JM Beyer

Somerville House

Inspection report

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Ratings

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

Overall summary

We undertook this unannounced inspection on the 26 and 27 March 2015. The last full inspection took place on 23 May 2013 and the registered provider was compliant in all the areas we assessed.

Somerville House is registered to provide accommodation and personal care for 18 older people, some of whom may have dementia. The home is situated close to the city centre and has good access to all local facilities. Bedrooms are located on each of the three floors. The upper floors are accessed by a passenger lift and stairs. On the day of the inspection there were 18 people using the service.

The service has a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Summary of findings

There were enough staff to meet the current needs of people who used the service. We saw there were some potential gaps in staffing numbers at specific times of the day. These were discussed with the registered manager and registered provider to check out. There were recruitment systems in place that would ensure all employment checks were carried out prior to staff starting work at the service.

Staff completed safeguarding training and knew what measures to take to help to protect people from the risk of abuse or harm. Risk assessments were completed although we found these lacked some important information to guide staff in how to manage and minimise risk.

People had their health needs met and had visits from professionals for advice and treatment. Staff administered medicines in a timely way so that people were not left waiting for their tablets.

People told us they enjoyed their meals and had enough to eat and drink.

Staff received guidance and completed essential and more specific training in order for them to feel confident when supporting people. The registered manager had completed training in how support people whose primary need was related to their mental health. A community psychiatric nurse had provided an awareness session for staff and additional training was being sourced.

Staff approach was seen as caring; they took time to speak to people, they respected privacy and dignity and they involved them in day to day decisions. We saw people were encouraged to participate in activities, to maintain their independence and to access community facilities.

We saw the care plans could be improved to include more personalised care and provide more thorough guidance to staff. Despite this we found staff knew people's needs well.

People felt able to raise concerns and the registered manager and registered provider were available for people who used the service, their relatives and staff to talk to.

There were some checks completed but the quality monitoring system was more ad hoc than planned in a structured way and lacked robust recording. People's views were sought in meetings and via questionnaires about the service. This helped to identify shortfalls so they could be addressed.

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?

Requires improvement

The service was not always safe.

People who used the service were protected from the risk of harm and abuse. Staff had completed training and knew what to do if they had any concerns. Risk assessments were completed although we found these could contain more information to guide staff in how to manage and minimise risk.

People received their medicines as prescribed. How staff record the temperature of stored medicines is to be reviewed so there is an audit trail.

Although there had not been any new staff employed since the last inspection, the registered manager told us full employment checks would be carried out during the recruitment process.

People who used the service currently had low level needs and there was sufficient staff employed to meet them. However, there were some potential gaps and the registered manager and registered provider are to review staffing numbers to check these out.

Is the service effective?

Good

The service was effective.

People accessed a range of health professionals to ensure their day to day health needs were met.

People's nutritional needs were met and they told us they enjoyed the meals provided for them. The menus could have more information about the alternatives that were available especially at lunch and the evening meal.

People were able to make their own choices and decisions. When people were assessed as lacking capacity to make their own decisions, the registered manager worked within the principals of the Mental Capacity Act 2005.

Staff had access to a range of training considered essential to the registered provider. More in-depth specific training, identified to meet some people's needs, was being sourced by the registered provider. There was a support system in place with supervision meetings.

Is the service caring?

Good

The service was caring.

We observed positive interactions between staff and the people who used the service. People told us they were treated with respect and their privacy and dignity was maintained. Some issues raised by a relative about how situations were handled were addressed by the registered provider during the inspection.

Summary of findings

People were encouraged to be independent and involved in decisions about their care.

Is the service responsive?

Requires improvement

The service was not always responsive.

People had their needs assessed and aspects of their care was planned for them. Although staff knew people's needs well, not all the person-centred information was written down in care plans.

People had the opportunity to participate in activities in the service and were also encouraged to access local community facilities.

