Mr & Mrs J Boodia

Gables Care Home

Inspection report

Gables Care Home
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Tel: 01483828792

Date of inspection visit:
02 March 2016

Date of publication:
04 July 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 was an unannounced inspection that took place on 2 March 2016.

Gables Care Home is registered to provide accommodation with care for up to 16 people. There were seven people living at the home, some living with complex needs as a result from living with long term conditions. During our visit, we were informed that there were at least three people living at the home with dementia. After the inspection the registered provider informed us this was incorrect and only two people had received a dementia diagnosis. The accommodation is provided over two floors that were accessible by stairs.

The registered provider was also the registered manager for Gables Care home. 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.

Systems and procedures to protect people from harm were not being followed correctly. Whilst some risk assessments were in place, others were not, they were not person centred or in line with current guidelines.

There were quality assurance systems in place, to review and monitor the quality of service provided, however they were not robust or effective at identifying or minimising risk or correcting poor practice.

Medicines were administered safely, however arrangements in place for the management of medicines needs to be reviewed to ensure the safe storage and disposal of medicines. Protocols regarding the administration of as and when needed medicines (PRN) were not in place therefore people were at risk of not receiving this type of medicine in a consistent way. We made a recommendation that the registered provider reviews and ensures arrangements and systems in place for the management of medicines are in line with current national guidelines.

Staff did not have the appropriate support that promoted their development. However, people were supported by staff that had the necessary skills and knowledge to meet their assessed needs. Staff we spoke with told us they spoke to their manager about concerns they had. The registered provider confirmed that regular meetings with staff to discuss their work and performance had not taken place.

People were not always protected from being cared for by unsuitable staff because although recruitment processes in place, they were not always followed. We made a recommendation that the registered provider obtains information as specified in Schedule 3 of the regulations.

People living at the home had different opinions about how staff were deployed to meet their needs. During the visit we observed how staffing levels had an impact on how staff responded to people's needs. We made a recommendation that the registered provider reviews best practice techniques when allocating the

deployment of staff to meet people's needs.

Staff had basic understanding of Deprivation of Liberty Safeguards (DoLS), the Mental Capacity Act (MCA) and their responsibilities in respect of this. Documentation regarding MCA and people appointed to make decisions on people's behalf was not always fully completed in accordance with current legislation. We made a recommendation that the registered provider reviews its MCA assessments and DoLS applications to ensure that people are protected from having their freedom restricted in accordance with current legislation.

People attended activities in the home and in their community; however they were not always specific to people's needs or preferences. We have made a recommendation that the provider reviews individual hobbies and interests and looks at ways these could be implemented and people supported to participate.

Staff responded to people's needs and information about people's care and support needs were not always detailed with the correct information.

People told us they felt safe at the home. Staff had a good understanding about the signs of abuse and were aware of what to do if they suspected abuse was taking place.
The home had a business contingency plan that identified how the home would function in the event of an emergency such as fire, adverse weather conditions, flooding or power cuts.

The manager ensured staff had the skills and experience which were necessary to carry out their role. The staff team were knowledgeable about people's care needs. People told us they felt supported and staff knew what they were doing.

People had enough to eat and drink throughout the day and night and there were arrangements in place to identify and support people who were nutritionally at risk. People were supported to have access to healthcare services and were involved in the regular monitoring of their health. Staff worked effectively with healthcare professionals and were proactive in referring people for treatment.

Staff involved and treated people with compassion, kindness, dignity and respect. People's preferences, likes and dislikes had been taken into consideration and support was provided in accordance with people's wishes. People's relatives and friends were able to visit. People's privacy and dignity were respected and promoted. Staff told us they always made sure they respected people's privacy and dignity when providing personal care.

People told us if they had any issues they would speak to the staff or the manager. People were encouraged to voice their concerns or complaints about the home and there were different ways for their voice to be heard. Suggestions, concerns and complaints were used as an opportunity to learn and improve the service provision.

The provider had sought, encouraged and supported people's involvement in the improvement of the home. Action taken had been recorded to make people aware of the concerns raised and how these were being addressed.

