there was a risk that people would not always be moved safely.

Risks to peoples' skin, such as the development of pressure ulcers, had not been assessed. Staff knew the signs that people were at risk of developing pressure ulcers and had referred people to their doctor or nurse. Special equipment, such as cushions and mattresses were provided to keep people's skin healthy, we observed these being used. Some special mattresses and cushions were not on the right setting and there was a risk that people would not get the maximum benefit from them.

The registered manager had failed to assess risks to people's health and safety. This was a breach of Regulation 12(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Accidents and incidents involving people were recorded. Accidents when people did not suffer an injury were recorded as incidents. A process was in operation to review accidents but not incidents. There was a risk that patterns and trends would not be identified and action would not be taken to keep people safe as all the information regarding each person was not considered.

People had been referred to health care professionals for support and advice when they had fallen. The support and advice was used to plan the care they received. Changes in the support people were offered, such as a change in their medicines had reduced the number of falls they had.

Plans to evacuate people in the event of an emergency did not consider each person's needs. The provider did not know if the lift could be used in an emergency or if special equipment was needed to support people to evacuate safely. The provider contacted a fire safety consultant during our inspection to obtain advice on evacuation plans. Staff were confident to contact the manager for support in an emergency. Contingency plans were in place to keep people safe, including moving people to another local service if they were unable to stay at Tarrys.

The service was clean and odour free. All areas of the service were cleaned regularly and domestic staff worked at the service each day. The building and equipment were well maintained and regular checks, such as hoist safety and electrical checks had been completed. Maintenance plans were in place. Many areas of the home had been redecorated or refurbished since our last inspection including lounges and the kitchen. The temperature of bath and tap water were checked regularly and staff knew the correct temperature range to make sure people were protected from the risk of scalding.

The building was secure and the identity of people was checked before they entered. Internal doors were not locked and people moved freely around the service and were not restricted. Fire and environmental risk assessments had been completed and action taken to keep people safe. An enclosed garden was available at the back of the service.

Furniture was of a domestic nature and the service was comfortable and homely. People were able to bring personal items with them into the service and these were on display in their bedrooms.

Staff recruitment processes were in place to protect people from staff who were not safe to work in a care service. These were not consistently followed for all staff. Information about staff's conduct in previous employment had been obtained however written references were not in place for all staff before they began working at the location as the provider required.

Disclosure and Barring Service (DBS) criminal records checks had been completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Information about candidate's physical and mental health had been requested and checked. Other checks, including identity checks, had been completed.

Processes were in operation to protect people from the risks of unsafe management of medicines, including systems for ordering, checking, disposal and administration of prescribed medicines. Medicines were stored securely. People received their medicines at the time advised by their doctor. Staff's medicines administration skills were assessed annually to make sure they continued to use safe practices.

Some people were prescribed medicines 'when required' (PRN), such as pain relief and inhalers for breathlessness. Guidance about how to manage each person's PRN medicines had not been provided to staff. Some people were taking their PRN medicine regularly every day. For example, one person was taking their PRN inhaler three times each day. The person was not showing signs of being breathless before being offered their medicine. Staff had not recognised that the PRN medication was being given regularly and discussed the person's medicines with their health care professional. The lack of guidance for staff about the use of PRN medicines meant that there was a risk that people would not receive their PRN medicine when they required or it would be offered too often.

Staff asked people if they wanted pain relief regularly and only gave it when they wanted it. All the people prescribed PRN pain relief at the time of the inspection were able to tell staff when they needed it.

Some people were prescribed creams to help keep their skin healthy. Guidance had not been provided to staff about when and where to apply prescribed creams. A template record had been given to staff by the pharmacist but this was not being used. There was a risk that creams would not be used correctly and people would not get the maximum benefit from them.

The registered manager had not taken action to ensure that people's medicines, including 'when required' (PRN) medicines and creams, were managed safely at all times. This was a breach of Regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service effective?

Our findings

People were able to make choices about their lives, such as when they got up, when they went to bed and what they wore. One person told us, "I can get up when I want to". People choose how they spent their time and who they spent it with. During our inspection people were offered choices and staff responded consistently to the choices they made.