There was a complaints procedure and people knew about this and felt able to raise concerns in the belief they would be addressed.

Is the service well-led?

Requires improvement

The service was not always well-led.

Although quality monitoring took place in the form of some checks and questionnaires, there was no structured system and it tended to be more ad hoc than planned.

The registration of the service required a minor update to ensure it reflected the type of people whose needs were met in the service.

There was good leadership, sound values and an open culture which would encourage staff and people who used the service to raise concerns.

Somerville House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the registered 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 26 and 27 March 2015 and was unannounced. The inspection was completed by one adult social care inspector.

Prior to the inspection we spoke with the local safeguarding team and the local authority contracts and commissioning team about their views of the service. We also spoke with the district nursing team. They did not have any concerns about the service.

During the inspection we spoke with eight people who used the service and two of their relatives. We also received information from a health professional visiting the service during the inspection.

We spoke with the registered provider, the registered manager, the deputy manager, two care staff and a cook.

We looked at four care files which belonged to people who used the service. We also looked at other important documentation relating to people who used the service such as nine medication administration records (MARs). We looked at how the service used the Mental Capacity Act 2005 and Deprivation of Liberty code of practice and checked if any person was deprived of their liberty.

We looked at a selection of documentation relating to the management and running of the service. These included some policies and procedures, the training record, the staff rotas, minutes of meetings with staff and people who used the service and maintenance of equipment records.

Requires improvement

Is the service safe?

Our findings

People told us they felt safe living in Somerville House. They said staff answered call bells quickly and they received their medicines on time. Comments included, "Yes, I do feel safe here", ""It's alright here; the staff are alright and they help me", "I have my tablets every morning", "They are all good to me" and "I just have to ring my bell and they come."

A relative told us, "I'm happy and very pleased with the care; it's safer here than at home." Another relative said, "Staff give medicines when they are needed."

We found there were 18 people who used the service, 17 of whom had full mobility. One person required the assistance of one member of staff, sometimes two, to transfer them out of bed and into a chair using standaid equipment. People who used the service had low level needs, for example eight people were able to access community facilities without staff assistance. Some people just required prompts regarding their personal care needs but were independent with carrying out the tasks and others needed minimal assistance of one staff with personal care. A few people had low level needs associated with dementia and memory impairment. Staff spoken with told us there was sufficient staff on duty, however there could be a potential gap at weekends and in the evenings at tea-time. The staff rotas showed there were two care staff on duty at all times day and night and the registered manager worked approximately 6-7 hours a day, six days a week. There was a cook and domestic worker on duty from 8am to 2pm each day. The cook prepared a selection of sandwiches to be provided to people at the evening meal and care staff prepared hot choices such as items on toast. When one member of staff was preparing the evening meal, this left the other one to oversee the people who used the service. We spoke with the registered provider about the potential for staffing gaps and they told us they will discuss this issue with staff and look at people's dependency levels to reassess the staffing numbers.

There was an on call system for out of usual working hours and bank staff available to cover care staff absences.

Care files demonstrated risk assessments were completed for some people in areas such as falls, food and fluid intake, mental health needs, smoking and accessing the community unescorted. However, these lacked some of the steps required to provide staff with full guidance in how to minimise risks. This was discussed with the registered provider to address with staff. The registered provider told us how they had installed voice activated smoke alarms that, when triggered, verbally prompted people not to smoke in their bedroom. This had been effective in reminding people of the risk this posed.

We found the service was clean and tidy bar the laundry room. This was a small room with a commercial washing machine and drier. The sink in the laundry was dirty and the area behind the machines near the sink was very dusty. We saw people's clothes were left in two piles on the laundry floor instead of in the baskets provided. The open weave plastic baskets used for carrying laundry would not be appropriate as they were a risk of cross-contamination when carried through the home. The registered manager confirmed they had laundry bags to carry soiled laundry as required. The laundry room was accessible to people who used the service, which could pose a risk to some people. We also found some linen stored on the floor in one of the linen cupboards which could pose an infection control risk. We mentioned these points to the registered manager and they told us they would address these shortfalls in practice with staff. They told us the laundry room would be locked when not in use. We saw that infection prevention and control training had been planned for May 2015.

