Habilis Operations Limited

Sutton Lodge Residential 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?	Good
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

We inspected Sutton Lodge Residential Home on 13 October 2016. This was an unannounced inspection. The service provides care and support for up to 24 people. When we undertook our inspection there were 15 people living at the home.

People living at the home were older people. Some people required more assistance either because of physical illnesses or because they were experiencing difficulties coping with everyday tasks, with some having loss of memory.

There was no 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.

CQC is required by law to monitor the operation of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS authorisations are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect themselves. At the time of our inspection there were no people subject to such an authorisation.

We found that there were not sufficient staff to meet the needs of people using the service at all times. The provider had not taken into consideration the complex needs of each person to ensure their needs could be met through a 24 hour period.

We found that people's health care needs were assessed, and care planned and delivered in a consistent way through the use of a care plan. People were involved in the planning of their care and had agreed to the care provided. The information and guidance provided to staff in the care plans was clear. Risks associated with people's care needs were assessed and plans put in place to minimise risk in order to keep people safe.

People were treated with kindness and respect. The staff in the home took time to speak with the people they were supporting. We saw many positive interactions and people enjoyed talking to the staff in the home. The staff on duty knew the people they were supporting and the choices they had made about their care and their lives. People were supported to maintain their independence and control over their lives. However, there was little stimulation for people during the day to keep them occupied and social activities were limited to group events three times a week.

Staff had taken care in finding out what people wanted from their lives and had supported them in their choices. They had used family and friends as guides to obtain information. However there was little stimulation and social activities for people to take part in each day.

People had a choice of meals, snacks and drinks. Meals could be taken in a dining room, a sitting room or people's own bedrooms. Staff encouraged people to eat their meals and gave assistance to those that required it.

The provider used safe systems when new staff were recruited. All new staff completed training before working in the home. The staff were aware of their responsibilities to protect people from harm or abuse. They knew the action to take if they were concerned about the welfare of an individual.

There was no plan of maintenance in place and some areas of the home were looking in need of refurbishment and redecoration. Some pathways had uneven surfaces and were a trip hazard if people which to walk in the grounds.

People had been consulted about the development of the home and some quality checks had been completed to ensure services met people's requirements. There had been a lapse in quality checks being made to test the quality of the services being offered, so the provider did not have up to date information as to whether people were currently happy staying in the home. The provider's website and signage at the front of the home gave incorrect information about the home as they had not been updated for some time.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Checks were not made to ensure the home was a safe place to live.

Insufficient staff were on duty to meet people's needs for some parts of the day.

Staff in the home knew how to recognise and report abuse.

Medicines were stored and administered safely.

Is the service effective?

Good

The service was effective.

Staff ensured people had enough to eat and drink to maintain their health and wellbeing.

Staff received suitable training and support to enable them to do their job.

Deprivation of Liberty Safeguards and the key requirements of the Mental Capacity Act 2005 were understood by staff and people's legal rights protected.

Is the service caring?

Good

The service was caring.

People were relaxed in the company of staff and told us staff were approachable.

People's needs and wishes were respected by staff.

Staff respected people's needs to maintain as much independence as possible.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care was planned and reviewed on a regular basis with them.

Activities were not planned into each day and some outside agencies who provided activities had been cancelled and no longer came to the home.

People knew how to make concerns known and felt assured anything raised would be investigated.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Audits had begun to be undertaken to measure the delivery of care, treatment and support given to people. However, these had only just been recommenced to ensure quality in the services being offered to people.

People's opinions were sought on the services provided and they felt those opinions were valued when asked.

The provider was giving incorrect information about the service on their web-site and on the information boards at the entrance to the home. This was misleading for people who may think this home could still look after people with nursing needs, for which it was no longer registered.

There was not a registered manager in post, although their application had been received by CQC.

Sutton Lodge Residential 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 13 October 2016 and was unannounced.

The inspection was undertaken by an inspector and an expert by experience. An expert by experience is a person who has personal experience of using services or caring for someone who requires this type of service.

