Mrs C Duffin

Freegrove Care Home

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

Freegrove Care Home can accommodate up to 17 people. The accommodation is arranged over two floors with a lift available to access the upper floor. People in care homes receive accommodation and their care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided and both were looked at during this inspection. Freegrove Care Home is owned and managed by Mrs C Duffin who, throughout this report, is referred to as the provider. This inspection took place on the 3 and 4 December 2018 and there were 14 people using the service.

The service is not required to have a registered manager. This is because the provider is registered with the Care Quality Commission as an individual and is providing the day to day management of the service. 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.

At our last inspection we rated the service as overall good. At this inspection, whilst we found some areas where improvements could be made, our findings continued to support an overall rating of good.

The areas for improvement were:

Notifications of incidents and accidents that had occurred had not always been sent to CQQ as required.

Some of the records relating to how the service was managed contained missing information or were not accurately completed.

Whilst incidents and accidents were investigated, these sometimes lacked robustness and learning from these was not yet being consistently applied.

The provider's governance and quality assurance systems were not yet being fully effective at monitoring the quality and safety of the service.

Other areas were overall good.

There were times when staff could have been more effectively deployed. The provider is reviewing staffing arrangements to address this. Recruitment was safe.

Overall medicines were managed safely and people received their medicines as prescribed.

Staff followed infection control guidance and the home was visibly clean.

People had individual assessments of risk associated with their care and support and the staff knew how to support people in a way that minimised these risks.

Health and safety checks were carried out to ensure the safety of the building and equipment within it.

Staff had received training in safeguarding adults, and had a good understanding of the signs of abuse and neglect.
Staff understood their responsibility to raise concerns and report on incidents and accidents.

People received effective care from staff that had the right skills and knowledge to carry out their role. Whilst staff felt supported in their roles. The frequency with which they were receiving supervision had declined.

The provider demonstrated a clear commitment to protecting people's rights. Where people's liberty or freedoms were at risk of being restricted, the proper authorisations were in place or had been applied for.

People told us they enjoyed the food provided and staff were informed about whether people were nutritionally at risk.

Staff worked effectively with a number of health care professionals to ensure that people received co-ordinated care, treatment and support.

People were treated with dignity and respect and staff were kind and caring in their interactions with people.

People and their relatives were involved in making decisions and planning care.

People received care that was centred on them as an individual. Staff recognised and responded to changes in people's health care needs.

People were supported to follow their interests and take part in social activities.

People and relatives were confident they could raise concerns or complaints and these would be dealt with.

People and their relatives expressed confidence in the provider and their ability to manage the home well. Everyone continued to speak positively about the friendly and homely culture within the home.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service remained safe.

Is the service effective?

Good

The service remained effective.

Is the service caring?

Good

The service remained caring.

Is the service responsive?

Good

The service remained responsive.

Is the service well-led?

Requires Improvement

The well led domain continued to be rated as requires improvement.

Notifications of incidents and accidents that had occurred had not always been sent to CQQ as required.

Whilst incidents and accidents were investigated, these sometimes-lacked robustness and learning from these was not yet being consistently applied.

The provider's governance and quality assurance systems were not yet being fully effective at monitoring the quality and safety of the service.

People and their relatives expressed confidence in the provider and their ability to manage the home well. Everyone spoke positively about the friendly and homely culture within the home.

Freegrove 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 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 was an announced inspection which took place on 3 and 4 December 2018. The inspection was undertaken by one inspector.

Before the inspection, we reviewed all the information we held about the service including previous inspection reports and notifications received by the Care Quality Commission. A notification is where the registered manager or provider tells us about important issues and events which have happened at the service. The provider had completed a provider information return in February 2018. A PIR is a form that asks the provider to give some key information about the service, such as what the service does well and improvements they plan to make.

During the inspection we spoke with five people and five relatives. We also spoke with the registered provider, and five care workers. We viewed the care and support records for four people and the recruitment record for the one staff member who had been employed since our last inspection. We also viewed other records relating to the management of the service such as staff rotas, audits and policies.

Following the inspection, we received feedback from four health and social care professionals about the care provided at Freegrove Care Home.

Good

Is the service safe?

Our findings

Each of the people we spoke with told us they felt safe living at Freegrove Care Home and this view was shared by the relatives we spoke with.