We found people received their medicines as prescribed. The service used a colour-coded monitored dosage system dispensed by a local pharmacy. Medicines were obtained, stored, recorded and administered to people safely. We were unable to see that staff had recorded the temperature of medicines stored in the treatment room. There was a thermometer on the wall but daily readings were not available. Staff told us they recorded the temperature of the room on a white board but wiped this clean each day. This meant there was no record of the daily temperature readings to audit. We saw the fridge used to store medicines was broken. There were no medicines that required cold storage at present and we were told the fridge was due to be repaired.

We saw staff turnover was very low and there had been no need for staff recruitment since the last inspection. The registered manager described the recruitment process and told us all employment checks would be carried out prior to new employees starting work at the service.

Requires improvement

Is the service safe?

The service had policies and procedures in place to guide staff in how to respond to allegations of abuse or poor care. The majority of staff had completed training in how to safeguard vulnerable people from abuse. In discussions, staff were able to describe the different types of abuse, the signs and symptoms that would alert them to concerns and how they would respond to keep people safe. There was a flow chart to guide staff and a risk matrix tool provided by the local authority safeguarding team to assist staff in gauging risk and when to refer concerns to them.

We saw the registered provider visited the service at least weekly. They checked the environment and liaised with maintenance personnel when repairs were required. There was a book for staff to record any faults or repairs and these were signed off when completed. The registered provider also completed checks on the fire alarm system and hot water outlets, although we saw some of these were behind schedule. The nurse call system and moving and handling equipment such as the lift, hoists, bath lift and stair lift were maintained and serviced in line with manufacturer's instructions. We observed staff had to manoeuvre the medicines trolley up a small step between two rooms. This was a heavy and bulky trolley and could pose a risk to staff. We spoke with the registered provider who agreed to provide a ramp to make passage through the doorway easier and safer for staff when using the medicines trolley.

A winter contingency plan had been developed which indicated the action to be taken in the event of evacuation, heating failure, interruption of gas supply and severe weather conditions.

Good

Is the service effective?

Our findings

People told us their health needs were met and they were able to access health professionals when required. Comments included, "I'm due for an operation soon and I have an appointment next week", "Some people come to test your eyes and a bloke comes to cut toe-nails; I see the doctor sometimes for my legs", "They don't do anything I don't want them to do", "They put my legs on a pillow as they ache" and "I go out to see my GP."

People also told us they liked the meals provided. Comments included, "The food is not too bad at all", "They sometimes come round in the morning to ask us what we want", "The food is lovely, couldn't be better; I get plenty to eat and drink", "I like chocolate squares; the cook goes to the shops and gets chocolate squares for coffee in the morning", "It's fish and chips today but I like a 'patty' so they go and get me one" and "I'd like to have baked potatoes at teatime." This last point was mentioned to staff who said this would be easy to accommodate and they would address it. A visitor told us their relative enjoyed the food and their appetite had improved since admission to the service.

A visiting health professional said, "No concerns raised by my patient", and "Yes, staff follow instructions; they respond well to questions asked. They always expect my arrival and are ready and aware of the purpose of my visit." They also said, "They appear to respect his choices as he has capacity and does not place himself at risk."

Care files showed that people who used the service had access to health care facilities in the community. We saw people had visited their local health centre to access GPs for treatment and the practice nurse for flu vaccines. People also had visits from community psychiatric nurses, chiropodists, opticians and district nurses when required. Prior to the inspection we spoke with the district nursing team who covered Somerville House and they told us they had no concerns with the service. They said they were not currently treating any person who used the service. Staff were clear about how they monitored people's health care needs and described the action they would take if they had concerns about people.

