The Fremantle Trust

Chesham Leys

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**

Summary of findings

Overall summary

This inspection took place on 31 October, 01 November and 09 November 2016. The first day of the inspection was unannounced.

We previously inspected the service on 19 and 22 October 2015. The service was not meeting the requirements of the regulations at that time. We identified areas of concern in relation to records, medicines practice, infection control practice, supporting staff and meeting people's nutritional needs. We asked the provider to take action to make improvements. They sent us an action plan which told us the changes they would make at the service.

Chesham Leys provides nursing care for up to 62 people. Forty nine people were living at the service at the time of our inspection. The service provides nursing care to older people and people with dementia.

The service did not have a registered manager in post. 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. A new manager had started at the home shortly before this inspection. They would be submitting an application to become registered.

We received largely positive feedback about the service. Comments from people included "If I had won the lottery and won a million pounds I couldn't have found better care," "It's absolutely wonderful here" and "I have no fear about my mum's personal safety, she is safe here." Other comments included "The staff seem quite caring" and "The staff are kind and compassionate. They can take a joke and have a good sense of humour. I can't fault their attitude." Some people commented about continued use of agency staff. For example, a relative said "I have noticed that there has been a drive in recruitment, but a lot of agency and new staff are not equipped to deal with the people here. There is quantity but not quality." Another relative told us "The care is up and down and a bit of a lottery, it depends on who is on and the type of agency staff that are on duty. The permanent agency staff are very good and dependable, the day to day care agency staff appear to be lost."

There were safeguarding procedures and training on abuse to provide staff with the skills and knowledge to recognise and respond to safeguarding concerns. Written risk assessments had been prepared to reduce the likelihood of injury or harm to people during the provision of their care. We found improvement to how people's medicines were handled. However, we have made a recommendation for staff to sign record sheets to show when they have used creams and other topical preparations.

We found there were sufficient staff to meet people's needs. They were recruited using robust procedures to make sure people were supported by staff with the right skills and attributes. However, we found staff did not always receive appropriate support and training to ensure they kept up to date with their skills and professional development.

Care plans had been written, to document people's needs and their preferences for how they wished to be supported. These had been kept up to date to reflect changes in people's needs. People said there had been improvement to the activities provided for them. Staff supported people to attend healthcare appointments to keep healthy and well. Improvement had been made to meeting people's nutritional needs and assessing the risk of malnutrition. We have made a recommendation about the effective use of fluid monitoring charts.

Improvement had been made to infection control practice. The building was clean and hygienic. The premises complied with gas and electrical safety standards. However, we found fire safety checks had not been carried out in line with the provider's guidance over the past year. These were being addressed.

The provider regularly checked the quality of care at the service through visits and audits. Improvement had been made to some records since the last inspection. However, we have identified some areas where further work is needed to ensure accurate records are maintained.

We found breaches of the Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to staff support and safe care and treatment. 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 always safe.

People were not fully protected from the risk of fire as routine safety checks were not always carried out.

Improvements had been made to management of people's medicines. However, records were not always maintained where creams and other topical preparations were used.

People were protected from the risk of infection. Improvements had been made to ensure staff followed safe infection control practices.

Is the service effective?

Requires Improvement

The service was not always effective.

People may not have received safe and effective care because staff were not always appropriately supported through regular supervision. Training was not consistently updated in line with the provider's policy, to ensure skills were refreshed.

Improvement had been made to meeting people's nutritional needs and assessing their risk of malnutrition. However, further work was needed to ensure fluid monitoring charts were used effectively.

People received the support they needed to attend healthcare appointments and keep healthy and well.

Is the service caring?

Good

The service was caring.

People's wishes were documented in their care plans about how they wanted to be supported with end of life care.

People were treated with kindness, affection and compassion.

People were supported by staff who engaged with them well and took an interest in their well-being.

Is the service responsive?

Good

The service was responsive.

People's preferences and wishes were supported by staff and through care planning.

People were able to identify someone they could speak with if they had any concerns. There were procedures for making compliments and complaints about the service.

People were supported to take part in activities to increase their stimulation.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Some improvements had been made to record keeping. However, we found further work was needed to ensure records were accurately maintained.