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 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.

Arrangements in place to manage risks safely were not effective or robust enough.

Medicines were administered safely, however some arrangements in place need to be reviewed in line with current national guidelines.

People were not always protected from being cared for by unsuitable staff because although recruitment processes were in place, they were not always followed.

People were cared for and supported by staff to keep people safe and meet their individual needs.

Staff were trained in safeguarding adults and knew how to report any concerns. There was a contingency plan in place in case of an emergency.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were supported by staff that had the necessary skills and knowledge to meet their assessed needs. However staff did not always receive appropriate support.

Staff understood and knew how to apply legislation that supported people to consent to treatment. Where restrictions were in place, this was not always in line with appropriate guidelines.

People's care, treatment and support promoted their well-being and there was good communication with healthcare professionals.

People had enough to eat and drink and there were arrangements in place to identify and support people who were nutritionally at risk.

Is the service caring?

Good

The service was caring.

People were treated with kindness and care, respect and dignity.

Staff encouraged people to make their own decisions about their care and staff supported people to lead independent lives.

People's relatives were made to feel welcome in the home.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There were inconsistencies in the way staff responded to people's needs and information for people around their care was not always detailed with the correct information.

There were not enough activities provided for people's specific needs.

People were encouraged to voice their concerns or complaints about the home and they were dealt with promptly.

People's needs were assessed when they entered the home and reviewed regularly.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The provider had systems in place to regularly assess and monitor the quality of the home but they were not robust or effective enough to identify and minimise risk or correct poor practice.

The provider had sought, encouraged and supported people's involvement in the improvement of the home. People's opinions had been recorded.

Gables 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.

We visited the home on 2 March 2016 and it was an unannounced inspection. The inspection was conducted by two inspectors.

Before the inspection we gathered information about the service by contacting the local authority safeguarding and quality assurance team. We also contacted two health and social care professionals who were involved with the service to obtain their views. We reviewed records held by the Care Quality Commission (CQC) which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the home is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the home, what the home does well and improvements they plan to make.

During the visit we spoke with six people living at the home, one care staff, the registered provider and the owner. We spent time in communal areas observing the interaction between staff and people and observed how people were being cared for by staff. We reviewed a variety of documents which included two people's care plans, risk assessments, medicines administration records and accident and incident records. We also reviewed four staff files, minutes of meetings, complaints records and some policies and procedures in relation to the quality of the service the home provided.

Our previous inspection of the service was in November 2013 where no concerns were identified.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe at the home and with the staff who provided care and support. We observed that people looked at ease with the staff that cared for them. However people were not always safe because there were inconsistencies in the systems and arrangements in place to protect them from harm.

Risks to people were not always managed safely and in accordance with their needs. Risk assessments contained information about people's support needs, views, wishes, likes, dislikes and routines of people. Risk assessments regarding people's behaviour, health and care needs were discussed with them. However there were inconsistencies with the information recorded in people's risk assessment, information recorded was not always specific to people's needs. For example where people had been diagnosed with epilepsy, a plan was in place but did not contained information about what kind of seizure they had and what signs to look for. Another example was of a person who had a moving and handling risk assessment in place but the registered provider had not involved a healthcare professional in their assessment. This indicated that records were not always completed in accordance to people's needs or action taken to minimise the risk of harm to people.

People were not safe because the systems in place to prevent and control infection were not satisfactory. Although the registered provider had systems to ensure appropriate standards of cleanliness were maintained, not all of these were being followed. For example, we found a bucket in one of the bathrooms soaking a resident's underwear; one of the toilet basins was cracked and very dirty, there was also mould growing behind the toilet on the wall. In one of the resident's room the sink was not working properly, water was very slow to flow away. In the laundry room, a laundry bin was overflowing with dirty clothes. There were no red bags available. Red bags are used to handle soiled laundry & avoid double handling of dirty linen. All these were environments that enabled germs and bacteria to grow and spread infection, placing people at risk of infection or harm.