The Care Quality Commission is required by law to monitor the use of Deprivation of Liberty Safeguards (DoLS). DoLS are applied for when people who use the service lack capacity and the care they require to keep them safe amounts to continuous supervision and control. There were no people subject to a DoLS at the time of this inspection. The registered manager and deputy manager had completed training in the Mental Capacity Act 2005 and DoLS and told us they would seek advice from the local authority if they thought any person who used the service met the criteria for DoLS.

We found the application of the Mental Capacity Act 2005 (MCA) in regards to assessments of capacity and best interest decision making had been used appropriately. We checked the documentation for two people when MCA had been used. Specialist social workers had completed the assessments of capacity for people and when this showed they lacked capacity, appropriate measures had been put in pace to include relevant people in best interest meetings, for example relatives and an advocate. Staff told us all the people who used the service were able to make day to day decisions about aspects of their life. When asked how they gained consent from people to undertake care tasks with them, they said, "The majority of people can tell us what they want. We ask people, give them a choice; there are no rules here."

The registered manager told us there was no person who had a 'do not attempt cardiopulmonary resuscitation form' (DNACPR) in place. They said staff were fully aware that any medical emergency of this nature would be responded to straight away. Staff had completed first aid training and in discussions they confirmed they were aware of each person's DNACPR status. The registered manager told us DNACPR had been discussed with one person who was potentially at risk and they had chosen for resuscitation to take place.

We found people's nutritional needs were met. There was sufficient food and fluids provided to people who used the service. The service had sitting and standing scales to weigh people and their weight was monitored according to any nutritional risk. We saw people's weight was stable and currently there was no dietician involved with people and no requirement for food supplements to be prescribed. The registered manager had acquired a recognised nutritional risk assessment tool but this had not been implemented yet. Information about likes and dislikes, nutritional needs

and swallowing issues were checked at the initial assessment stage during admission; the registered manager told us this would be revisited if there were concerns.

Information about the days menu was written on a board in the dining area and the weeks menu was stored in the kitchen rather than on display. There was one choice served at the main meal although staff told us they provided alternatives for people if required. The cook said, "The other day X didn't want gammon so we did eggs, chips and peas." The menus did not detail what the alternatives were, which meant people may not know what was available. Also some people didn't get up until late in the morning, which may be too late to order an alternative. There had been some people recently admitted to the service who were younger than the rest of the people who used the service. Although people told us the age difference did not have an impact on them, there may be differences in meal times and quantities for the evening meal that may have to be taken into consideration. Staff told us some specific people chose to purchase takeaway meals in the evenings and we were unsure if this was due to individual choice, previous routines or the system of having the main meal at lunchtime with more snack type evening meals and suppers. The people were out during the inspection when we became aware of this so we were unable to discuss it with them. This was mentioned to the registered manager and registered provider to explore with specific people who used the service and address if necessary.

The training matrix showed staff had access to training considered to be essential by the registered provider. This included, safeguarding adults from abuse, fire safety, moving and handling, nutrition and first aid. There were some gaps such as infection prevention and control, health and safety and basic food hygiene refresher training but these had been planned for May and June 2015. All staff who administered medicines had completed safe handling of medication training. Six out of the eight care staff had completed dementia care training in June 2014 and were due to refresh this in July 2015. Staff had also completed training in dental and mouth hygiene. The service had recently admitted some people with mental health needs and a community psychiatric nurse had provided staff with an awareness session. The registered manager told us they were to source an appropriate training course for staff that covered the subject in more depth.

Staff told us they felt supported by management and most confirmed they had supervision meetings were they discussed issues of concern and training needs. Staff said, "The manager is always available or there's the deputy; Mark (the registered provider) always lets us know when he is in" and "You can go to any of the managers to talk to them." We saw the deputy manager had not received supervision for quite some time. This was mentioned to the registered manager.