The provider monitored the service to make sure it met people's needs safely and effectively.

The registered manager knew how to report any serious occurrences or incidents to the Care Quality Commission. This meant we could see what action they had taken in response to these events, to protect people from the risk of harm.

Chesham Leys

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 checked 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 31 October, 01 November and 09 November 2016. The first day of the inspection was unannounced.

The inspection was carried out by an inspector and specialist advisor on two days. The specialist advisor's area of expertise was nursing care of older people and people with dementia. An expert by experience was present for part of one day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. One inspector was present on the third day of the visit.

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 service, what the service does well and improvements they plan to make. We reviewed notifications and any other information we had received since the last inspection. A notification is information about important events which the service is required to send us by law.

We contacted healthcare professionals and the local authority commissioners of the service, to seek their views about people's care.

We spoke with the manager, regional director and 13 staff members. This included nurses, care workers, the chef, housekeeper and activity organisers. We checked some of the required records. These included seven people's care plans, medicines records on two of the three floors of the home, six staff recruitment files and nine staff development files.

Some people were unable to tell us about their experiences of living at Chesham Leys because of their dementia. We therefore used the 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.

Requires Improvement

Is the service safe?

Our findings

People were not fully protected from the risks associated with unsafe premises. We found the provider had systems to carry out routine fire safety checks but these were not always followed. For example, weekly tests of fire call points had not been carried out between February and July 2016. A daily check was expected to be made of the means of escape, to ensure all exit routes were kept clear. We found gaps to the records, such as between 24 August and 27 August 2016 and 11 October and 15 October 2016. We looked at a further record sheet for weekly fire extinguisher checks. None had been recorded between 21 January and 26 September 2016. The manager was unable to provide any further records to show these had been carried out.

The provider told us these gaps to fire safety checks had been identified as part of their service monitoring. Improvement had been made to records since the occasions we have referred to.

Guidance on the fire drill record sheet said staff were expected to take part in a fire drill at least twice a year. Records did not show this took place. The most recent drill was conducted on 18 August 2016. The previous drill was recorded as having taken place on 25 March 2015. We mentioned this to the manager on the first day of the inspection. A further fire drill was carried out by the last day of the inspection.

In acknowledging recent improvement to fire safety checks, we would need to see sustained improvement over a period of time to be certain the service was fully meeting the requirements of the regulations.

These were breaches of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we visited the service in October 2015, we had concerns about management of people's medicines. This was because people were placed at risk of harm as systems for managing medicines were not safe. We asked the provider to take action to make improvements. They sent us an action plan which told us the changes they would make at the service.

On this occasion, we found improvements had been made to how people's medicines were managed. There were medicines procedures to provide guidance for staff on best practice. No one managed their own medicines at the time of our visit. We saw staff administered medicines safely and did not rush people to take them. Appropriate records were kept to show when medicines had been given to people. We noted some inconsistency, however, in signing to show when topical preparations, such as skin creams, had been applied.

We recommend good practice is followed by recording when creams and other topical preparations have been applied.

Medicines were stored securely. Those which required refrigeration were stored appropriately and the temperature monitored to make sure it was within a safe range.

Medicines which required additional controls because of their potential for abuse (controlled drugs) were stored safely and securely within the treatment rooms. When a controlled drug was administered, the records showed the signature of the person who administered the medicine and a witness signature. Stock checks were completed once a day. The controlled drugs register was appropriately maintained.

The home had implemented good practice guidance to reduce medicines waste in care homes. This meant that medicine left over at the end of the month was carried over to the next month, instead of being thrown away or re-ordered. Staff recorded the balance of each medicine daily. We found all medicines were accounted for in the sample we checked.

When we visited the service in October 2015, we had concerns about infection control practice. This was because people were placed at risk of harm as systems for preventing, detecting and controlling the spread of infection were insufficient. We asked the provider to take action to make improvements. They sent us an action plan which told us the changes they would make at the service.

On this occasion we found improvements had been made. The home was clean and hygienic. The laundry was in good order. Good practices were followed to prevent the spread of infection. For example, soiled laundry was placed in red bags which were then placed into the washing machine to prevent contamination from further direct handling. Clinical waste was disposed of appropriately at the service.

