St Valery Ltd

St Valery Care Home

Inspection report

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Ratings

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

Overall summary

The inspection was unannounced and took place on 15 & 16 September 2015. St Valery is a residential service for up to 16 people living with dementia, but shared rooms are often used for single occupancy. At the time of inspection there were 15 people living in the service.

The service has a registered manager who is a director of this family run company. They had taken a leave of absence for some time and in the interim the service had been managed by another director and family member. These arrangements had worked successfully and changes to the manager registration were in the process of being formalised. A registered manager is a person who is 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.

We last inspected this service on 9 July 2013 when we found the provider was meeting all the regulations.

Some improvements were needed however, to ensure the service continued to offer a safe and responsive environment for people living with dementia. Staff showed sensitivity warmth and understanding for the people they supported, they were provided with a wide range of training but were not accessing this fully with

Summary of findings

75% or less having completed the essential training they needed to support people safely. Staff understood how to protect people from abuse but two out of three were unable to say how they would report concerns to the local authority.

The premises were well maintained and equipment used to support people was serviced regularly, checks and tests of the fire alarm, and extinguishers were conducted on weekly and monthly intervals respectively to ensure these remained in working order. Emergency lighting tests were not happening monthly and we have asked that required frequencies be checked with the local fire service. Each person had a personal evacuation plan in the event of fire; we have asked that those for people on the first floor be reviewed with the local fire service to ensure they meet the legal requirements.

Medicines ordering, receipt, administration and disposal were well managed by trained staff, but storage temperatures were not recorded and monitored; staff might not therefore, be aware when temperatures exceeded the recommended level and that this could impact on the effectiveness of the medicines. Sticky labels were used on Medicine Administration Records: this is not seen as good practice because these can so easily be removed or tampered with.

The interim manager undertook regular spot checks and audits at the service. For the most part these were effective in ensuring good standards were maintained throughout, but, had not been sufficiently comprehensive to pick up some of the shortfalls we have identified from this inspection for example, shortfalls in recording, and improvements needed to medicines.

We spoke with relatives that visited regularly. They told us they felt their relatives were safe and received a good standard of care. They thought that staff had the right attitudes and showed they cared and understood the needs of people living with dementia commenting how kind and lovely the care staff were.

We saw many very positive interactions and people were seen to enjoy the talks they had with staff. We observed people were sitting companionably with others or engaging in an activity on their own or with staff. Staff were attentive and vigilant in their observations and attention to people's need for support. Visitors were made welcome and there were no restrictions.

Appropriate checks were made of new staff to ensure they were suitable. Staff were provided with induction in line with the new care certificate to give them a basic awareness of how to work with people correctly. Staff also had access to specialist intensive courses overseen by a college that gave them an advanced understanding of for example medicines, and dementia. Thirteen out of 22 staff had achieved nationally recognised qualifications at level 2 or 3 in health and social care.

Systems were in place to ensure people ate and drank enough and their specific dietary needs were catered for. Their health was monitored, staff referred them for health treatment, and they were supported by staff to access healthcare appointments.

People were treated with kindness, compassion and respect and staff took time to speak with them. They and their representatives were involved in discussions about care needs. Staff support assumed people had capacity to make their own everyday decisions; however they understood more difficult decisions needed to be more widely discussed. The interim manager ensured the service provided was compliant with the Mental Capacity Act principles and there was evidence of best interest discussions and Deprivation of Liberty Safeguarding authorisations.

There were enough staff with the right skills and attitudes to support people with their care and support. Staff were respectful of people's privacy, dignity and rights, they encouraged people's independence. The interim manager and staff were innovative in trying to find the most suitable and effective ways of working with people. Health and social care professionals spoke highly of the service and had no concerns about the quality of the support and care people received.

Staff said they felt well supported and motivated by the interim manager and found her approachable, they said the other directors of the company were a visible presence in the service and they found them easy to talk to. Staff had opportunities to express their views and felt able to share ideas, they received supervision and observations of their competency which gave them confidence that they were supporting people correctly. People and relatives told us they were asked to comment about the service people received. They felt able to raise concerns if they needed to and the majority were confident these would be dealt with to their satisfaction.