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.

Before the inspection we reviewed other information that we held about the service such as notifications, which are events which happened in the service that the provider is required to tell us about, and information that had been sent to us by other agencies.

We also spoke with the local authority who commissioned services from the provider in order to obtain their view on the quality of care provided by the service. We spoke to health and social care professionals before the site visit.

During our inspection, we spoke with nine people who lived at the service, three relatives, four members of the care staff, a housekeeper, a cook and the manager. We also observed how care and support was provided to people.

We 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.

We looked at four people's care plan records and other records related to the running of and the quality of the service. Records included maintenance records, staff files, minutes of meetings and audit reports the registered manager had completed about the services provided

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at the home. They were consistent in their opinions of how staff treated them.

Staff had received training in how to maintain the safety of people and were able to explain what constituted abuse and how to report incidents should they occur. They knew the processes which were followed by other agencies and told us they felt confident the manager would take the right action to safeguard people. This ensured people could be safe living in the home.

Accidents and incidents were recorded in the care plans. The immediate action staff had taken was clearly written and any advice sought from health and social care professionals was recorded. There was no process in place for reviewing accidents, incidents and safeguarding concerns. The provider did not have information about whether any themes and trends were taking place when accidents and incidents occurred. Therefore risk management plans could not be updated or new ones completed.

To ensure people's safety was maintained a number of risk assessments were completed and people had been supported to take risks. For example, where people had a history of falls and difficulties mobilising around the home. Falls assessments had been completed. Staff had sought the advice of the local NHS falls co-ordinator to ensure the correct equipment was in place for each person. This was recorded in each person's care plan. We observed staff assisting people to use a variety of walking aids throughout the day. Staff gave reassurance and advice to each person on how to walk safely around the building. This was to ensure each person was capable of being as independent as possible.

People had plans in place to support them in case of an emergency. These gave details of how people would respond to a fire alarm and what support they required. For example, those who needed help because they would not remember where the exit doors were in the building. Outside each room was a coloured sticker to help staff if an evacuation should take place. These identified who was at highest to lowest risk of ability to evacuate the building quickly. One person told us, "[Named staff member] tests the alarms, [named staff member] is a lovely bloke." A plan identified to staff what they should do if utilities and other equipment failed. Staff were aware of how to access this document. There was a signing in book for visitors, but this was not placed in an obvious place and we saw two people fail to sign in. This means in the event of an evacuation of the building staff would be unaware of how many people were in the building. A notice was in the reception area informing people of the weekly fire test.

We were invited into eight people's bedrooms to see how they had been decorated. People told us of their involvement in the layout of the bedrooms. They told us they were happy how their rooms were kept clean. Staff had not taken environmental risks into consideration when writing the care plans for some people, especially those with loss of vision and difficulty mobilising. We saw in three rooms some trailing wires which were a trip hazard. Staff moved them immediately. We were able to open a number of windows during the course of our visit. Most of the windows did not have restrictors on and the ones that did the restrictors were broken. This meant people could easily fall out of them or people could enter the building.

The manager immediately asked the maintenance person to start replacing them.

The entrance to the home was through two doors. The first was open all day as people and staff used the area outside as a smoking area. This meant visitors had to walk through a smoky atmosphere each time they entered the building. The manager told us this was only used in the winter months and in poor weather conditions and pointed out the covered smoking area in the garden. The second door had a key pad to operate it on the inside of the building. The manager told us staff had the combination to that lock and would give it to people and their relatives when requested. However, this door was rarely closed properly during our visit. We saw on one occasion a person delivering food for the kitchen. They were able to walk straight into the home and exit without a challenge from staff. This would mean that people could exit the building when it was not safe for them to do so and people could enter at will as the path way outside the home led directly onto a main road.