People were at risk of harm as people had access to situations that could cause them harm. For example the cupboard that contained chemicals hazard to people's health such as bleach, fly spray and fungus fighter was not locked and people could gain access to. There were a lot of repairs required throughout the home. In one of the resident's room, their furniture was broken, which could cause an injury to a person. There were tiles broken in the communal toilets and the laundry room. A ventilation outlet was loose and hanging from the ceiling in the laundry room. The door to the laundry room which was deemed as a fire door (as gas boilers were situated in the room) was difficult to close, as it kept getting stuck on the floor. A rug situated by the door of the laundry room was a trip hazard, as we tripped over it. This demonstrated that people were at risk of harm due to the number of environmental risks to people living at the home.

Instructions displayed in the home about how to evacuate the building in the event of emergency. Only two people had a personalised fire evacuation plan in place. For people living at the home who had dementia or with complex needs, this indicated that staff did not have full information on how to support individual people in the event of an evacuation.

The premises was not fully accessible to people. The lift was not in use and we were informed that it had never been in use. For example a person told us they had difficult with climbing the stairs due to their mobility problems. The only access to the first floor is via stairs which did not have a stair lift. This indicated that people who lived on the first floor and had mobility issues found it difficult to have full access to the communal areas on the ground floor. We noted that residents were not confined to the first floor.

There were arrangements in place for the security of the home and people who lived there. However windows did not have restrictors attached to them. Window restrictors are used to reduce the opening of a window that helps to prevent people falling out of the window or from people entering the building. After the inspection the registered provider informed us that the window restrictors had been purchased and installed. There were no risk assessments in place regarding the environment. Entry to the home was through a bell system managed by staff. A book recorded all visitors to the home. The entrance to the garden was secure through a locked gate.

Accident records were kept which contained a description of the accident, time it occurred and if people required hospital treatment. Each accident had an accident form completed, which included immediate action taken. The registered provider told us that there was no summary of identifying trends and patterns as there had only been two accidents in 2015. However in one person's care plan that they had had an accident on 24/2/2016, but this accident was not recorded in the accident book, nor was a body map completed.

Failing to ensure that the premises were clean and secure was a breach in Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Stocks of medicines were not always managed in a safe way. For example, prescription creams were not recorded with opening dates. Once medicines such as creams, gels and ointments are opened this effects their expiry date. The temperature of the cupboard that stored medicines was not recorded on a daily basis as per company policy; the last entry was made on 28/2/2016. Medicines must be stored at specific temperatures to ensure their effectiveness. When we checked the medicines in stock that there was one tablet was missing when we compared with information against the medicines administration records. As the registered provider administered medicines they could not explain the error. This indicated that medicines were not always stored in line with national guidelines and that medicines could be used beyond their expiry date or their effectiveness.

Medicines were not always disposed of in a safe manner. We found prescribed tablets that should have been disposed of, stored in the office in an unlocked drawer. The registered provider told us they had forgotten they were there. First aid kits were not up to date; the majority of the kits supplies such as dressing and bandages had expired in 2010 and 2011. This demonstrated that the first aid kits to assist staff in administering first aid to people had not been checked on a regular basis. After the inspection the registered provider stated they had restocked the first aid kits. Although people did not require their medicines to be refrigerated we found the medicines refrigerator had not been plugged in. After the inspection the registered provider informed us that the refrigerator had been turned on and was in working order. This indicated that arrangements in place were not in line with current guidelines.

The provider did not have individual PRN [medicines to be taken as required] protocols for each medicine that people took. These would provide information to staff about the person taking the medicine, the type of medicine, maximum dose, the reason for taking the medicine and any possible side effects to be aware of. This meant people might not receive their medicines in a consistent way.

Documentation to record the administration of medicines were correct. The medicines administration records (MAR) recorded when medicines were administered. A medicines profile had been completed for each person, and any allergies to medicines recorded so that staff knew which medicines people received. A photograph of the each person was present to ensure that they were giving the medicine to the correct person. All medicines coming into the home were recorded. Any changes to people's medicines were prescribed by the person's GP.