Summary of findings

We have made two recommendations:

The provider should consult the Fire Service regarding the frequency of emergency lighting checks and whether evacuation plans for people on the first floor meet current fire legislation Regulatory Reform (Fire Safety) Order 2005.

We have recommended that the provider review the use of sticky labels on Medicine Administration records and considers their use in line with NICE guidance in regard to Managing medicines in care homes (published March 2014).

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not always safe

Staff did not fully understand their reporting responsibilities to the local authority. Improvements were needed to the management of medicines.

The premises were clean and well maintained but arrangements for evacuation and frequency of emergency lighting checks needed to be checked with the fire service. Equipment used for the care and support of people was serviced regularly.

Contingency plans were in place in the event of an emergency. Systems for the recruitment of suitable staff were in place. There were enough staff to support people.

Is the service effective?

Requires improvement

The service was not always effective

People were supported safely but less than 75% of the staff team had completed their essential training to ensure their practice was kept updated and this could place people at risk. People's records did not make clear strategies for managing behaviour that could be challenging or provide staff with guidance about specific health conditions people needed support with.

Staff protected people's independence and ability to make their own decisions; they worked to the principles of the Mental Capacity Act 2005. People were supported to access routine and specialist healthcare. People's nutritional needs were assessed; they made their own choices about what they ate.

Staff undertook a nationally recognised induction programme. The interim manager undertook regular observations of staff competency. There were enough staff to provide assistance at meal times where needed.

Is the service caring?

Good

The service was caring

Staff showed kindness, compassion and an understanding of people's needs. They were vigilant and provided interventions appropriately.

People were treated with dignity and respect by staff. Staff encouraged and promoted people to retain their independence.

Visitors were made welcome, and people's representatives were kept informed about their wellbeing and consulted about their care.

Is the service responsive?

Good

The service was responsive

Summary of findings

People had individualised plans of care that took into account their personal preferences, they and their representatives were consulted about their care and support.

People were provided with a range of activities and stimulation suited to their needs.

People and relatives were confident of raising concerns and that these would be dealt with.

Is the service well-led?

The service was not consistently well led

Improvements were needed to the audits conducted by the interim manager to identify and act on shortfalls in recording and staff training.

Staff said they were well supported and that they felt motivated by the interim manager.

People, their representatives, staff and other stakeholders were given opportunities to express their views through surveys or meetings. Relatives and representatives said they felt they were consulted and kept informed.

Requires improvement

St Valery Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 15 & 16 September 2015 and was unannounced. The inspection team comprised of one inspector and an expert by experience that had experience of the care of older people and of people living with dementia. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the completed PIR and previous inspection reports before the inspection. We checked the information we held about the service and the service provider.

We spoke with ten people who use the service. We also used the strategic Short Observational Framework for Inspection (SOFI); SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We met and spoke with four relatives, a visiting training professional and interviewed nine staff including the provider/registered manager, interim manager, deputy manager, cook, housekeeper, and four care staff. We contacted a further six relatives following the inspection for their views about the service.

We looked at three staff recruitment records, three care plans with associated risk information and health care needs information and guidance for staff. We looked at accidents and incident reporting, we viewed records of staff induction, training and supervision, risk assessment information, premises and equipment maintenance records, audits of service quality, staff and resident meetings minutes and emergency and contingency planning for the service.

We contacted three health and social professionals, from clinical commissioning group, and adult social care safeguarding and commissioning to gain their views about the service and received feedback from all three that was positive and indicated they had no concerns about the service.

Requires improvement

Is the service safe?

Our findings

Our observations showed that people were happy, relaxed, and engaged with staff, other people, and their surroundings throughout the inspection. People told us “I love it here I can't think of anything bad to say about it". A second person said "I feel safe as there are always people around; they check when I wake up if I need anything and are always so cheerful". Another said “My bedroom is clean and nice and I get help if I need it”. “I like to do somethings for myself and staff respect this”.

The interim manager and deputy were aware of their roles and responsibilities in safeguarding people from abuse and the proper processes to follow if any abuse was suspected and had done so previously when necessary. The provider and staff had access to the local authority safeguarding policy and protocols and this included how to contact the safeguarding team.