Some areas of the garden were not safe to walk in. There were some uneven path ways and a fire exit ramp was unmarked and consisted of two sloping surfaces which were not clearly marked. People would be at risk of falling off the edges of the ramp in the event of an evacuation of the building. The provider had made the garden area more secure by fencing off sections from the main car park. This gave a secluded area for people to walk in. All bedroom areas had locks on the doors. These are only enabled at a person's request. No-one had requested keys to lock their bedroom door at the time of our visit.

People had name plates on their bedroom doors, which enabled them to identify which room was theirs. There were also signs on the doors indicating what each room was used for, for example, a bathroom or toilet. The signs were in words only. However, there were no directional signs in corridors to direct people around the home, other than fire exits. This could mean that people who had a poor memory could walk for a long time until they found where they wanted to be.

We pointed out to the manager equipment which had been left in rooms and corridors which could constitute a trip hazard. This included a vacuum cleaner and broken equipment in the hairdressing area and laundry room.

People told us their needs were being met and that staff were caring and kind to them. However, some people told us that the home seemed short staffed. One person said, "The staff are always stretched for time."

Staff told us that the staffing levels were currently good. They told us that there had been many changes in the last year after they had stopped taking people with nursing needs. They told us the senior staff had held it together and now everyone worked as a team. One staff member told us, "Staffing at the moment is fine, but if we have more high dependency it would need looking at again." Another staff member said, "We can meet people's needs, but I would like more time just to talk with people." Staff told us that there were days when they could not spend quality time with people. Staff told us that if there were short term staff shortages that the manager would assist with the personal care and treatment of people who needed it.

The manager told us how the staffing levels had been calculated, which depended on people's needs and daily requirements. These were completed on a monthly basis by the manager and submitted to the provider's head office. Contingency plans were in place for short term staff absences such as sickness and holidays. The rotas identified when shifts were needed to be covered and staff had signed to say when those vacant shifts had been covered. This ensured there are sufficient staff available to meet people's needs.

We looked at two personnel files of staff. Checks had been made to ensure they were safe to work with

people at this location. The files contained details of their initial interview, references and the job offered to them. There were current staff vacancies for care staff, but a recruitment drive was in place, with notices displayed locally.

Medicines were kept in a locked area. This area showed a marked improvement in tidiness and cleanliness since our last visit. The manager told us the refrigerator temperature gauge had recently broken and this was on order. Previous records showed the refrigerator had been working within the temperature guidance required until very recently. The room temperature was also taken to ensure medicines were kept at the correct temperature and were safe to use. Records about people's medicines were accurately completed. Medicines audits we saw were completed by staff at the home and the pharmacy supplier. Staff at the home completed medicine audits on a weekly basis. This showed when records were not complete and the immediate remedial action taken by staff. The local pharmacy had not completed an audit recently.

We observed medicines being administered at lunchtime and noted appropriate checks were carried out and the administration records were completed. Staff informed each person what each medicine was for and stayed with each person until they had taken their medicines. Staff who administered medicines had received training. Reference material was available in the storage area and staff told us they also used the internet to gain more information on medicines they were giving. There was also a folder of information for staff to use which had been supplied by the local pharmacy supplier.

Good

Is the service effective?

Our findings

One of the staff we spoke with had been newly recruited. They told us that the induction programme at the time of their initial days at the home had suited their needs. They told us what the programme had consisted of which followed the provider's policy for induction of new staff. This included manual handling and the fire procedure. Details of the induction process were in the staff training files. The manager was not aware of the Care Certificate, but stated they would seek advice from another home within the company. This would give everyone a new base line of information and training and ensure all staff had received a common induction process.

Staff said they had completed training in topics such as manual handling, fire and infection control. They told us training was always on offer and consisted of distance learning courses and people to come and give practical training at the home. They told us it helped them understand people's needs better. The training records supported their comments. Staff had also completed training in particular topics such as dementia awareness, continence care, first aid and nutrition. This ensured the staff had the relevant training to meet people's specific needs at this time. We saw training was recorded on a computer data base. This recorded what topics staff had covered and the dates of training plus when updates were required.