The environment had been adapted to support people's needs. The deputy manager told us they were aware of what measures were needed to improve the environment for people with dementia and memory impairment. They spoke about the sitting room carpet and told us the registered provider had chosen one without a pattern which was to fitted in the near future. They had also read about the usefulness of having a different colour for toilet seats and doors to aid recognition. There were hand rails, raised toilet seats, moving and handling equipment, a passenger lift and stair lift. There were appropriate signs on toilet doors downstairs and signs ready to be fitted to doors on bathroom and toilet doors upstairs when repainting had been completed. There was also arrows reminding people were toilets were located. These measures helped people with dementia and memory impairment to locate the facilities independently. A small slope leading from the patio doors to the garden area at the rear had been covered with non slip material and provided with a hand rail. There was seating and a space to walk in the garden. The registered manager told us the registered provider had purchased a piece of land at the back of the service and was intending to use this to make more outdoor space for people.

Good

Is the service caring?

Our findings

People who used the service told us staff treated them well and respected their dignity and privacy. Comments included, “The staff are very nice”, “They give me a strip wash every evening and put me a clean nightdress on, freshen me up; they make sure I don’t want for anything else”, “Yes, the staff are alright; better than at my other place”, “The staff are all good to me; they can’t do enough for me and are up and down the stairs like troopers”, “They make sure I have everything around me”, “ and “They do look after me.”

A relative said, “Staff are absolutely brilliant” and “It really does feel homely here.” A visiting health professional said, “Staff appear open and warm.”

One relative raised some issues they felt could have been handled in a better way by specific staff. We spoke with the registered provider about this and he had a meeting with the relative to address the concerns.

We observed staff promoted privacy, dignity and respect during their interactions with people who used the service. They were patient and used humour appropriately when bantering with them. Staff said, “It is a nice home for people and a relaxed atmosphere; everybody does their utmost to keep residents happy and well” and “If people want to lie in this is respected.” Staff described how they respected privacy by knocking on doors prior to entering, by providing personal hygiene care in a sensitive way and being mindful of people’s possessions and the way they liked to use their personal space. Telephone conversations with health professionals or relatives were held in private to prevent them from being overheard. Staff kept information and records secure. Computers were password protected and care files were locked in a secure cabinet when not in use.

We saw staff provided information to people who used the service and involved them as much as possible in decisions about their care. Assessments and care plans had been signed by people who used the service to show they had agreed the contents. One person had care that was shared between the service and their relatives; this had been agreed at multi-disciplinary meetings. An advocate had been used for another person to ensure their views were represented at a meeting. The registered manager described a recent occasion when a member of the catering staff gained a promotion and two people who used the service were involved in asking them questions during an interview. This was confirmed in discussions with one of the people who used the service. We saw four people who used the service had joined staff in a training session about dental hygiene to help them understand the importance of this. Meetings took place so staff could ask people their views and involve them in planning activities.

We found people were encouraged to be independent. There were eight people who used the service who were able to access community facilities unassisted by staff. There were systems in place to check when people went out and the approximate time of their return. There was also a system for some people to carry their name and address on their person when they went out in case of emergencies. Some people attended support groups and visited health professionals, others attended local hairdressers and barbers independently. Several people managed their own finances. A visiting health professional said, “My patient is encouraged and supported to go out and meet friends and go to the shops for example.”

We saw the registered provider had consulted people who used the service regarding the provision of facilities for people who wished to smoke. There was already an outside covered area but it was recognised this was cold for people in winter. One person also liked to play their guitar but it was isolating for them always to play this in their bedroom and could be noisy for other people if they used the sitting rooms. A wooden summer room was provided in the garden at the rear of the house. The registered provider told us the finishing touches of electrical sockets and a heater were yet to be installed then it would be ready for use. This would provide space and shelter for people who wished to smoke and a room for the person to play their guitar.