We looked at the staffing arrangements within the service. Day shifts were staffed by three care staff one of whom was a senior care worker. In addition, on weekdays, the registered provider was also working within the home. During night shifts there were two care staff on duty. Many ancillary staff were also employed including a full-time chef, a laundry assistant and a housekeeper. The service did not employ staff specifically to provide activities or entertainment and this remained the responsibility of the care staff. Either the provider or deputy manager were on call at weekends.

Since our last inspection, some staff had left and recruitment of new staff remained a challenge. However, to ensure that any vacancies were covered by suitably skilled staff, the provider had arranged for regular agency workers to be available most days. Most people and relatives felt the staffing levels were satisfactory. For example, one person told us, "They quickly respond to the buzzer". One person did tell us they felt additional staff were needed in the early evenings to support people to bed. They said, "Sometimes, I feel I need to step in". This was a reference to them having seek a staff member to assist another person. Relatives were positive about the staffing levels. One said, "They [staff] are very good, there are always two staff with [family member], he was falling five or six times a week, he's not had that many the whole time he's been here". Another said, "Yes there are enough staff, there is always someone in and out, there are agency staff but they are the same ones and we have got to know them too". A healthcare professional told us, "They never appear short staffed or stressed" and another said, "There always seems to be the necessary staff numbers".

Feedback from staff about the staffing levels was however, more mixed. One staff member said, "It is not always possible to have someone in the lounge…an extra pair of hands would allow us to do more". Another staff member said, "There could be more on in the morning". A third care worker said, "If everyone pulls their weight we don't have a problem, they are all good staff here". Our observations indicated that staff, whilst busy and hardworking, could be more effectively deployed. For short periods of time, the communal areas were left unsupervised whilst staff attended to other tasks or provided support to people in their rooms. We discussed this with the provider. They were confident that this was a communication problem and not indicative of there being insufficient numbers of staff. They assured us that they always available during weekdays to provide support and back up for staff to ensure that communal areas remained supervised if they were called away. In response to the feedback, following the inspection, they planned to hold a meeting with staff to discuss how they might more effectively communicate with one another to provide adequate supervision of communal areas alongside their other duties and responsibilities. They also contacted the agency provider to request an adjustment to the shift patterns to allow more flexibility in staff numbers over key periods like handover and bedtime.

Recruitment was safe. Only one of the current staff had been recruited since our last inspection. Their recruitment records were well organised and detailed the checks that had been undertaken before they

started work. The provider had obtained references from previous employers and checked with the Disclosure and Barring Service (DBS) to ensure they had not previously been barred from working in adult social care settings or had a criminal record which made them unsuitable for the post.

During our visit we looked at the systems that were in place for the receipt, storage and administration of medicines. Monitored dosage systems (MDS) continued to be used for most of medicines with others supplied in boxes or bottles. The medicines were stored safely and only administered by staff that had been appropriately trained and assessed as competent. People's had a medicines administration record (MAR) which contained relevant information such as their photograph and information about allergies they might have. Where people were prescribed 'as required' or PRN medicines, there were protocols in place which described the circumstances in which these might be needed.

Whilst people had received their medicines as prescribed, we did identify some concerns with regards to the accuracy of some the records relating to people's medicines. We have discussed this further under the well led section of this report.

Staff followed infection control guidance and the home was visibly clean. Protective clothing, including gloves and aprons, was available and was used by staff appropriately. A cleaner was employed for four hours each weekday and records were maintained to show that cleaning schedules were followed including at weekends when the care staff oversaw this task. The provider was the infection control lead and had undertaken additional training for this role. Food continued to be stored safely. Cleaning schedules were in place for the kitchen and the service continued to be awarded the highest food hygiene rating when assessed by food safety officers in June 2018.

People had individual assessments of risk associated with their care and support and the staff knew how to support people in a way that minimised these risks. For example, where people were at risk of skin damage, relevant risk assessments had taken place and were reviewed monthly. Screening for the risk of malnutrition was routinely carried out and people's weight was regularly monitored. Where necessary people had falls risk assessments and in most cases, although not all, there was evidence that following falls or other incidents, staff completed an observation record for 24 hours which helped to monitor whether the person was experiencing increased pain, bruising or loss of mobility that might require a review by a healthcare professional. We did note that where people were assessed as being at risk of falls, they did not always have a falls care plan which clearly stated how the risk was to be managed. Since the inspection, the provider has advised that falls care plans will be place for each person who requires this by the end of December 2018.

Staff understood their responsibility to raise concerns and report on incidents and accidents. There was some evidence that these were monitored by the provider and we could see examples where clear actions had been taken in response to mitigate any risks and prevent reoccurrences. For example, a chair alarm had been put in place to alert staff that one person was attempting to mobilise, so that they could check on him. We did note however, that overall, the provider's review of incident and accident records could be more robust or inquisitive. We have commented on this further under the well led section of this report.