Staff told us the provider was encouraging them to expand their knowledge by setting up courses on specific topics. This included national awards in care. Some staff had undertaken courses in team leadership as their roles within the home had changed. They told us this had helped them with new tasks and being in charge of the home when the manager was not available.

Staff told us a system was in place for formal supervision sessions. They told us that they could approach the manager at any time for advice and would receive help. The records showed when supervision sessions had taken place, which was in line with the provider's policy. There was a supervision planner on display showing when the next formal sessions were due. All staff had received at least one formal supervision since January 2016.

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

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

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that the provider had followed the requirements in the DoLS authorisations. Six applications had been submitted to the local

authority and the provider was waiting for the supervisory bodies authorisation. The provider had properly trained and prepared their staff in understanding the requirements of the MCA and DoLS.

Staff told us that where appropriate capacity assessments had been completed with people to test whether they could make decisions for themselves. We saw these in the care plans. They showed the steps which had been taken to make sure people who knew the person and their circumstances had been consulted. Staff had recorded the times best interests meetings had been held and assessments completed to test their mental capacity and ability. When a meeting had not been held staff had recorded how they had arrived at the decision to commence a mental capacity assessment in a person's best interests.

People told us that they liked the food. One person said, "The cook knows what I like." People seemed at ease talking with the cook and other staff about their meals. Staff knew which people were on special diets and those who needed support with eating and drinking. Staff had recorded people's dietary needs in the care plans such as when a person required a special diet. We saw staff had asked for the assistance of the hospital dietary team in sorting out people's dietary needs. The cook also kept a dietary profile on people in the kitchen area. This included people's likes and dislikes and any special diets. This ensured people received what they liked and what they needed to remain healthy.

Menus were not on display in the dining rooms, but were in the kitchen area. The cook explained and showed us the new menus, which were waiting for approval. These were to be changed for a menu more suited to winter months. There was no evidence to support people had been asked about their choices for the menus. However, we did observe the cook asking people if they liked the food that day, which other staff told us was a common occurrence.

We observed the lunchtime meal. The meal was well presented and looked appetising. Portion sizes were altered to suit people's wishes. Most people ate in the dining room, but some preferred their bedrooms. One person liked to sit in the reception area and told us they preferred this as they only had ice cream and milk at that time of day. We observed staff sitting with people who needed help to eat and drink. They spoke kindly to them, maintaining eye contact and informing them what was on the plate or bowl. Staff did not hurry people. Staff took meals to people who preferred to eat in their rooms. They ensured each person was sitting comfortably and had all the utensils and condiments they required. The cook also visited people in their rooms to see if they had enjoyed their meal. People were offered hot and cold drinks throughout the day. Each bedroom area had a jug of water and squash in the room.

We observed staff attending to the needs of people throughout the day. For example, one person needed help to mobilise and was unsure of themselves. Staff were patient with them and praised their efforts. We heard staff discussing whether the aids in use were appropriate for that person.

People told us staff treated them with dignity and respect at all times. One person said, "They look after me quite well."

Staff had recorded when people had seen the optician and dentist. Several people had hospital appointments which they had attended. Staff had recorded outcomes of those visits. Staff told us the rapport they had with other health professionals had improved and they felt supported by them when they required assistance. This was affirmed by the health and social care professionals we spoke with before our visit.

Good

Is the service caring?

Our findings

People told us they liked the staff and felt well cared for by them. One person said, "They are lovely." Another person told us, "I like them all. They are patient and kind." Someone else said to us, "Care very good." People's care records and staff personal records were stored securely which meant people could be assured that their personal information remained confidential.

The people we spoke with told us they were supported to make choices and their preferences were listened to. One person said, "I like sitting where I want to and where I can see what is going on during the day." Another person told us, "I can get up and go to bed when I want to. If I want to have a day in bed, a duvet day I call it, I can do that as well." People told us staff were good listeners. One person said, "We all have off days and want to get things off our minds, but staff have always been there for me."