Five people who used the service had recently been admitted when their previous home closed. The transition for them was managed in a kind and caring way. It was recognised that some of the people were friends and had lived together in the previous service for quite some time and wanted to remain together. Some people had attended for lunch prior to admission, to look around and familiarise themselves with the service and the people who lived there. The registered manager described how one person, who was several years younger than other people decided they also wanted to live in the service. The age

Good

Is the service caring?

difference was discussed with them and has been closely monitored. The registered manager said, “There really has been no issues with the age difference between some people; it has all worked so well.” This was confirmed in discussions with staff and people who used the service. Staff said, “The dynamics seem to be working.”

Requires improvement

Is the service responsive?

Our findings

People who used the service told us they could make choices about aspects of their lives. They said they could choose when to get up and go to bed, what to have for their meals, what activities to participate in and when and where they went in the community. They also said they would be able to raise concerns or complaints with staff. Comments included, "I'm independent, do what I want and get up and go out when I please", "I like to sit in this room; it's quieter", "I get up and go to bed whenever I want", "I'm teaching myself to knit and I like watching Sky TV in my room", "I go out to the barber and I go for a paper each morning", "Yes, I'd tell the staff if I had a complaint" and "I'd go to X (staff) if I had a complaint and they'd sort it."

One person told us their choice of cereals for breakfast had been restricted, as the service had run out of them. We checked the stock of cereals and found this one specific type had run out. We mentioned this to the registered provider who told us there was no reason why stocks should run out as there were shops locally to replenish items. They told us this would be addressed.

We saw people who used the service had their needs assessed and plans of care were developed. We saw people had been consulted during the assessment stage and they had signed the assessment and care plan to agree the contents. Some of these were person centred and included what was important to the person, how best to support them, likes, dislikes and preferences. For example, one care plan specified the person preferred a female care worker. However, some care plans were not as detailed and would not provide the full range of guidance staff would need to support the person. Despite the gaps in information in some care plans we found staff were very knowledgeable about people's needs and could describe the support required to meet them. The evaluations of the care plans were signed each month, however it was difficult to check how these had been completed as staff had just stated there were no changes or the care plan remained the same. We spoke with the registered manager and registered provider about the need to have full person centred information and thorough evaluations written down in the care plans to ensure any new members of staff would have up to date and important information to guide them in supporting people.

We could not see any information sheets called, 'patient passports' which were sent with people during any hospital admissions. The registered manager told us these were completed when needed and sent with people but were often not returned. The registered manager confirmed they would ensure each person who used the service had an up to date 'patient passport' ready for use, which was to be photocopied to prevent staff having to re-write them each time.

We saw there were activities for people who used the service to participate in. The daily programme was displayed on the notice board. These included: baking sessions, craft work, karaoke, quizzes, board games, movement activities such as skittles, visiting entertainers each month, shopping and outings to local facilities such as cafes and pubs. There were monthly church services for people to attend if they chose to. The registered manager told us most of the people who used the service joined in a specific television game show when it was on and really enjoyed it. We saw that in the last year there had been several trips out to the coast and people who used the service had been supported by staff to go by train. Staff told us some people went to a local coffee morning each week. They said, "We do a lot of things with people" and "Last year some people had a weekend holiday in Bridlington."

The cook told us they went shopping each day for fresh food and vegetables and often one of the people who used the service would accompany them. We saw some people liked to do small jobs around the service such as sweeping the back yard and setting the tables at mealtimes. One person preferred to clean and tidy their own bedroom; others were encouraged to do this.

There was a complaints policy and procedure and people spoken with knew how to complain. The registered provider and registered manager both told us they would be available to talk to people who used the service or their relatives to discuss any areas of concern. Staff told us they would try to deal with issues straight away to prevent them developing into more formal complaints. They said, "When there are niggles we talk it out, sort it for people and provide alternatives." We saw niggles were not recorded as concerns or complaints, which made it difficult to check that these small issues had been dealt with. This was mentioned to the registered manager and registered provider to consider recording them for auditing purposes.