Not all staff had received training in safeguarding. Those spoken with knew where to find the safeguarding policy and understood how to protect people from harm. They were able to tell us the signs of abuse and the actions they would personally take if they had any suspicion of abuse, for example reporting concerns to the interim manager or provider. Two out of three staff interviewed were able to identify those agencies they could report concerns to outside of the organisation, if they were unable to report them to the management team. One staff member however, was unable to identify anyone she could report concerns to outside of the organisation. There was a failure to ensure all staff had a full understanding of their reporting responsibilities under safeguarding.

There was a failure to ensure staff had a full understanding of their reporting responsibilities under safeguarding. This is a breach of Regulation 13 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Improvements were needed to ensure the safe management of medicines and protect people from harm. Medicine temperatures were not recorded in the stock cupboard or the medicine trolley. Staff were unaware that high temperatures could impact on the efficiency of some temperature sensitive medicine. The interim manager took immediate action to purchase thermometers, but these were not in place during or at the end of the inspection. The failure to ensure that medicines were stored at the correct temperature is a breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014

Medication administration Records (MAR) contained sticky labels supplied from the pharmacy with printed prescribing instructions.; there is a risk these could be tampered with or removed altogether and we have made a recommendation for this.

New staff completed application forms and attended for interview. Recruitment checks undertaken of new staff showed that the provider had processes in place to check applicant’s criminal record, request proof of identity and seek previous conduct in employment and character references, and reasons for leaving previous care roles. These checks ensured applicants were suitable to work with the people in the service. In two out of three new staff records viewed however, we found gaps in the employment histories of these staff; the provider could not evidence these gaps had been explored at interview. They were therefore unable to assure themselves that there were no issues of concern that could impact on the safety of people in the service. The failure to undertake full recruitment checks on new staff and this is a breach of Regulation 19 (3) (a) and Schedule 3 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

People were protected because the interim manager had arranged for regular servicing checks of the fire alarm and fire fighting equipment to ensure these remained in good working order. Weekly routine tests of the fire alarm were completed most weeks by staff, monthly checks were made of the emergency lighting system but these checks had not been undertaken since 15 June 2015 and is an area for improvement.

Staff recorded incidents and accidents and that some incidents were referred for investigation as safeguarding. Staff were aware of the whistleblowing policy and were confident of using this to report concerns about staff practice. Staff said they had confidence that the interim manager would support and protect their confidentiality in using this procedure.

Only trained staff administered medicines. We observed this was done carefully and correctly ensuring the right medicine was given to the right person. Some medicines were mixed in food and drink to ease swallowing and make

Requires improvement

Is the service safe?

them more palatable but this was done with the knowledge of the person receiving the medicines. Medicines were kept securely. Storage was tidy with good stock rotation. A drugs fridge was used and temperatures recorded for this. Procedures for the receipt and disposal of medicines were completed properly and overseen by the interim manager. A record of medicine errors was maintained to analyse and track trends and patterns and this also showed that where needed, disciplinary action was taken.

Fire drills were conducted and the interim manager also undertook walkthroughs with staff to ensure they understood the evacuation procedure, day care staff told us they could ask for these at any time but these were not recorded. Staff had received fire training, fire risk assessments were in place and all staff knew the evacuation procedure and assembly point.

Individual personal evacuations plans (PEEPS) were in place for people; these took account of their specific needs. For some people on the first floor these highlighted a risk that they may not want to leave their room in an emergency. We recommend that these plans be discussed with the fire service to ensure the existing arrangements meet current fire legislation requirements. Plans had been developed to inform staff about the actions they needed to take if an event that stopped the service happened.

Relatives told us that there were enough staff to meet people's everyday needs and the rota confirmed staffing levels were maintained. We observed that staff were a visible presence; they provided stimulation and engagement for people throughout the day in the communal areas where people were mainly located. At peak times in the morning and evening additional staff were brought in to ensure everyone was given the support they needed to get up and go to bed, when they wished to. At lunchtime there were enough staff available to ensure that everyone was able to eat together with staff providing assistance or supervision to those that needed it.