We recommend that the registered provider reviews and ensures arrangements and systems in place for the management of medicines are in line with current national guidelines.

People were not always protected from being cared for by unsuitable staff because although recruitment processes in place, they were not always followed. There were gaps in employment history in three out of the four files we reviewed. Records contained an application form which recorded their employment and training history, provided proof of identification and contact details for references. There was no current information on people's files of their eligibility to work in the UK. After the inspection the provider provided some information about people's eligibility but not all. The registered provider conducted checks to ensure that staff were of good character. Staff confirmed they were not allowed to commence employment until satisfactory criminal records checks and references had been obtained.

We recommend that the registered provider obtains information as specified in Schedule 3 of the regulations.

People living at the home had different opinions about how staff were deployed to meet their needs. During the visit we observed how staffing levels had an impact on how staff responded to people's needs. The home consisted of two floors and there were a number of people who had mobility issues and would require support from two members of staff. A person told us, "I wish there was more staff, one staff member does everything. Sometimes I have accidents (personal ones) and have to wait for staff to help me." The registered provider told us they did not use a dependency tool to ascertain the number of staff required to work in accordance to people's needs. The registered provider said that there should be a minimum of 3 staff on duty during the day. This would be reduced to 2 staff in the afternoon. The registered provider and the owner were included in the number of staff allocated. We asked what would happen if they became ill, she stated that a family member would take over. We were also informed that two members of staff were currently on long term sick leave.

We recommend that the registered provider reviews best practice techniques when allocating the deployment of staff to meet people's needs.

People were involved in how they were kept safe at the home. Staff were knowledgeable about people's needs, and what techniques to use to when people were distressed or at risk of harm. This meant that people were supported by staff who understood their needs. People had access to specialist equipment such as pressure mattresses, walking frames and wheelchairs.

Staff knew how to report concerns if they witnessed abuse or poor practice and told us they would feel confident in doing so if necessary. Staff told us, "I would report to the manager or go to CQC." Staff were able to describe the different types of abuse and what might indicate that abuse was taking place.

The home did not have the most recent Surrey County Council (SCC) multi agency safeguarding policy. This provided staff with guidance about what to do in the event of suspected abuse. Incidents and safeguarding had been raised and dealt with and notifications had been sent to CQC in a timely manner. After the

inspection the registered provider confirmed that arrangement were in now place.

The home had a business contingency plan that identified how the home would function in the event of an emergency such as fire, adverse weather conditions, flooding or power cuts. The provider had identified alternative locations which would be utilised if the home was unable to be used.

Requires Improvement

Is the service effective?

Our findings

Staff did not always receive appropriate support that promoted their development. Staff told us they had regular conversations with the manager to discuss their work and performance. A member of staff told us, "I get the support of the manager; she is always here when you need her." These discussions were not recorded as a formal meeting which would enable the registered provider to monitor people's performance. The registered provider informs us they did not conducted formal supervisions or appraisals. This demonstrated that staff did not receive regular supervision or appraisals relevant to their role and responsibilities.

People were supported by staff who had the necessary skills and training to support their needs.
The manager ensured staff had the skills and experience which were necessary to carry out their roles. Staff told us they received training and support that enabled them to care for people effectively. One told us, "I have had moving and handling, fire and food hygiene training." New staff attended induction training and shadowed an experienced member of staff until they were competent to carry out their role.

Staff had a basic understanding of their responsibilities under the Mental Capacity Act 2005 (MCA), and the Deprivation of Liberty Safeguards (DoLS). The MCA is a legal framework about how decisions should be taken where people may lack capacity to do so for themselves. It applies to decisions such as medical treatment as well as day to day matters. People whenever possible should be enabled to make decisions themselves and where this is not possible any decisions made on their behalf should be made in their best interests. We reviewed the provider's records and saw that staff had received training in the MCA.