Most people living at Tarrys were able to chat to staff and tell them how they preferred their care and support to be provided. Staff knew everyone using the service well. Staff spoke clearly and showed people the things they were talking about.

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 homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. Staff did not have a good understanding of the requirements of the Mental Capacity Act 2005 (MCA). They had received training in relation to the MCA, however they needed to develop their knowledge and skills further to make sure that they complied with the MCA. For example, people's capacity to make decisions had not been assessed, and staff did not know what decisions people were able to make for themselves and the support they required to do this.
Some people were not able to make straightforward decisions, such as what they wanted to eat or drink. Information about people's preferences, such as the foods they liked, was not always available to staff to refer to. There was a risk that people would not be consistently supported to make decisions and care would not always be provided as they preferred.

Some people were unable to make complex decisions about the care and treatment they received and needed other people to make these decisions in their best interests. Decisions made in people's best interests had been made by relatives and friends who knew them well, with staff, and health and social care professionals on occasions, such as moving bedrooms. Records of the reasons for some decisions and who had made them had been kept.

The registered manager had failed to operate effective systems to assess people's capacity to make decisions. This was a breach of Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed staff respecting decisions people made and offering them alternative choices to keep them safe and well. For example, one person refused the medicine that one staff member offered them. Another staff member offered the person their medicines later and explained the benefits to them. The person took their medicine.

Staff were aware of most of their responsibilities under DoLS. Applications had been made for standard authorisations for some people. An assessment of the risk of people being deprived of their liberty had not been completed and two applications had been rejected because the people had the capacity to leave the service when they wanted to.

Staff had received an induction when they started work at the service to get to know people, the care and support they needed and to understand their roles and responsibilities. A process to assess staff's skills at the end of their induction was in place. Staff's induction and skills assessments were not consistently recorded to demonstrate they had developed the skills and knowledge they needed. New staff worked alongside experienced staff to help them build relationships with people and learn how their care was provided.

Staff had received most of the training they needed to perform their duties. However, not all staff had completed training to develop basic skills and knowledge such as health and safety and fire safety. Other staff had completed training but had not completed the annual training updates the provider required. There was a risk that they would not be aware of changes to recognised techniques and guidance. The provider had a plan in place to provide training to staff but this did not prioritise the important safety training that staff required such as moving and handling training. Some staff had completed further qualifications such as level 2 or 3 qualifications in social care.

Regular checks of staff's skills were completed, including administration of medicines and moving and handling. These checks were not always undertaken by staff who had completed the required training to keep their skills up to date and to assess the competency of other staff. There was a risk that poor practice would not be identified.

The provider had failed to make sure that all staff received appropriate training and development to enable them to carry out their duties effectively. This was a breach of Regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they felt supported to deliver safe and effective care. Staff met with their supervisor regularly to talk about their role and people's care and support. They told us they were able to raise any concerns they had about people with the deputy manager quickly as they worked alongside them. People's needs were discussed with staff throughout the shift to make sure they were supported to provide effective care. An annual appraisal process was in operation.

People were not consistently supported to maintain good health. Staff monitored people's health but had not always acted when changes in people's health were identified. One person had lost approximately 10lbs in a month. Staff had not recognised that the person had lost a significant amount of weight and had not contacted their doctor. The person was referred to their doctor during our inspection.

Action staff had taken when people were at risk of becoming unwell had not always been checked to make sure it was successful. One person had been given treatment by staff when they blood sugar levels were too high. Staff had not rechecked the person's blood sugar levels to make sure they were at a safe level following the treatment.

The registered manager had failed to operate effective systems to monitor people's health needs and take all the necessary action to keep them as well as possible. This was a breach of Regulation 12(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person's relative told us, "The staff are very good with managing healthcare needs and at arranging appointments". The care recommended by health care professionals was provided to people to meet their health care needs. Staff contacted health care professionals when they identified a concern and followed the treatment plans they prescribed. Community nurses visited some people to provide treatment for short term illnesses. People had been offered an annual flu vaccination. People were offered regular health checks such as eye tests.