The premises were visibly clean with no unpleasant odours. Relatives told us they were very happy with the standard of cleanliness. There were appropriate arrangements in place for undertaking daily, weekly and monthly cleaning, of bedrooms, communal areas, toilets bathrooms and kitchen areas. Staff told us they had access to gloves and aprons and stocks were monitored to ensure these did not run out. The interim manager conducted an infection control audit every six months. Spot checks were also undertaken where shortfalls were highlighted these were made known to staff to address immediately.

The environment was safe for people to live in in. The premises were well maintained and staff reported that repairs were undertaken quickly. We highlighted the lack of restrictors on some downstairs rooms facing onto a busy road as we felt this could pose a risk, also a remote control for the stair lift that was not working although the lift could still be used. The interim manager took immediate action to address these matters. Restrictors were installed in the identified rooms before the inspection ended. Repair or replacement of the stair lift remote was underway. All electrical, gas installations and equipment used for the support of service users was serviced by external contractors to the required intervals to ensure this was maintained in good working order.

Risks people may be subject to from their environment or as a result of their own care or treatment needs were assessed; risk reduction measures were implemented and staff provided with guidance on how to support people safely. These were kept updated and reviewed. For example, one person was at risk of falls getting in and out of bed. The interim manager and staff reviewed how this risk could be reduced, the person's bed was relocated, and the immediate effect was they had less falls and could in and out of bed independently following the change.

The provider should consult the Fire Service regarding the frequency of emergency lighting checks and evacuation plans for people on the first floor to ensure these meet current fire legislation Regulatory Reform (Fire Safety) Order 2005.

We have recommended that the provider review the use of sticky labels on Medicine Administration records and considers their use in line with NICE guidance in regard to Managing medicines in care homes (published March 2014).

Requires improvement

Is the service effective?

Our findings

One person told us “The food is very good; we get cooked breakfasts, which are my favourite. I like all the things and get plenty to eat”. Another said “I am a poor eater, I always have been but the food is nice, I just don’t want too much of it”. A relative told us “The food is a nice variety; my relative has put on weight so it must be good”. One person said they were “pleased with the way they look after you; they come and talk to you and are always friendly and smiling”.

The interim manager was hands on and led by example providing informal training to staff so that people were well looked after and staff had developed a good understanding of the needs of people with dementia, they demonstrated a level of skill and knowledge about people’s individual needs and support that ensured these were being met in every day practice. Staff said they found the training they received was good; one commented “We all do it including management." Training records however, showed that with the exception of emergency first aid and moving and handling, less than 75% of staff had completed or updated their essential basic training; which would enhance their knowledge and skills and help ensure their support of people was in keeping with current best practice.

The failure to ensure that all staff attended and completed recognised essential training required for their role is a breach of Regulation 18 (2) (a).

A relative said they were impressed at witnessing a staff member manage a person who was expressing behaviours which were challenging to others. They said the staff member had showed patience, and de-escalated the situation in a very professional way. Staff were consistently able to describe the strategies used with some people to manage their behaviour, but records failed to reflect this in detail. Similarly staff were able to describe the methods of communication people used including what their body language meant, but this was not recorded in detail within care records to ensure all staff had access to this information and interpreted this in the same way.

Staff may not recognise when some people with specific health conditions were experiencing a deterioration, because care plan records did not give detailed guidance to staff about individual conditions, for example Diabetes. This information would help staff to recognise signs and symptoms and act quickly to seek interventions.

The failure to record how some aspects of people’s specific care and treatment risks were managed is a breach of Regulation 12 (2) (b) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Care plans were in place for when people who had recurring illnesses for example, urinary infections, or chest infections experienced an episode of illness. Medicines to manage the condition had been provided by the GP surgery, but authorisation to use them still needed to be sought from the GP before a course of medicines could be started.

Staff were available to support people with their health appointments People accessed a range of health care professionals based on individual needs. Staff were vigilant in checking health related needs for example, bowel charts, continence issues, skin integrity, and food and fluid intake. A relative told us that staff vigilance in monitoring their relative’s skin and health had led to a diagnosis and treatment for cancer.