Staff ensured they obtained people's consent before providing care and support in accordance with their wishes. Staff told us, "I show X clothes that they can choose from." Staff had a clear understanding for the need to obtain consent for day to day decisions and knew where people lacked capacity who was able to make important decisions in their best interest. We observed that staff sought people's agreement before supporting them and then waited for a response before acting on their wishes. Staff maximised people's decision making capacity by seeking reassurance that people had understood questions asked of them. They repeated questions if necessary in order to be satisfied that the person understood the options available. Where people declined assistance or choices offered, staff respected these decisions. People's care plans contained forms which detailed that consent had been obtained in certain aspects of people's care. For example, in relation to administering medicines.

The registered provider informed us that everyone living at the home had capacity to make decisions. All of the mental capacity assessments we reviewed stated that the person had capacity. However some of the people living at the home had other people appointed to make certain decisions on their behalf, care plans did not always have the relevant information recorded regarding people's authority to make decisions on people's behalf known as Power of Attorney (PoA). This demonstrated that where people lacked capacity they were not fully protected and best practices were not being followed in accordance with the MCA.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS)

which applies to care homes. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. No DoLS application have been completed or submitted as the registered provider stated that no-one's liberty has been restricted, however the registered provider also told us that some people had PoA in place and were making decisions on their behalf.

We recommend that the registered provider reviews its MCA assessments and DoLS applications to ensure that people are protected from having their freedom restricted in accordance with current legislation.

Most people were able to move freely around the home. When we spoke to the registered provider they told us that people were able to go out whenever they wanted to and we did not see people being stopped by staff or their movements restricted.

People told us about the food at the home. One person told us, "I would like more choice of food." Another person told us, "The food is good." Staff prepared and cooked all of the meals in the home. People were involved in the consultation about the choice of menu for breakfast, lunch and tea. There was a choice of nutritious food and drink available throughout the day; an alternative option was available if people did not like what was on offer. People who required soft food or needed their food cut up were catered for.

Lunchtime was a very quiet occasion. Some people had their lunch together in the dining room or in their room. However there was a limited amount of interaction between staff and people during lunchtime which could affect the atmosphere at lunchtime. Detailed information about people's food likes and dislikes and preferences such as religious or cultural needs was available.

People had access to healthcare professional such as doctors, district nurses, psychiatrists, and other health and social care professionals. People were supported by staff or relatives to attend their health appointments. Outcomes of people's visits to healthcare professionals were recorded in their care records.

People's bedrooms were personalised with pictures, photographs or items of personal interest. Evidence of people's individual or personal interests integrated into the home outside of their rooms.

Good

Is the service caring?

Our findings

The atmosphere in the home was calm and relaxed during our inspection. People told us staff were kind and caring. A person told us, "I love this lady (pointing to the registered provider)." Another person told us, "Staff have their good days and their bad days, they are jolly good really."

Staff showed kindness to people and interacted with them in a positive and proactive way. We observed a member of staff gently supporting a person to walk. This was conducted at the person's own pace and the member of staff talked and encouraged the person throughout the task.

People were encouraged to make choices and be involved in their care. Such as when to get up in the morning, what to eat, what to wear and activities they would like to participate in so they could maintain their independence. People personalised their room with their own furniture and personal items so that they are surrounded by things that were familiar to them. People had the right to refuse treatment or care and this information was recorded in their care plans. Guidance was also given to staff about what to do in these situations.

People were supported by staff who knew their care and support needs. Staff told us, "I would get to know someone by talking to them." They went onto say "I treat them all like family." They told us any changes in someone's needs were reported to the manager. Staff were able to talk about people, their likes, dislikes and interests and the care and support they needed. There was information in care records that highlighted people's personal preferences, and what support was required so that staff would know what people needed from them. Information was recorded in people's plans about the way they would like to be spoken to and how they would react to questions or situations. Staff knew people's personal and social needs and preferences from reading their care records and getting to know them.

Staff treated people with kindness and compassion. A person told us, "Staff are caring." Staff treated people with dignity and respect. Personal care was provided in private. Staff called people by their preferred names. Staff interacted with people throughout the day, for example when supporting them throughout the home, attending activities in the home, listening to music and watching television. At each stage they checked that the person was happy with what was being done. Staff spoke to people in a respectful and friendly manner.