People were supported by staff or people who knew them well to attend health care appointments, including emergency visits to hospital or outpatient appointments. This was to support them to tell their health care professional about their health and medicines and to make sure that any recommendations were acted on when they returned to the service.

People told us they liked the food at the service and had enough to eat and drink. One person told us, "They feed us very well here. You can't complain about the food. You can choose what you want". Another person said, "I always get a choice of meals and they are very nice". A third person told us, "Staff always check that I have a drink and everything I need". Some people asked for more of things that they liked and these were given if they were available. The registered manager had taken action to make sure that staff always gave people food they liked, including when people chose to eat unusual food combinations.

People were able to eat their meals in different areas of the service depending on their preferences. People who required assistance to eat were supported to do this. This was not always done in a respectful way. Some staff did not always sit with the person or stay with them throughout their meal. Other staff made sure people were comfortable and ate at their own pace.

Food and drinks were offered regularly throughout the day. Snacks were offered between meals, such as tea and biscuits, which people enjoyed. Staff offered people drinks often to make sure they did not become dehydrated.

Meals were planned to meet people's needs. People who required a low sugar diet or a reducing diet and were offered the same foods as everyone else but made with sweetener rather than sugar so they did not feel they were missing out. Menus were balanced and included fruit and vegetables. There was an alternative at lunchtime and several lunch and tea options, which people could choose. Staff knew people's likes and dislikes and offered them alternatives if they did not fancy the food they were offered.

Good

Is the service caring?

Our findings

People told us that of the staff were kind and caring, their comments included, "Staff have the patience of saints. They are very kind", "Staff are always cheerful", and "The staff are nice and helpful".

People and their families were encouraged to share information about their life history to help staff get to know them and provide their care in the way they preferred. This information was included in their care records. Staff spent time chatting to people about their lives before they moved into the service. They knew about people's preferences, likes, dislikes and how they liked things done. Some staff knew lots of details about people's backgrounds and life histories but this was not all recorded so not all staff were aware. This is an area for improvement.

People told us they always had someone to talk to and we observed people chatting to each other in a relaxed way. Staff showed genuine affection for people and people responded in a similar way. People were called by their preferred names. Staff spoke with people individually and in a respectful way. Staff responded quickly to people's requests, for example, support to go to the toilet. Staff chatted with people about things that they enjoyed and people responded.

There was some flexibility in the routines of the service to respond to changes in people's needs and to their requests. Staff knew people's preferred routines, such as where they liked to spend their time and who with. One person told us, "Staff know I prefer this room [one of the lounges] so they always let me sit in here when I want". Another person told us, "I have made friends here and I can sit with my friends when I want to". Staff responded to people's requests, such as to stay in their bedroom; this gave people control over their lives and reduced the risk of them becoming anxious or worried. Staff treated people with kindness and people appeared relaxed in their company.

People told us staff treated them with respect. They received the individual support and attention they needed. Staff told us, they treated people as they would like their family members to be treated. We observed staff discretely asked people if they needed assistance.

Systems were in place to make sure that people's laundry did not get mixed up and items were returned to the correct person. The registered manager had taken action when these systems were not operated correctly to make sure people's clothing was returned to them.

People were treated with dignity at all times. For example, staff explained to people about care they would receive before it was provided and asked them what they would like to do and when.

People had privacy. Staff knocked on people's bedroom and bathroom doors before entering. People had privacy when they washed, dressed and used the toilet and staff only stayed with them at their request or to keep people safe.

Personal, confidential information about people and their needs was kept safe and secure. Staff told us at

the time of the inspection that people who needed support were supported by their families, solicitor or their care manager, and no one had needed to access any advocacy services.

Requires Improvement

Is the service responsive?

Our findings

People had been involved in planning their care, with their relatives when necessary. Some people were able to tell staff how they liked their care provided and told us that staff did as they requested. One person told us, "I have seen my care plan". Another person told us, "I am very well looked after here". A third person said, "I like to keep independent and staff let me do this. I am getting worse, but staff are good and make sure I feel alright".