People were given choices throughout the day if they wanted to remain in their rooms or bed or where they would like to sit. Some people joined in happily and readily in communal areas. Others declined, but staff respected their choices on what they wanted to do.

We heard staff speaking with relatives about hospital appointments and home visits, after obtaining people's permission. This was to ensure those who looked after the interests of their family members' knew what arrangements had been made. All events and comments we saw staff record in the care plans.

We observed staff knocking on doors prior to being given permission to enter a person's room. They asked each person's permission prior to commencing any treatment and respected if they wanted pain relief medication prior to commencement of treatment. Although one person commented to us, "That's the first time they have done that." Staff ensured they had all items with them when they entered a room. For example, to help change the bedding of someone who was remaining in bed. Staff told us this was to ensure they were not disturbed once they had commenced a task.

People told us staff obtained the advice of other health and social care professionals when required. One relative told us, "We were told that the doctor had been to visit." Another person talked at length about the 'goodness' of the staff in calling a doctor when required. They explained they had seen the doctor recently and staff were good at listening to them.

All the staff approached people in a kindly manner. They showed a great deal of friendliness and consideration to people. They were patient and sensitive to people's needs. For example, when someone wanted to use the toilet. The person beckoned the staff member, asked quietly and staff summoned assistance to help move the person ensuring they were comfortable before leaving them in a toilet area. Staff ensured they made eye contact with each person and if the person did not object lightly touched their arm to give reassurance.

We also observed people who wanted to mobilise independently, but slowly, being allowed to do so. In some cases staff stayed with each person until they were safely in the room they wanted to be in. We saw

staff ensuring each person had the correct footwear on and it was safe to walk in. Staff also checked the tyre pressures of wheelchairs and the ends of walking aids to ensure they were safe to use. If not, the staff member spoke quietly to each person, explained the problem and rectified this as quickly as they could so not to impede a person's wishes to move about the home.

Some people either through choice or because they were ill choose to remain in bed. We observed staff attending to people's needs. They ensured they answered people's call bells promptly, politely asked what they required before fulfilling the person's wishes. The manager explained the home was fitted with a portable call bell device, which people carried around with them. People told us they were happy with this type of system. We did observe that sometimes people forgot to pick up their devices and staff had to retrieve them. There were occasions throughout the day when staff took longer to answer the call bells than others, but staff told us this was because they were dealing with a complex issue and could not suddenly stop what they were doing. There was no method of auditing the call bell system, only by the manager and senior staff listening throughout the day. We did see senior staff and the manager respond if they thought a call bell was ringing for too long. Staff told us this would be monitored and they would be spoken with if there was a problem and they had not reacted quickly enough.

Staff in the home were able to communicate with the people who lived there. They altered the pitch and sound of their voices to suit each person's needs. For example, where someone wore hearing aids, but still found it difficult to filter out other noises, staff spoke clearly and slowly and did not leave them until the person understood the answer to their question. The staff assumed that people had the ability to make their own decisions about their daily lives and gave people choices in a way they understood. They also gave people the time to express their wishes and respected the decisions they made.

People told us they could have visitors whenever they wished and this was confirmed by relatives. We saw signatures in the visitors' book of when people had arrived at the home and saw several people visiting. Staff told us families visited on a regular basis. We saw visitors being offered refreshment when they arrived. We observed any visits by relatives was recorded in the care plans by staff. This ensured people could still have contact with their own families and they in turn had information about their family member. People told us staff would telephone their family members when they wanted to speak with them. They told us they could have those phone calls in a private area so they would not be disturbed.

All members of staff were involved in conversations with people and relatives. Each staff member always acknowledged people when walking around the building. Staff greeted people with their first names if this was their wish. Staff were smiling all day as they went about their tasks. Staff engaged with people about each person's day or engaged in lengthier conversations. There was a lot of laughter and banter between staff, people and visitors throughout the day which people appeared to enjoy.