People were involved in making decisions about their care. We observed that when staff asked people questions, they were given time to respond. For example, when being offered drinks or food. Staff did not rush people for a response, nor did they make the choice for the person. Relatives, health and social care professionals were involved in individual's care planning. Staff were knowledgeable about how to support each person in ways that were right for them and how they were involved in their care

People were protected from social isolation with the activities, interests and hobbies they were involved with. People were able to attend various activities outside in the community as well as activities held in the home. Relatives and friends were able to visit and maintain relationships with people. People confirmed

that they were able to practice their religious beliefs, because the provider offered support to attend the local religious centres. People from the local religious community also visit people at the home.

Requires Improvement

Is the service responsive?

Our findings

People told us they were happy with the support they received. One person told us, "I am happy here."

However there were inconsistencies in the way staff responded to people's needs. For example one person approached us and informed us that their back was hurting and asked us if we could assist them. We asked them if they wanted some pain relief, they replied yes. We got the owner who told them to go and sit back down and relax and told the person 'we can't give you tablets.' The registered provider came to talk to the person and she told them sit back down and she would come and see them later to see is they were ok. This never happened during the visit. We also saw good intervention when the owner was able to de-escalate a problematic situation between two residents. They spoke calmly to both people, whilst distracting them and managed to calm the situation.

Pre assessments were carried out before people moved into the home and then were reviewed once the person had settled into the home. The information recorded included people's personal details, care needs, and details of health and social care professionals involved in supporting the person such as doctor and care manager. Other information about people's medical history, medicines, allergies, physical and mental health, identified needs and any potential risks were also recorded. This information was used to develop care and support in accordance to people's needs to ensure staff had information about people's care and support needs.

The care records had detailed information which identified individual's care and support and any changes to people's care was updated in their care record, however the information recorded was not always up to date or in accordance with people's care needs. For example, where people had behaviour that was challenging to themselves or others, there was no specific information recorded except 'agitated and upset'. There was no information provided to staff about what that meant and how they should manage this. The registered provider confirmed that they involved people, health care professionals and relatives in the decisions and planning of care. People received care that was based on their individual needs. Although some current information was not recorded, staff were knowledgeable about people's needs. People were provided with the necessary equipment to assist with their care and support needs. Items such as lifting equipment, wheelchairs and pressure mattresses.

Information about people's care and support needs was made available to hospital staff if they required hospitalisation. This enabled hospital staff to know important things about people's medicines, allergies, medical history, mental and physical needs and how to keep them safe. However this information was only recorded for two people. This indicated that salient information for people who are admitted into hospital might not be available.

People confirmed they were involved in the planning and delivery of their care. Care records were reviewed regularly and any healthcare visits, treatment given and instructions to staff were noted. Outcomes of people's visits to healthcare professionals were recorded in their care records.

People had mixed feelings about the activities in the home. One person told us, "I like to watch TV" "I do exercises at church." Another told us, "I go to a day centre for lunch and another one for exercise. I wish it was more." Some people told us they did activities, whilst others did not want to do any activities. People also confirmed that friends, relatives and people from the local community visited them at the home. Activities consisted of art and crafts, quizzes, chair exercise and bowling. People were able to attend various activities outside in the local community.

However, we found there was no physical stimulation around the home for people that would provide them with something to do during the day when organised activities were not happening. There were no areas in the home that could create sensations to assist people living with dementia, sensory impairment or complex needs with relaxation.

We recommend that the provider reviews individual hobbies and interests and looks at ways and means of these being implemented to support people to participate.

People had their comments and complaints listened to and acted upon. People were aware of the complaints system and told us that they knew what to do if they needed to make a complaint. There were various ways that people could voice their opinion about the home. For example, discussing issues with staff or the registered provider. We looked at the provider's complaints policy and procedure which was displayed at key points around the home. The policy was provided in a picture format which made it easier for people to under the process When people first moved in there was a copy provided in the resident's guide which people kept in their rooms. The registered provider maintained a complaints log and we read complaints were dealt with in a timely manner, in accordance with the complaint policy. There were no complaints in the last twelve months.