Health and safety checks and risk assessments were carried out to make sure the building and equipment within it were maintained and serviced as required to make sure people were protected. These included regular checks of the environment, fire safety, gas and electric systems. Whilst checks were made to protect people against legionella, these were not always clearly documented. We discussed this with the provider who is acting to address this. Each person had a personal emergency evacuation plan (PEEP) which detailed the assistance they would require for safe evacuation of the home. The provider also had a detailed business continuity plan which set out the arrangements for dealing with foreseeable emergencies such as

fire or damage to the home and the steps that would be taken to mitigate the risks to people who use the service.

Staff had received training in safeguarding adults, and had a good understanding of the signs of abuse and neglect. Policies and procedures were readily available and set out the responsibilities of staff with regards to sharing and managing safeguarding concerns. A review of records showed that the provider had undertaken appropriate investigations and liaised effectively with the local authority when safeguarding concerns had been identified. A health care professional told us, "I have no concerns in their ability to raise safeguarding's, when necessary". Staff were aware of the whistle-blowing procedures, but were also confident they could raise any concerns with the provider and that these would be dealt with.

Good

Is the service effective?

Our findings

People, their relatives and healthcare professionals told us Freegrove Care Home provided effective care. For example, one person told us, "I am as happy here as I can be anywhere which isn't my home". Another person said, "They have looked after me extremely well". One relative told us, "They are fantastic here…. It is homely [family member] is very content". Another relative told us how the provider and staff had worked hard to improve their family members mobility and independence following a hospital stay. They said, "If it hadn't been for [provider] and her support and help to get her back home to Freegrove with everything in place, her future could have been very different". They also commented on how well staff reassured people new to the service who were perhaps a bit bewildered or overwhelmed. They said, "They manage it very well, [person] was very puzzled and they were very good with her, they sit with her, put their arm round her, they are very calming". A social care professional told us the service had effectively helped one person to settle into their placement at the home. They said, "They have done really well, they were very good at working out what was going to help [the person] settle".

Care workers told us they were supported in their role and felt able to approach the provider for advice or support at any time, however, they also told us they were not currently receiving regular or formal supervision. Supervision is important as it helps to ensure staff receive the guidance required to develop their skills and understand their role and responsibilities. We discussed this with the provider. They acknowledge that the provision of supervisions had fallen behind, but since the inspection they have implemented a clear schedule for supervisions over the coming year. Appraisals had taken place in the early part of 2018 and were due to be undertaken again early in the new year.

New staff completed an induction during which they learnt about their role and responsibilities, read policies and procedures and became acquainted with the environment and people using the service. One staff member told us, "My induction was pretty good, I was showed all around and read all the care plans". Records showed that a new member of staff had been supported by the local college to complete the Care Certificate. The care certificate sets out explicitly the learning outcomes, competences and standards of care that care workers are expected to demonstrate.

Staff had completed training in a range of subjects such as infection control, Mental Capacity Act (MCA) 2005, fire safety, safeguarding, health and safety and manual handling training. The service supported staff, where appropriate, to enrol on nationally recognised health and social care qualifications at a local college. All the staff we spoke with said that the training provided was adequate to enable them to perform their role effectively. For example, one care worker told us they had undertaken a virtual training experience that provided an understanding of what it was like for people to live with dementia.

We looked at how the service was acting in accordance with the Mental Capacity Act 2005 (MCA). The MCA 2005 provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible. The provider had a good understanding of

protecting and respecting people's human rights and they demonstrated a commitment to supporting people's choices and, when required, of meeting their different and diverse needs. Where necessary, people had mental capacity assessments regarding the decision to live at Freegrove Care Home. We did, however, observe that best interest's consultations still needed to be more clearly documented and demonstrate how external professionals and family members had been involved in reaching decisions about how people's care and support should be provided when they lacked the capacity to decide this for themselves.

People had signed consent forms to having their photographs taken and to information about them being shared with other professionals. Where people had appointed a legal representative to make decisions on their behalf, copies of these were available in the persons care plan. Staff were observed to seek people's consent before assisting them and checked that they understood and were happy with the support being offered.

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 (Dolls). Many applications for a Dolls had been submitted by the home and had either been authorised or were awaiting assessment. We saw evidence that conditions attached to one person's authorised Dolls were being met.