The interim manager and staff told us about ways in which they could support people, using strategies and equipment to improve their quality of life. For example, staff told us about a person at risk of falls who was given a walking frame following assessment by health professionals. Staff noted that using the frame caused the person to overreach with a risk of overbalancing. After discussion with the persons GP and Occupational therapists the interim manager implemented a handling belt instead of the walking frame; this had worked well and reduced the risk of falls the person experienced. We observed staff using this method successfully enabling the person to walk safely to the dinner table or to the toilet, or their bedroom.

Staff had received training in the Mental Capacity Act 2005 (MCA). This provides a legal framework for acting and making decisions on behalf of people who lack the mental capacity to make particular decisions for themselves. MCA assessments were completed where necessary. Staff were aware that some complex decisions might need to be

Requires improvement

Is the service effective?

made in a person's best interests with their representatives for example health tests/checks and interventions that people might need to have to maintain their health and wellbeing.

Staff assumed people's capacity in everyday decision making, even where their ability to do so had become impaired. For example, a staff member told us that a person who previously was able to choose between two outfits could no longer do so, however the staff member still offered the choice but prompted them by saying "you always liked to wear this one or this colour". The interim manager was familiar with the need to apply for Deprivation of Liberty Safeguards (DoLS) authorisations for some people who had restrictions in place to keep them safe, she had already done so for one person and was proactive in seeking a review of this authorisation which was due to expire.

We observed a lunch period. Food was well presented and looked appetising. People were offered a choice at mealtime by being shown both the main meal and dessert options. People's preferences were taken account of in the development of the menu. Nutritional assessments undertaken highlighted anyone at risk from poor nutrition. Some people had special diets because of their specific health conditions and these were catered to, for example people with diabetes. People were referred as needed to dieticians or the speech and language team (SALT) for advice and guidance around risks from poor eating, drinking or concerns about choking or swallowing difficulties. Our observations showed there were enough staff available to provide individual assistance or support to those that needed it, people ate well and were provided with drinks throughout the day.

The staff training programme showed that 13 out of 22 Care staff had completed nationally recognised vocational qualifications at level 2 or 3. Staff told us they also had access to some enhanced courses in dementia and medicines to further improve their support of people.

New staff completed an induction programme at the start of their employment; this followed the nationally recognised Care Certificate standards. Induction included shadowing other staff, familiarising themselves with peoples care needs and with policies, procedures and routines. New staff said they completed a workbook to show what they had learned and this was assessed and marked by the interim manager, who assessed their overall competency through probationary meetings.

Staff received support to understand their roles and responsibilities through supervision and annual appraisal. Supervision consisted on one formal face to face review with a number of observations of practice by the interim manager to assess staff competency, staff felt this gave them confidence that they were supporting people correctly.

Good

Is the service caring?

Our findings

People told us about the care they received. They and the relatives we spoke with without exception told us that staff treated people with kindness and respect. One person told us that they felt "Very comfortable here, I get some personal care and although I have a favourite carer they are all so nice". "They help with washing and dressing", "They always chat to me and make me laugh", "The girls are so good, I felt a bit cold so they got me a blanket and they are going to get my coffee in a minute".

Another person said how cheerful everyone was; always smiling "I have no regrets at all about being here". A relative told us "I am very confident about his care. I have visited at odd times and it hasn't been a problem, now he is settled I usually come in morning or afternoon but I am always made welcome. I can tell he is well cared for as he has put on weight and the place itself is so homely".

We observed many positive interactions between staff and people, with acts of kindness and affection, from the care staff member tucking the persons hair behind their ear where it had fallen down, to taking pride in the appearance of someone they had supported to get ready, and who was receiving lots of positive comments about their appearance. Staff took time to ensure ladies had their make up on, if this was something they liked, and wore their jewellery. Blankets were laid over people's laps if they were a little cold.

We observed staff were discreet in the way they supported people around personal care giving; they closed doors when they took people to their bedrooms,, they were heard asking people if they would like to go for a little walk with them, when they had observed the person needed to go to the toilet. Staff showed they were attentive and observant to the body language and facial expressions people used to indicate they might need assistance or support.

Staff said they tried to involve people and support them to maintain independence as much as possible. One said "We try to involve people because some of them love to help, just as they would do at home, like laying the table or helping with the washing up or folding clothes".