Staff knew what people were able to do for themselves and encouraged and supported them to continue to do this. One person told us, "I can't walk very well at all because of my legs, but I do like to try to manage as much as possible. I need a member of staff with me and they let me walk on my own. They just make sure I am safe". We observed a staff member walking with the person around the service. A wheelchair was always available if the person suddenly felt tired and needed to rest.

Before people were offered a service at Tarrys their needs were assessed to make sure the staff could provide all the care they required. People and their relatives were able to visit the service before deciding if they wanted to move in.

Further assessments of people's needs had not been completed to find out what they could do for themselves and what support they needed from staff to keep them safe and healthy. Action had not been taken to identify changes in people's needs during their stay at the service and use this to change and update their care plans. Information was not available to staff to help them plan people's care and support to make sure it met their needs and preferences.

Detailed guidance had not been provided to staff about how to provide the care people needed, such as how people preferred their personal care provided. Staff described to us the way in which they met people's needs in the ways they preferred. Staff were not confident that they all provided people's care and support in the same way so there was a risk of inconsistent care.

People's care plans contained very little information about what they were able to do for themselves and how they preferred their care to be provided. Care plans had been regularly reviewed and additional information had been added when people's needs changed. It was not clear if older information remained relevant. When changes occurred it was the responsibility of the person's keyworker to make the changes to the care plan. A keyworker is a member of staff who is allocated to take the lead in co-ordinating someone's care. Other staff did not make changes to the care plan when a person's keyworker was not on duty and on occasions there was a delay in guidance being provided to staff about people's care.

Staff told us that they did not refer to people's care plans for information about how their care and support should be provided. Handovers were completed between shifts and brief records were kept about any changes in people's care. Systems were not in place to make sure that staff had accurate information about any changes in people's needs and the care they required when staff returned from leave or days off. Staff relied on other staff to inform them about changes and there was a risk that important information about

people would not be shared with all staff.

We would recommend that the provider seek advice and guidance from a reputable source, about assessing people's needs and planning their care. We would also recommend that the provider review their process for communicating changes in people's needs with staff and take any necessary action to make sure information is shared with all staff without delay.

Some people became confused at times and could become frustrated. Staff knew the signs that people were becoming frustrated or upset and ways to support them to remain calm and happy. They monitored people and checked they were happy. Staff distracted or diverted people if they were becoming frustrated. This kept them calm.

People had commented at the September 2015 residents meeting that they would like a wider variety of activities on offer at the service. People had not been asked about what other activities they wanted to take part in and new activities had not been included in the activities schedule.

People did not always have enough to do during the day and told us they did not like all the activities on offer. One person told us they didn't get involved in the activities as there was nothing they particularly liked. Another person said they didn't think there was much happening at the service. A third person told us they played dominos with the activities person occasionally and they enjoyed this.

The activities co-ordinator provided a limited variety of activities each day. People were not involved in planning the activities. We would recommend that the provider involve people living at the service in planning activities, as well as seeking advice and guidance from a reputable source, about activities for people with dementia.

Everyone told us that they had enjoyed the Christmas celebrations at the service, including the Christmas party. One person said, "Christmas was nice. We had a super buffet and there was lots of singing and entertainment and I really enjoyed it".

People were confident to make complaints about the service. A process was in place to receive and respond to complaints. Information about how to make a complaint was available to people and their representatives. The manager and staff supported people and their representatives to raise concerns or make complaints about the service. No complaints had been received in the past year. One person told us, "I have nothing to complain about".

Staff recognised when concerns were raised and took action. They told us that any concerns raised were addressed immediately. Action had been taken to address day to day concerns or worries to people's satisfaction.

Requires Improvement

Is the service well-led?

Our findings

The registered manager is also the registered provider. They were not managing the service on a day to day basis and had recognised that a strong manager was required to undertake this role. They were advertising this post at the time of our inspection. In the meantime a deputy manager was in day to day charge.