People's needs were assessed before they came to live at the service to ensure that the staff would be able to meet their needs safely. Following their admission, a care plan was developed which included information about the person's needs and how these should be met. This helped to ensure people received care and support which suited their needs. For example, people had personal cleansing and continence care plans. Where necessary people had plans to support pain control or the management of breathing problems. People continued to have sleeping plans and night time assessments which were written by the night staff who knew the person's night time care needs best. Where necessary people had a care plan to support staff to manage behaviour which others might find challenging. Staff told us care plans were regularly updated to ensure they remained relevant.

People were positive about the food and comments included, "It's tasty" and "Yes the food is good". A relative told us their family loved the food and "Ate everything put in front of them" and another said, "Everything is home cooked and looks nice".

People's dietary needs were catered for and the chef continued to be well informed about their dietary needs and food likes and dislikes. We observed the lunch time meal on the first day of our inspection. People could choose where they ate their meal and some had friends or family join them. Tables were laid with cloths and placemats and people had access to variety of condiments, a gravy boat and squash or water. The main meal was a meat casserole with fresh vegetables and potatoes. The meal smelt and looked appetising and people appeared to enjoy the food provided. Dessert was home-made jam tarts which were greatly enjoyed by all. No-one needed a modified diet or assistance to eat and drink, but staff remained available to encourage and motivate people who benefitted from this. At supper, people were offered a choice of lighter meals such as sandwiches or egg on toast. Home baked cakes were offered each day and we observed that people were offered regular hot and cold drinks throughout the day.

Staff were well informed about whether people had been assessed to be nutritionally at risk or were losing weight. They knew who needed a little extra encouragement to eat and used a range of techniques to support this. For example, staff served one person's meal on a side plate rather than a dinner plate. Although the portion was not smaller, the person appeared to feel less overwhelmed with the smaller plate and we were told this meant they usually ate well. Food and fluid charts were being used to monitor the

nutritional intake of some people. We did note that one person's fluid charts did contain some gaps, which meant we could not be confident that they had been offered regular drinks. The provider told us that this would be a recording issue and when asked the person told us, "They [staff] make sure I have plenty of drinks". We also noted that the fluid charts were not being totalled. The provider plans to review how and when fluid charts are used to ensure these are an effective monitoring tool.

Where necessary the provider worked with other organisations and a range of healthcare professionals to ensure people received effective care and support. The provider had decided for a local doctor to undertake a planned visit to the home each month to monitor chronic conditions and undertake medicines reviews for example. The provider had recently agreed to provide a transition service for people being discharged from hospital who were not quite able to return home but no longer needed an inpatient bed. The aim was that staff would support the person's recovery and maximise their independence within a six-week period. The provider was hopeful that this would achieve a positive outcome for people. Following our inspection, the provider was meeting with representatives of the local clinical commissioning group to discuss how they could support the service to implement schemes aimed at ensuring a smooth transfer to and from hospital and to promote identification of the onset of conditions such as sepsis. This helped to ensure that people received co-ordinated care, effective treatment and support.

Staff maintained clear records which demonstrated that prompt medical advice was sought when it was suspected people might be suffering with health complaints such as a urine infection for example. Short term care plans continued to be used when people were being treated for acute conditions. For example, one person had a short-term plan which described how staff were to manage and monitor concerns about their weight loss. This helped to ensure that staff could effectively monitor the person's recovery. A healthcare professional told us, "The [staff] are very caring and I feel do manage risks to people's health and wellbeing…. they communicate well with the surgery. The patients are really well cared for".

Some of the feedback we received commented that the home would benefit from "Updating" or "Refreshing" the premises. Improvements were ongoing to ensure that the premises were decorated and adapted to a consistent standard throughout and to meet people's needs. Many new armchairs had been purchased and the carpet was being gradually replaced throughout the home for a practical cushioned lino. There were plans to renovate the upstairs bathroom and install new fire doors throughout the home.

There had been some limited progress to make the environment more suitable for those living with dementia. For example, some additional accessible signage had been put in place to help people identify the toilets and the quiet lounge. However, there was more that could still be done and we recommend that the provider consult best practice guidance with regards to this.

Good

Is the service caring?

Our findings

People told us they were supported by staff who were kind and caring. One person said of the staff, "They are cheerful, very positive and kind". A relative said, "Yes they [staff] are definitely kind and caring…I have never heard anyone get angry". Another relative said, "Yes the staff are kind and caring, not only with how they treat [family member] but others too". A health care professional told us, "I have always seen the residents being treated with respect and dignity when I have attended the home. The staff always appear kind and caring".