One person liked to help with folding small pieces of laundry like tablecloths or towels, this activity gave them a sense of being part of the staff team, and because of this they had shown that they wanted to also receive a wage slip like staff. The interim manager had accommodated this wish by providing the person with a notional wage slip, and a small sum from petty cash which they understood was a responsibility of theirs to purchase items for the service with. They visited the local shop with staff to do so. In response to the person showing an interest in record keeping like staff they had provided the person with their own folder of blank forms and they used this to write in from time to time.

Another person who had found it difficult to settle into the service had been provided with a bedsit arrangement in their bedroom, staff referred to the person as living in flat X which the person concerned found more acceptable.

Staff were observed to spend time with people who were confused from just moving in, talking with them and taking them to a quieter area where they could adjust. Relatives told us they were always made welcome and those who had the legal authorisation to act as representatives were consulted and kept informed about people's individual care needs and progress.

Good

Is the service responsive?

Our findings

Some people liked to join in activities others preferred to sit in the quieter area of the lounge. Comments about activities included “I join in the activities, they have bingo and exercises and I do like the singing". "I have visitors and sometimes am able to go out if I feel like it". A second person said "There is plenty to do". A relative told us that they took the person they visited out "For short walks when the weather is good which makes a nice change for us both". We also go and sit in the garden when we can”.

There was a happy busy atmosphere in the service with lots of smiles and chatting. People chose where they wanted to be, either in their room, or the lounge and dining area. Those on their own although not participating looked actively interested in the goings on around them, and moved around often. We observed one group where a person was completing a puzzle helped by three other people, they were all happily helping and chatting together and this took up most of the morning.

A few people were in another area of the lounge, singing to a DVD that was playing. Another person had taken their newspaper out into the courtyard and was sitting at a table under an umbrella in the sunshine. There was a planned programme of activities on three days each week, on other days of the week and at weekends staff were actively involved in facilitating and participating in activities with people, for example helping with puzzles, sitting and chatting to people, joining in sing along to music, running quizzes, outside entertainers were also brought in to provide musical events. At inspection we observed staff spending time with individual people or with small groups, monitored their wellbeing and progress with some activities, and ensuring they had something else to offer when necessary, “You look like you’ve finished that one, would you like to try another?”

Before people moved into the service they, their relatives and if appropriate other professionals were asked about their support needs. We met someone who wanted to come and live at the service. They were visiting with their relative. The relative confirmed that the interim manager had undertaken an assessment of their relatives needs prior to them being accepted onto the waiting list. They were undertaking a second visit to the service. The person told us what they liked about the service; they said it was “Just like a house, like your own home”. They thought they would like to live here.

Following admission initial risk assessments were completed for all aspects of the persons support, these informed the development of the care plan. This was planned with the person or/and their relatives following their admission to the service and after staff had been able to make a closer assessment of the person’s needs. Care plans were personalised and identified what people needed and wanted in the way of support to live their daily lives. In addition to health sections, care plans contained a reminiscence section where people could talk about their life history to give staff a holistic view of the person as a whole and not just their care needs.

Each person’s care and treatment was planned and recorded in an individualised plan of care, this informed staff about what people needed and wanted in the way of support to live their daily lives. These plans guided staff in how they delivered supported to the person around maintaining their personal care, social interaction, leisure interests, night time support including continence management, some people had also made clear their future wishes and this was a discussion that the interim manager or deputy had with people and their relatives when it was suitable to do so.

Staff knew people well enough to respond to their needs in a way they preferred and was consistent with their plan of care, even where they conveyed their needs unconsciously through gestures or body language. Changes in their care and treatment were discussed with them and their relatives and representatives before these were put into place. People and their relatives were included in the regular assessments and reviews of their individual needs.

Staff were able to describe the level of support and care provided to each person and what they were doing to help them maintain their independence. We observed that people could ask any staff member including the interim manager for help if they needed it. Staff knew the needs and personalities of the people they cared for.