Requires improvement

Is the service well-led?

Our findings

People who used the service referred to the registered manager and registered provider by their first name. They told us they had the opportunity to speak with the registered manager on a daily basis and the registered provider when he visited the service each week. Comments included, "There is nothing they could do better."

A relative told us, "The manager is very good and I do see Mark (the registered provider); he does get on with any jobs that need doing."

We saw there was a quality monitoring system in place but this had not been fully developed to provide a structured programme of audits and questionnaires. There were some surveys completed, for example, one on catering provision had been completed this month. A full survey of what people thought about the service was completed in January 2014. We saw the results of this which indicated people were happy with the quality of the service provided to them. The registered manager showed us new surveys which had recently been redeveloped in a simpler format. There were questionnaires for staff, which were just about to be sent out. The registered manager told us the one for professional visitors had not been developed yet.

Some checks were undertaken, for example of the environment, and any concerns were recorded in a book for the registered provider or maintenance personnel to address. We found several towels in use were frayed and in need of replacement. This was mentioned to the registered provider who told us it would be addressed straight away and in future they would ensure a linen audit was added to the environment check. The registered manager told us an audit of care plans was completed when they were evaluated each month but there was no record of an action plan to indicate what was required to improve them. They also told us the deputy manager audited medicines when they were delivered each month and went through the medication administration records to look for errors. However, there was no checklist for the medicines audit and no record of the shortfalls identified and the action that had been taken to address them. The registered manager told us the domestic staff had a job description regarding their cleaning duties but there was no schedule to evidence these had been completed or checked by staff in charge of the shift.

We saw the registered provider was in the process of updating policies and procedures. Some had been completed but there were others that required some attention. The registered provider told us they were to develop a more structured approach to quality monitoring and the review and update of policies and procedures would be added to the annual audit plan.

We saw some people who used the service had main needs associated with their mental health. When we checked the registration of the service, the provision of care and support to people with mental health needs was not included in the initial application for registration. This was discussed with the registered provider to address via an application to change their registration so it reflected the different groups of people they provided support to. During the writing of this report we received an updated statement of purpose from the registered provider so the change could be addressed. We saw there were two registration certificates on display, one of which was out of date. We mentioned this to the registered manager who removed it. It was important only up to date and correct information about the service's registration status was on display.

We saw there was a statement regarding the philosophy of care. This spoke about providing a 'warm, family-like environment' and supporting people to 'continue living as independently as possible'. We found this had been achieved in practice. The registered manager spoke about creating the right atmosphere for people who used the service and for staff. They said their approach was laid back, open and approachable. They described how two members of staff didn't like going on training courses so he encouraged them by attending the courses with them. We observed the registered manager's and registered providers' style was respectful, friendly and professional to people who used the service and staff. It was clear both knew the people who used the service well. The registered manager said, "It really is like a family here; the residents have made it like this."

We saw people who used the service had very few accidents. The registered manager was aware of their responsibilities in notifying the Care Quality Commission of any accidents or incident that affected the safety and welfare of people who used the service.

Requires improvement

Is the service well-led?

The registered manager told us they had a support network with other registered managers in the area. This was set up to enable them to share good practice and to discuss issues of concern.

There were meetings for people who used the service and staff to express their views. We saw issues such as activities, meals, a check about any concerns and an exchange of information took place at the meetings for people who used the service. We saw a record of a staff information meeting for January 2015 which included discussions about key worker responsibilities, chiropody, care plan evaluations and documentation. Not all care staff had attended the meeting and it was unclear if the information had been disseminated to all staff. The next meeting was planned for April 2015. The registered manager told us they tended to speak with staff on a daily basis and there was a communication book in use to pass on and record relevant information.

Staff confirmed they had team meetings and could speak to the registered manager and registered provider when they needed to. They described the culture of the service as open and friendly. They said, “They are easy to talk to” and “I like working here; we have a good staff team.”