We observed staff interacting with people throughout the day and it was evident that staff had good relationships with them. This was demonstrated by one care worker who told us, "It's the happiest time when I walk in and the residents are happy to see me…. It's a lovely homely home". We observed that staff spoke to people kindly, respectfully and cheerfully. The kind and patient approach of staff was commented on by many relatives. For example, one said, "They [staff] are completely respectful even in difficult situations, they handle it brilliantly, they are very, very kind". This relative also commented on how sensitively the staff communicated with people living with dementia, helping to ensure the person continued to feel valued. Staff were confident that their colleagues were kind and caring

Many of the compliments received by the service had commented on the caring nature of the service and of the staff. For example, one read, 'Mum came to look upon [Freegrove] as her second home…. you and the team always welcomed her like a family member'. A second read. 'Thank you for the care, compassion and love shown to [family member]. You treated her like family. We were so fortunate we found Freegrove'.

People using the service were encouraged and supported to develop and maintain relationships with people that mattered to them. Friends and relatives could visit at any time and share a meal with their family member if they wished. Relatives said they felt welcome and had a good relationship with care workers and management. For example, one relative said, "I come every day, I'm always welcomed, they are ready with a drink". One relative told us they had become involved in supporting events and celebrations. They told us how they and their family had put on a fire work display with glow sticks and hot dogs which was enjoyed by all. Each person continued to have a 'relative involvement' sheet in their care plans. These demonstrated that relatives were updated promptly when people's needs changed or if they were unwell.

Staff were mindful of people's privacy and dignity. They spoke with people in a polite and respectful manner. Staff knocked on people's doors before entering their room and doors were kept closed when staff attended to people in their rooms.

People were encouraged to remain as independent as possible and details of what people could do, and those things they needed support with, were recorded in their care plan. One care worker told us, "I encourage [people] to undress the top half and do what they can, they appreciate it, [person] likes to help do the dining table and collect the cups and saucers". Another care worker told us how they encouraged a person to walk to their chair for breakfast and then walk to the bathroom for personal care. They said, "[Person] will do their face and front and I will do their back".

Good

Is the service responsive?

Our findings

The people we spoke with were happy that care workers understood how to meet their care and support needs. For example, one person said, "They are very good to me… I have all the food I need and can have a nice hot bath whenever I ask". It was evident that people and their family members had been involved in developing their care plans. One person told us, "Yes I know I have got a care plan" and a relative said, "Yes I have seen the care plan and have been through it with [staff member]. Overall care plans provided an a good, person centred record of the person's needs. The care plans viewed contained information about the person's life before coming to live at the service such as their interests and hobbies and the holidays they had enjoyed. They also contained some specific, individual information, about the person such as their preferred daily routines. For example, care plans contained information about when a person preferred to get up and go to bed and their preferred style of dressing. Where necessary, people had communication plans which described the ways in which the person might communicate and how they might best understand information due to being hard of hearing or having sight loss.

Our observations indicated that staff, including the agency workers, knew people and their individual preferences well and this helped to ensure that people received care that was centred on them as a person. The consistency of some of the staff and their understanding of people's needs was commented on by some of the families we spoke with. One relative said, "The most important thing is the staff, they are long termers, we've known [deputy manager] for a long time and the two other senior people know people well". A health care professional also commented positively on staff's knowledge of people and their needs. They said, "Whoever I have asked in the home, the staff have always been able to answer my queries and questions about the well-being of the resident".

Daily records were used to record information including, the personal care that had taken place and the activities people had taken part in. This information was shared at handovers
and helped to ensure that staff were aware of any new risks or concerns about a person's health. Staff continued to use a handover sheet which recorded whether any residents needed increased observations or had been involved in an incidents or accidents. This helped to ensure changes to people's needs were effectively communicated to those that needed to know.

Relatives told us that people's changing care needs were identified promptly and action taken to address these. For example, one relative told us, "Staff mentioned [family member] was more confused and might have an infection, a urine sample was sent off the next morning and all the staff were made aware of what was happening".

People were supported to follow their interests and take part in social activities. Each person had an activity plan which described how they enjoyed spending their time. During the inspection, we observed people taking part in an exercise class provided by an external professional, they all appeared to be greatly enjoying this. The next day a visitor to the service was leading an art and craft session during which people were making Christmas wreaths. People also told us they had been involved in baking biscuits over the weekend. A mural had been painted on the wall in the lounge and was decorated with a range of artwork people had

made. Other photographs showed people taking part in pumpkin carving and a range of other activities.