People we spoke with told us they felt safe. A relative said "I have no fear about my mum's personal safety, she is safe here." Another relative told us "It is a very nice and safe environment for our mum to be in." Staff had access to procedures for safeguarding people from abuse. These provided guidance on the processes to follow if they suspected or were aware of any incidents of abuse.

People were protected from the likelihood of injury or harm. Risk assessments had been written for a range of potential risks such as the likelihood of developing pressure damage, supporting people with moving and handling and the risk of falls. Where assessments identified significant risks, measures had been put in place to reduce harm to people. For example, pressure-relieving equipment had been provided where people scored high for the likelihood of developing pressure damage. Risk assessments had been kept under review and updated where there were changes to people's circumstances. We saw emergency evacuation plans had been written for each person. These documented the support and any equipment people needed in the event of emergency situations.

The service used robust recruitment processes to ensure people were supported by staff with the right skills and attributes. Recruitment files contained required documents, such as a check for criminal convictions and written references. A photograph was needed to complete some of the files we checked. There were photocopies of personal identification documents to refer to in the meantime.

Staffing rotas were maintained and showed shifts were covered by a mix of nurses and care workers. A duty manager co-ordinated each shift to ensure, for example, people were referred to GPs and other healthcare professionals, as needed.

We observed there were enough staff to support people. People's needs were met in a timely way with call bells answered promptly. We saw staff managed busy times of the day well to ensure people's needs were met, for example, at meal times. Some of the people we spoke with commented about high use of agency staff to support the home. One relative said "Having a different person everyday for somebody with dementia can be very confusing." The manager told us they aimed for the agency to supply staff in block bookings to try and ensure continuity of care. We saw this was achieved wherever possible, such as the

nurses in charge on each floor of the home. A relative told us "Recently they have employed one qualified nurse from the agency. Her presence is a breath of fresh air, they should try to recruit her permanently." From discussions with the regional manager and the home's manager, we were satisfied all reasonable attempts were being made to recruit and retain staff.

Requires Improvement

Is the service effective?

Our findings

When we visited the service in October 2015, we had concerns about staff support. People were placed at risk of harm because staff had not received appropriate support, training, professional development and supervision to enable them to carry out the duties they were employed to perform. We asked the provider to take action to make improvements. They sent us an action plan which told us the changes they would make at the service.

On this occasion, we found there were still gaps to the support provided to the staff team. In five of the staff files, there was no record that probationary assessments had been undertaken before staff were confirmed in post. This meant satisfactory measures to assess their performance and training needs had not been carried out. Patterns of supervision varied. In one file, there were no records to show supervision had taken place in 2016. The member of staff had worked at the home during this time. Their line manager was unable to produce records to demonstrate meetings had taken place. In another file we found the member of staff had not received supervision between May 2015 and September 2016. The member of staff had also worked at the home during this time.

The home continued to use agency workers to ensure there were sufficient staff to meet people's needs. We found there was no clinical induction for agency nurses to ensure they carried out nursing tasks in a consistent and safe way. This placed people at risk of receiving inconsistent or unsafe care.

We looked at records of staff training. We found some refresher training had not always been undertaken in line with the provider's policy. For example, safeguarding training needed to be repeated every two years. Training records showed 11 staff were overdue for this training and there were no dates set to undertake refresher courses. Fire training required updating every two years, in line with the provider's policy. We found two staff had not completed fire training since 2013. There were no courses booked to ensure they and staff who had completed the training two years ago would have their skills refreshed.

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

New staff were enrolled onto the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers need to demonstrate in their work. They include privacy and dignity, equality and diversity, duty of care and working in a person-centred way. Staff also completed their training as part of this induction.

Specialist training had been undertaken by some of the staff team. For example, oral health care, and person-centred care. Staff spoke positively about these courses as well as opportunities to undertake higher level training. This included the Qualifications and Credit Framework (QCF) and Business and Technology Education Council (BTEC) awards.

When we visited the service in October 2015, we had concerns because people's nutritional and hydration needs were not being met. We asked the provider to take action to make improvements. They sent us an action plan which told us the changes they would make at the service.