Some people who could not easily express their wishes or did not have family and friends to support them to make decisions about their care could be supported by staff and the local lay advocacy service. Advocates are people who are independent of the service and who support people to make and communicate their wishes. We saw details of the local lay advocacy service on display. There were no local advocates being used by people at the time of our visit.

Requires Improvement

Is the service responsive?

Our findings

People told us staff had talked with them about their specific needs and responded to their needs as quickly as they needed staff to. They told us they were aware staff kept notes about them, but most people preferred to have their relatives read and respond to their care plans. People told us they were involved in the care plan process with their relatives, but if they could not read their notes staff would do this for them.

Staff received a verbal handover of each person's needs each shift change so they could continue to monitor people's care. Staff told us this was an effective method of ensuring care needs of people were passed on and tasks not forgotten. There was also a handover book in use. Staff told us this was used as a reminder of what had been said and for them to sign off tasks as they occurred. We observed the lunchtime handover. This was unhurried and staff were given time to ask questions. Details included the well-being of each person, what medicines required to be ordered and which relatives had requested an update to their family member's care.

People told us staff had the skills and understanding to look after them and knew about their previous personal lives. People told us that staff knew them well and how each person's beliefs could influence their decisions they made each day. This meant people had a sense of wellbeing and quality of life.

People told us that staff took time each day to discuss their care and treatment. As well as the opportunity to speak with other health professionals. This was recorded in each care plan. For example being able to see a nurse or doctor when they required one to discuss their needs as older people. One person said, "They call a doctor whenever I need one. Sometimes the doctor comes or their nurse, but sometimes I have to go to the surgery. Staff are good and arranging the transport and will come with me." People told us medical help from GPs and community nurses were accessed quickly and efficiently by staff. This was also confirmed by the health and social care professionals we spoke with before our visit. They told us staff had learnt quickly to respond to situations they were unfamiliar with and could fulfil instructions left to help give treatment.

Where people had a history of falls, staff had recorded the incident in the daily notes. They had liaised with local community nursing teams and occupational therapists to see what aids and advice was available to ensure people were not at risk of injury. When a person had bed rails fitted to their bed permission had been sought either from the person themselves or the person speaking on their behaviour such as a son or daughter for their use.

When a person asked to stay in bed for long periods or were too ill to leave their bed, staff completed charts to show they had been seen on a regular basis and helped to move in bed. Staff had completed care plans for people's requests to stay in bed and also skin integrity charts to ensure their skin was intact.

We were informed that an activities co-ordinator was employed. This person was not available that day, so staff told us they or the manager arranged activities. The details of any activities were kept in the care plans. The activities records stated people's general interests, past employment and preferred social activities. For example different entertainment they enjoyed such as singers. They also recorded events which had taken

place such as board games and themed events such as Halloween. People told us they were encouraged by staff to invite family and friends to the home to take part in social activities. There was an activities plan on display stating such events as movie afternoon with popcorn and games afternoon. However, the manager told us the movie had not happened that week, but did not give an explanation as to why this had not occurred. Two people told us they had not been involved or seen activities for over a month. With people's permission, which was in their care plans, the provider put photographs of events on the care home's Facebook page. However, this had not been updated for some time, so was not a true record of what was currently taking place.

The provider had recently stopped sessions which had been provided for music and movement and reminiscence from outside agencies, but no explanation was given as to why this had occurred. The manager and staff expressed the value these had with people and hoped to reinstate them soon. Staff told us the home celebrated people's birthdays. This was confirmed by one person who told us they had just celebrated their birthday with a party and three cakes had been made so everyone could join in.

During the day we observed people sat for times watching others and listening or looking towards the television. There was some social interaction with people by staff throughout the day. However, staff attended to people's basic needs, but spent a limited amount of time with people just chatting. There was no meaningful interaction or stimulation for people during the day apart from the television to keep people occupied. One person told us, "I'm often bored, thank goodness for the TV and visitors."