There was a complaints procedure available for everyone, this was also displayed. People who were able to comment said they felt able to tell staff if they were upset or concerned about anything. Relatives told us they felt able

Good

Is the service responsive?

to raise any concerns with staff or the interim manager who they found approachable. There was a complaints log for recording of formal complaints received but the interim manager advised us that none had been received this year so far. A comments box with forms for making comments was provided in the entrance hall. The interim manager acknowledged that there had been a few minor concerns expressed by relatives, she kept a file for these and was able to show all the correspondence relating to the actions taken to address the concerns raised.

Requires improvement

Is the service well-led?

Our findings

This is a family run company. Due to personal circumstances the registered manager was unable to continue in that role but as a company director will continue to have oversight of the service. An interim manager had taken over the active day to day operation of the service and was making application to the commission to take on the registered manager position. was in the process of applying to CQC to become the registered manager.

The interim manager conducted a series of audits, of cleaning, kitchen and catering, and for the most part these had worked well, however audits in regard to medicines, records, health and safety and staff related matters had failed to identify the issues we have found at inspection; these required review to avoid similar shortfalls in future. The interim manager undertook spot checks of the service and identified shortfalls and took action to address these immediately but did not record these visits or the actions taken. The provider was not ensuring that their oversight and visits to the service to check day to day operation were recorded or that issues they may have raised had been actioned.

The failure to ensure that an effective system was in place to assess monitor and improve the quality and safety of the service were sufficiently comprehensive and this is a breach of Regulation 17 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service is well thought of amongst local health and social care professionals and has a waiting list for people to be admitted. Staff were proud that the service had a reputation locally as a good place to work; one member of staff said it was a "Homely home, not an institution". A relative spoke positively about how much they wanted their relative to live at the service but was aware that there was a long waiting list for places.

Our observations were of good team working. Staff were cheerful and there were enough of them around to help any person that needed it. There was a good rapport between staff and the interim manager and with people they supported.

Staff told us that they felt well supported and found the interim manager always available and easy to talk with.

Staff thought she was appreciative of their efforts and made this known to them in different ways. They were included in annual surveys and asked for their feedback and ideas for improvement. Staff meetings were usually held twice per year. These were comprehensive and covered not just practical tasks that staff needed to be aware of or adhere to, but also reflected on support offered to specific individuals, and reminded staff of their responsibilities to train and follow procedures. Points raised by staff were also addressed and actions in response taken and made known to them.

Systems were in place to seek feedback from people, their relatives and representatives through informal discussions with relatives when they visited, phone calls to relatives to update them of events. Survey questionnaires had recently been sent out for completion by people using the service, relatives and other external stakeholders, such as health or social care professionals. A large response to these had been received and the interim manager was working through these to analyse comments and develop and action plan to address any comments or issues highlighted. People told us they felt listened to and felt able to express their views at any time to the interim manager or any of the staff.

Staff had access to policies and procedures, which were contained within a folder and was held in the service. These were reviewed regularly and kept up to date by the provider. Staff understood the vision and values for the service and covered this within their initial induction to the service, they clearly demonstrated that this was embedded in their every day care practices in the support they gave to people and the attitudes they displayed.

The interim manager was an active participant in the Kent Care Homes Association and also attended Clinical Commissioning group meetings for providers; this ensured they were kept informed of changes that could impact on how they provided care and support to people.

Services that provide people with health and social care are required to notify the Care Quality Commission (CQC) of important events that happen. The Interim manager ensured that they reported notifiable incidents to the Commission when required, and had responded to and submitted requests for information from the Care Quality Commission on time.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment There was a failure to ensure that medicines were managed correctly Regulation 12 (2) (g) There was a failure to ensure guidance was provided to staff in regard to the management of people's behaviour and condition specific plans 12 (2) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment There was a failure to ensure that all staff had received training in safeguarding adults and therefore understood how to report concerns they might have about the registered or interim manager and/or directors of the company. Regulation 13 (1) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance There was a failure to ensure that systems that assess monitor and improve the quality and safety of the service were sufficiently comprehensive and this is a breach of Regulation 17 (2) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing There was a failure to ensure that all staff attended and completed their required essential training, Regulation 18 (2) (a)

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed There was a failure to undertake recruitment checks on new staff in accordance with schedule 3, in that full employment histories had not been obtained.