On this occasion we found improvements had been made. We received positive feedback from a healthcare professional. They told us there had been "Significant improvement in care of residents' nutritional needs." They added "Staff are now able to correctly identify and treat malnutrition following the Buckinghamshire MUST management guidelines." These are local guidelines to identify who is at risk of malnutrition and actions to take to improve their nutrition.

We saw people had been assessed for the risk of malnutrition. They were weighed regularly where required. We noted weight gain was recorded in the files we looked at of people who were at high risk of malnutrition. We observed people were offered high calorie snacks and milk shakes to increase the amount they ate, where necessary. The chef told us each month they were informed of people who were at risk of malnutrition. This ensured they were able to provide appropriate nutritional support to people.

People were referred to community healthcare professionals, such as the dietitian and speech and language therapist where necessary. Food and fluid monitoring charts were in place for some people. We found these were not always completed fully or evaluated to look at whether people needed any adjustment to their diet.

We recommend further work is undertaken to ensure fluid monitoring charts are used effectively at the service.

People were provided with choices at mealtimes and were given assistance to eat their meal where required. We observed staff assisted people gently and sat next to them; they offered encouragement where it was needed to make sure people ate enough. Non slip mats and adapted cutlery were provided to help people manage mealtimes independently.

Most people were complimentary about the meals provided for them and said they were given enough to eat and drink. People told us they had enjoyed the lunch time meals we observed. They were provided with the texture of food appropriate to their swallowing needs. For example, pureed meals were provided where people had been assessed by the speech and language therapist as requiring this consistency.

A relative told us "The meals are very nice but the food at tea time is not. We have said it a thousand times about the tea time but they don't respond. Mum would like boiled egg and toast but she is told this is not possible. But we would also say that when they have event days like Christmas and Easter the food is impressive and we are all invited too." Another relative said "When he was at home he liked spaghetti bolognaise and lasagne, they never have that here. They do a Sunday roast. The menu has only changed twice maybe three times in 18 months." A third visitor said staff always invited them to eat with their relative when they were at the home for mealtimes, which they thought was a lovely gesture.

People were supported with their healthcare needs. Care plans identified any support people needed to keep them healthy and well. Staff maintained records of when people had been seen by community healthcare professionals, such as their GPs, specialist nurses and dentists. Nurses carried out monthly checks of people's physical health such as their blood pressure and pulse rate.

Staff communicated effectively about people's needs. Relevant information about their health and welfare was documented in daily notes in care plan files. We saw significant information about changes to people's

health and welfare were communicated to duty managers and noted in a log book. This information was shared with the next shift to help ensure people could be appropriately monitored.

People lived in premises which had been designed to meet the needs of people with a range of disabilities. This ensured the layout and equipment provided supported people to remain independent. For example, doorways and corridors were wide enough to accommodate wheelchairs and bathrooms and bedrooms had enough space for manoeuvring hoists and other equipment. There was a passenger lift between floors. Sensory nodules had been fitted to grab rails in corridors, to assist people with visual impairments. There was level flooring throughout the building and around the garden, to enable people to move around safely.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found appropriate referrals had been made to the local authority to deprive people of their liberty. The outcomes of these applications had not all been determined at the time of our visit. In one example, we found staff did not understand the need to make applications to deprive people of their liberty where bed rails were used and no application had been made to the local authority.

Good

Is the service caring?

Our findings

People said staff were kind, polite and treated them with respect. We saw examples of this during our visit. For example, how staff referred to people and engaged with them. One person told us "The care is excellent." A relative told us "We are very content with the carers' extra chat and little things they do, like paint our mum's nails."

We observed numerous examples where staff smiled, maintained eye contact and got close to people when they spoke or assisted them. One member of staff told us they "Got an awful lot back from working with residents. I learn a lot from them."

We saw a nurse knocked on someone's door before going in their room. They greeting the person by name and explained the purpose of their visit: "I am here to give you your morning medication." Whilst explaining the medicine, the nurse also took the opportunity to find out from the person how they were. The nurse was pleasant in their approach and during conversation got close to the person with a smile on their face.

One person told us "The staff seem quite caring." Another said "The staff are kind and compassionate. They can take a joke and have a good sense of humour. I can't fault their attitude. It is just amazing that they do this day in and day out. I get tired for them." A relative commented "They are polite and never rude, they always approach us with respect and with a willingness to help and it is very good here."