Staff told us they felt supported by the deputy manager and the registered manager of another of the provider's services. They told us they enjoyed working at the service.

The registered manager's philosophy of care and vision of the quality of service they required had not been made not clear to staff. Staff did not know the aims of the service. The provider had not recognised that their statement of purpose was out of date, including the name of the registered manager and the health and social care regulations they were working under. A statement of purpose provides information to people and staff, about the aims and objectives of the service. Values including respecting diversity and independence did underpin the service provided by staff each day.

We would recommend that the provider review the statement of purpose to make sure it is up to date and includes information for people about the aims of the service and levels of quality they can expect.

Staff were not clear about their roles and responsibilities. The deputy manager had taken on additional management responsibilities and had delegated some of their responsibilities to senior carers. They had not identified that some delegated tasks, such as weighing people weekly and acting on any weight loss had not been completed. The registered manager had not recognised that the deputy manager was undertaking additional tasks and had not taken action to support them. Some management tasks, such as checks on the quality of the service and surveys of people's views of the service had not been completed. Staff told us they 'worked it out between them', when deciding who was going to complete tasks on each shift.

Systems were in place to obtain the views of people, their representatives, staff and visiting professionals. The process for 2015 had begun in September 2015 but had not been completed. Some people had made comments about improvements they would like to see at the service, including that they would like to see a hair dresser every week and 'the dining room could be cleaner'. The registered manager had not reviewed the responses received and was not aware of the comments people had made. People had not received feedback on their comments. Suggestions they had made had not been implemented.

Care staff chaired regular 'residents meetings'. Comments and suggestions made at the meetings had not been shared with other staff at the service and people's requests had not been implemented. For example, people had commented that they would like more ice-cream and fruit flan on the menu. The cooks were not aware of this request and the menus had not changed. People who did not attend the meetings spoke to staff on their own. These discussions were not recorded to make sure that people's comments and suggestions were acted on.

Staff meetings were held when the registered manager had information they needed to share with staff,

these were held approximately twice per year. The registered manager had not given staff other opportunities to share their views about the quality of the service and make suggestions about changes and developments. Staff told us if they thought that things could be done better they chatted to each other and implemented the changes.

We would recommend the provider review the policies and processes they have in operation to seek and act on feedback from relevant people, such as people who use the service and their relatives, to make sure they continually evaluate and improve the service.

A process was in place to regularly check all areas of the care that staff provided to people. However this had not used to check that people's care plans were up to date and their feedback about the service had been acted on. The registered manager was not aware of the shortfalls in the service found during our inspection. Staff practice was monitored and challenged to make sure people received a good standard of care. Systems were in operation to regularly check the safety of premises and equipment.

We would recommend that the provider put their quality assurance processes into operation to regularly monitor the quality of the service and take action to improve it where shortfalls are found.

Records in respect of each person's care and support were maintained. These were not consistently accurate and complete. For example, information about peoples likes and dislikes, guidance to staff about how to deliver people's care, people's care preferences and changes in their care needs. There was a risk that staff and health care professionals would not have accurate information to use when assessing people's needs and planning and providing their care.

The registered manager had failed to maintain an accurate, complete and contemporaneous record in respect of each person. This was a breach of Regulation 17(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager had sent notifications to CQC when they were required. Notifications are information we receive from the service when significant events happened at the service, such as a when DoLS authorisations were made.

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 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	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered manager had failed to operate effective systems to assess people's capacity to make decisions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered manager had failed to assess risks to people's health and safety. Regulation 12(2)(a) The registered manager had not taken action to ensure that people's medicines, including 'when required' (PRN) medicines and creams, were managed safely at all times. Regulation 12(2)(g) The registered manager had failed to operate effective systems to monitor people's health needs and take all the necessary action to keep them as well as possible. Regulation 12(2)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered manager had failed to maintain an accurate, complete and contemporaneous record in respect of each person. Regulation 17(2)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to make sure that all staff received appropriate training and development to enable them to carry out their duties effectively. Regulation 18(2)(a)