Staff told us they were aware of the complaints policy and procedure as well as the whistle- blowing policy. Staff knew what to do if someone approached them with a concern or complaint and had confidence that the manager would take any complaint seriously.

Requires Improvement

Is the service well-led?

Our findings

Where audits conducted by external bodies identified concerns, they were not acted upon. We reviewed the external audit conducted on the management of medicines and noted issues were identified. For example open dates on creams not noted; the care home does not have an up to date reference source in place, no systems in place to share information with hospital or transfer to other care homes; no record kept of medicines ordered or stock balance are not recorded on medicine administration chart . The audit which was conducted in May 2015 had identified the above concerns and more. Although this had been highlighted, this was still happening.

Quality assurance arrangements had been reviewed by the local authority that had also identified areas of concerns which also had not been actioned. This demonstrated that whilst there were some arrangements in place to monitor systems and standards, people were not fully protected against the risks as there was no systematic approach to managing them safely.

People's care and support needs could be affected due to care records not being fully completed or kept up to date. There were inconsistencies in the recording of people's care. We reviewed a person's care notes and even though there was information about people's care, there was no specific information about their condition for instance epilepsy, or behaviour that was challenging. One person's care plan stated 'Try to deescalate the agitation in a calming way, reassure and contact health team.' But there was no information about the signs to look for or triggers or how to manage the situation. Whereas for other people information about catheter care was recorded. This meant that there was inconsistency when recording information about people's care and may affect the care staff provided.

There was no robust or effective quality assurance monitoring checks carried out to monitor the level and quality of care provided to people living at the home. There were a number of systems in place to ensure the safety of the building. There were various audits carried out such as environment, maintenance, health and safety, Fire, electrical and safety equipment was inspected on a regular basis. But there were no audits of care plans and medicines administration records to identify concerns and action taken. This indicated that there was no robust arrangements in place to monitor or ensured that best practices were followed.

We saw records about accidents and incidents that had occurred. There were two accidents in 2015; however there was an accident that had occurred in 2016, which was not recorded. This meant that although there were systems in place to record accidents and incidents there were no arrangements to ensure records were correct.

There were a number of repairs that had been identified by the registered provider who informed us that they had a refurbishment programme in place, they told us they did not want to resume work until an inspection had taken place. We discussed the matter with the registered provider who informed us that there was no written programme in place. There was also no risk assessment in place to identify risks to people whilst maintenance work took place. This demonstrated that there were no arrangements in place to identify, and monitor the progress of refurbishment and repair work in the home.

There were no arrangements in place for staff to be involved in the improvement of the delivery of the service provided. The last staff meeting was held in February 2013. There was no information recorded about concerns discussed with staff about the care and support provided or their performance.

The lack of good governance was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed documentation of a residents meeting held in July 2015 where issues in regards to menus, day trips and activities were discussed. There was a record of actions taken. We also saw an independent survey conducted which obtained healthcare professionals and relative's feedback about the home. Comments included 'Excellent rapport with residents.', 'Carers always listen and follow advice regarding pressure sores and catheter care.' And 'Friendly staff.' 'Well run care home.'

People and staff said that the manager and staff were approachable and open to suggestions. One person told us, "She is always here when you need her."

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the home. Events had been informed to the CQC in a timely way.

We looked at a number of policies and procedures such as environmental, complaints, consent, disciplinary, quality assurance, safeguarding and whistleblowing. The policies and procedures gave guidance to staff in a number of key areas. Staff demonstrated that they were knowledgeable about these policies and procedures.

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 15 HSCA RA Regulations 2014 Premises and equipment The registered provider failed to ensure that the premises and equipment that is used to deliver care and treatment is clean, properly maintained and secure. Regulation 15 (1) (a)(b) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had not ensured good governance in the home.