One relative told us "I wish that the staff would come and talk to my mum outside 'treatment times.' They are very nice and talk to her when they are assisting her with her personal hygiene, feeding her, changing her, giving medicine, changing the bed and that's it." We noted staff attempted to engage with people outside of tasks, whenever the opportunity presented itself. Another relative said "I know that my mother always has her personal care attended to. She is always well dressed and her room is immaculate."

Staff were knowledgeable about people's histories and what was important to them, such as family members and previous occupations and interests. A member of staff told us "This person loves her chocolate. So I try to make her hot chocolate in the morning and at night. You should see the smile on her face."

People's visitors were free to see them as they wished. Relatives and other visitors told us they were made to feel welcome at the home. They were able to make themselves drinks from a coffee bar in the entrance area and help themselves to cake. We saw people made use of this facility and sat and chatted comfortably with their family members.

People's rooms were personalised and they had arranged them with items to make them homely and comfortable. The home was spacious and allowed people to spend time on their own if they wished. There were seated areas away from shared lounges which people could make use of if they wished to spend some quiet time away from other people or use see their visitors.

People and their relatives were given support when making decisions about their preferences for end of life care. Where necessary, people and staff were supported by palliative care specialists. Services and equipment were provided as and when needed. A recently bereaved relative spoke highly of the care their mother had received at Chesham Leys. They described the care as "Brilliant" and told us the nurse who had supported them and the family had been "So sensitive." They told us they had come in early one morning and the senior member of staff on night duty said they had been sitting with their mother. The relative added "If I'd won the lottery and won a million pounds I couldn't have found better care."

Another relative told us "I transferred my mother here because the care in the other place was atrocious. She was weak, frail and in pain and we thought that she had days. To our surprise she had picked up since she has come here and is now eating and drinking and has the adequate level of pain killers. The pharmacist and the doctor have ensured that the medicine is available when she needs it. We have worked out a plan should she deteriorate. She has an air mattress and is encouraged to sit out in a chair during the day and repositioned when she is in bed. We cannot be happier, given the circumstances."

Residents' meetings were held at the home and minutes were kept of items discussed. Additionally, a social committee had been set up which involved staff, people who lived at the service and relatives. Two meetings had taken place so far. People had been asked for their ideas about things such as activities, trips out and ways to celebrate popular events like Wimbledon.

Good

Is the service responsive?

Our findings

People had their needs assessed before they received support from the service. Information had been sought from the person, their relatives and other professionals involved in their care. The manager told us they had started to involve care staff with assessments in the community. They then aimed for this member of staff to be on duty on the day the person was admitted to the home so there was continuity for them.

Information from the assessment had informed the plan of care. Care plans were personalised and detailed daily routines specific to each person. Staff were able to describe to us the support needed for the people they cared for.

Care plans had been kept under review, to make sure they reflected people's current circumstances. Where necessary, health and social care professionals were involved such as social workers and community psychiatric nurses.

There was evidence people were involved in their care. For example, a person with pressure wounds told us staff shared information and photographs of the wounds with them and told them how they were healing. They told us they were given the option about when they would like to have dressings changed.

We saw staff were responsive to people's needs. We spoke with a member of staff about one person's needs. They told us how they had involved family members in finding out who particular people were that the resident called out for or spoke about. They said when they knew who people were, or in one instance a pet, it was possible to have more meaningful conversation with the person and offer them reassurance. They said this had resulted in the person being calmer.

In another example, a member of staff was speaking with someone and gently stroked their hand. When they noticed their cup of tea had gone cold, they offered a fresh cup and a choice of other drinks. They then brought the person's preferred option.

People were supported to take part in social activities to increase their stimulation. People told us there had been an improvement in activities. One relative told us "It has got better over the last three months." Another relative said staff knew their family member did not enjoy taking part in activities but liked art work. They said some flower arranging was organised for the person which they seemed to enjoy.

Posters were displayed around the building to inform people what activities were arranged. This included church services, quizzes, music and movement, visiting entertainers and an art exhibition. We saw Halloween was celebrated and one of the activity organisers arrived at the home complete with witch's costume and green face paint. On another day, we saw a group of people involved in making a Christmas cake. This was to be entered into the provider's Christmas cake competition, which the participants were keen to win. We observed the activity provided opportunity for people to chat, have coffee together whilst they made the cake and also to have fun.