People were actively encouraged to give their views and raise compliments, concerns or complaints. People's feedback was valued and concerns discussed in an open and transparent way staff told us, which people confirmed. People told us they were happy to make a complaint if necessary and felt their views would be respected. Each person knew how to make a complaint. No-one we spoke with had made a formal complaint since their admission. People told us they felt any complaint would be thoroughly investigated and the records confirmed this. The complaints log detailed the formal complaints the manager had dealt with since our last visit. It recorded the details of the investigations and the outcomes for the complainant. Lessons learnt from the cases had been passed to staff at their meetings in May 2016 and October 2016.

The compliments book was very full and give many positive comments about the care which had been delivered to individuals. Some thank you cards for care recently delivered were on display.

Requires Improvement

Is the service well-led?

Our findings

There was not a registered manager in post. However, the manager had submitted their application to CQC and this was being processed by the registration department. People told us they could express their views to the manager and felt their opinions were valued in the running of the home.

Questionnaires had been sent to people in July 2016 on topics such as personal care, the management of the home and making a complaint. People told us they had completed questionnaires. The results were displayed on a notice board showing there had been many positive comments. Relatives and people who lived in the home told us they did not have the opportunity to attend group meetings with the manager and other staff. However, they told us they could speak with the manger all the time and as this was a small home there was no need for them to have an appointment as they preferred one to one conversations.

On the home's website there was a lot of information about the home. This included a calendar of events, what type of services were provided and what the accommodation consisted of. There was a lot of information about the running of the home and the wider company. However, the website had not been updated for some time as it did not reflect the current running of the home as a care home and not a nursing home and staff positions had changed. Therefore this gave incorrect information about the home. The main notice board into the home also incorrectly stated the home was a nursing home, but it was not longer registered to take people with nursing needs. This meant that people passing by and looking for a nursing home would be incorrectly signposted to this home from the main road.

Staff told us they worked well as a team and felt supported by the manager. One staff member said, "It's had its moments this year with the nurses going, but staff have rallied around, learnt new skills and I feel people get good care here." Another staff member said, "We work together and I'm happy in my work. It's a happy environment." Another staff member told us, "Still happy to come to work. I feel I really fit in here."

Staff told us staff meetings were held when there was a need to give everyone the same message. Otherwise individual staff were spoken with if the manager had to tell them about the way they completed their work. This was confirmed in staff personal files. We saw the minutes of the staff meetings for May 2016 and October 2016. The meetings had a variety of topics which staff had discussed, such as keeping accurate charts for food and fluid intake, use of commodes and working together. This ensured staff were kept up to date with events. Staff told us they felt included in the running of the home and it was a good, friendly environment to work in. The minutes of the meeting showed staff were given time to express their views and explanations given for views expressed or suggestions for moving forward.

The manager was seen walking around the home. They knew the names of all the people, relatives and visitors. They gave support to staff when asked and checked on people's needs. The manager showed compassion and respect to people and assisted staff when they needed help.

There was some evidence to show the manager had completed audits to begin to test the quality of the services provided. These included health and safety, fire safety and medication audits. Where actions were

required these had been clearly identified and signed when completed. Any changes of practice required by staff were highlighted in staff meetings, in the communication book and shift handovers so staff were aware if lessons had to be learnt.

Staff wrote in a maintenance book when they required urgent repairs to be made to the fabric of the building and equipment. The maintenance person signed when jobs had been completed. However, there was no plan of maintenance for general upkeep and refurbishment of the premises. Some areas of the home were looking very tired and well-worn, including furniture and bed linen. Staff told us if any item required to be replaced immediately this was actioned by the provider. This did not make the home very welcoming to live in and visit.

The manager understood their responsibilities and knew of other resources they could use for advice, such as the internet. This home is part of a small company so the manager had the opportunity of meeting with other homes managers and the provider on a monthly basis. The manager told us this had proved useful as all the managers shared ideas and problems.

Services that provide health and social care to people are required to inform CQC of important events that happen in the service. The manager of the home had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.