There were procedures for making compliments and complaints about the service. There had been one complaint about the quality of people's care. We saw this had been handled appropriately. Several compliments had been received from relatives and other visitors to the home. People or relatives named staff they would speak with if they were worried or had any concerns. A relative said they had made a complaint in the past; "Initially when we first came. It was resolved and to our satisfaction." Another relative told us "Communication with staff about issues affecting the care of my mother have now improved…I was able to meet with the manager. I am also able to talk with the regular staff."

Staff took appropriate action when people had accidents. For example, where they fell or were found on the floor. Staff called for an ambulance where necessary so people could receive appropriate medical treatment.

Requires Improvement

Is the service well-led?

Our findings

When we visited the service in October 2015, we had concerns about record keeping. People were at risk of unsafe or inconsistent care because care records were not sufficient in identifying their needs and ensuring those needs were met. We asked the provider to take action to make improvements. They sent us an action plan which told us the changes they would make at the service.

On this occasion, we found some improvements had been made to details within people's care plan files. For example, information was now clearly noted where people had conditions such as diabetes and cross referred throughout the various care plan sections. This ensured staff were aware of people's needs and could provide appropriate care and support.

However, we found records had not always improved where monitoring was required, such as fluid intake. Similarly, records of topical preparations, for example, creams were not always completed. We have made recommendations for these specific areas to be addressed.

The home had a new manager in post. They said they would be submitting an application to become registered with CQC. We saw staff, relatives and people who lived at the home were comfortable speaking with the manager and welcomed them back after a break from work. A relative told us the manager was "So conscientious" and added "We were all pleased when she got the job." Another relative told us "I had complete faith in the duty managers" when their family member received end of life care.

Staff we spoke with said the home was a good place to work because it was friendly. They said managers were actively recruiting staff to fill vacant posts. A nurse told us they thought the appointment of a permanent clinical lead nurse had been helpful in identifying some of the issues facing the home, such as shortage of regular staff and improving care notes. Staff said they felt management were listening to them. One member of staff said the home was "Really moving on" and the manager was "So approachable."

We found there were varying patterns of staff support through supervision and some training had not been updated in line with the provider's policy. Staff said there were regular staff meetings to discuss practice and handovers between shifts. One member of staff told us handovers were important because that was where information was passed on about care of people. They added "At handovers you get to know what has been done and what remains to be done."

The home had links with the local community. For example, staff and people who live at the home had taken part in the Comic Relief choir project. This had linked the home with a theatre group for local children with learning disabilities and resulted in a public performance. A local school had also made contact with the home and children had visited to speak with people about what it was like in 'olden' days. Activity staff had contacted the local museum to loan a wildlife display to the home. A cheese and wine event was held to accompany this. Further involvement from schools and a local college was planned for Christmas.

Staff were advised of how to raise whistleblowing concerns as part of their induction and during their

training on safeguarding people from abuse. Whistleblowing is raising concerns about wrong-doing in the workplace. This showed the home had created an atmosphere where staff could report issues they were concerned about, to protect people from harm.

Providers and registered managers are required to notify us of certain incidents which have occurred during, or as a result of, the provision of care and support to people. There are required timescales for making these notifications. The manager had informed us about relevant incidents and from these we were able to see appropriate actions had been taken.

The provider regularly monitored quality of care at the service. This included regular monitoring visits and a range of audits. A comprehensive audit had been carried out in September this year. A detailed action plan had been produced with areas for improvement prioritised for attention. One of the trustees of the provider organisation was linked with the home. We saw they visited the service as part of their role.

We found there were good communication systems at the service. Staff and managers shared information in a variety of ways, such as face to face, during handovers between shifts and in team meetings.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were placed at risk of harm as fire safety checks were not carried out in accordance with the provider's policy, to ensure the premises were safe. Regulation 12(d).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing People were placed at risk of harm because staff had not received appropriate support, training, professional development and supervision to enable them to carry out the duties they were employed to perform. Regulation 18(2)(a).