The planned activities were advertised and the day after our inspection, there was to be a carol concert lead by a local church followed by mince pies. In addition to these external activities, staff continued to use a daily reminiscence newspaper to provoke stimulating discussion with people and led a variety of games and crafts. Feedback about the activities provided was mostly good. One relative said, "[Family member] really enjoys the music, the crafts and the exercises". Another relative said, "There is something on nearly every day, a singer who brings in instruments, that's fabulous, everyone is there shaking something". One person told us it could be a "Little quiet over the weekend" and a relative felt that the music played was sometimes a "Little too modern" and that more one to one activities would be beneficial for their family member who often found it hard to hear the reminiscence for example.

People and relatives were confident they could raise concerns or complaints and these would be dealt with. For example, one relative said, "You can go to [provider] with anything". No complaints had been received in the last 12 months. The provider encouraged people and their relatives to give feedback about the service. Questionnaires had been completed in January 2018 and the feedback from these was all positive with comments including, '[provider] is constantly trying to make improvements to the premises and the way [the home] is run'. Whilst no formal relative's meetings took place, those we spoke to feel the management team could be approached at any time. For example, one relative said, "You can pop your head round the door or speak with [deputy] she is fabulous as well, very knowledgeable".

Nobody using the service was receiving end of life care, but the provider told us that where this was the case, they worked with healthcare professionals to ensure that the person could have a pain free and dignified death, remaining at Freegrove if this was their wish. We did note that people's care plans would benefit from reflecting in more detail, their preferences and choices for how they would like their care to be managed in their final days. The provider told us they made every effort to obtain this information, but that some people and families did not feel comfortable discussing this. They expressed a commitment, however, to continue to develop the end of life care plans wherever possible. We have also recommended that the provider look at ways of making sure information about whether a person has a 'Do not resuscitate' decision in place is quickly accessible to staff.

Requires Improvement

Is the service well-led?

Our findings

People and their relatives expressed confidence in the provider and their ability to manage the home well. One person said, "Yes they are a good manager…I can go to her, I see her as a friend as well as a manager, she has done her utmost to make me happy". One relative said, "[The provider] is really approachable, we would feel comfortable saying anything to her". Another said, "[Provider] is sensitive and interested in caring for people with dementia". Our observations indicated that the provider had a good rapport with people using the service. They had a good knowledge of the people using their service and it was clear that they were committed to working in a collaborative manner with their staff team to meet people's needs.

Feedback from staff about the provider was also positive. One staff member said, "Yes she is a good manager, she does her best and worries a lot about the residents". Another staff member said, "She is a good manager, very supportive of me and other staff". A health care professional told us, "I feel the home is well led and the management team appear supportive towards their staff".

The provider continued to demonstrate a commitment to, and passion for, their role and they continued to foster a person centred and homely culture within the home which was commented on by many of the people and relatives we spoke with. For example, one relative told us, "It was the homely feel we were looking for and that is what we have got…They make it feel like a home from home, I can't think of anything they could do better".

Staff told us that they were happy working in the service and that teamwork and morale was good. For example, one staff member said, "I love coming to work, it's a nice home, nice atmosphere, its small and very intimate". Whilst the minutes of staff meetings were brief, these showed that staff were kept updated with any changes in the service or to people's needs and were encouraged to share their views and comments to improve the quality of care. For example, staff had discussed falls prevention at one team meeting and discussed the importance of maintaining a safe environment at another.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service in the form of a 'notification'. Important events include accidents, incidents or allegations of abuse. During the inspection, we noted that the provider had failed to notify us of three such events that occurred within the service. From our discussions with the provider about this, it was clear that they had taken all the appropriate actions to keep people safe and protect them from harm but had not made the required notifications to CQC. This is important as it ensures CQC have appropriate oversight of emerging risks within services. The provider was aware of the circumstances in which notifications should be submitted and acknowledged that this had been an oversight. They have submitted these retrospectively and have provided reassurances that notifications will be submitted in a timely manner in future.

A range of audits were being undertaken to monitor the effectiveness of aspects of the service including infection control and medicines management. Where areas requiring improvement were identified, an action plan had been drafted and we were able to see that these actions had been completed. For example,

a recent kitchen audit had identified the need for a new fridge. This had been purchased and arrived during the inspection. Despite this programme of audit, during our inspection we looked at records and paperwork that was used to manage the service and found that some of these records contained missing information or were not accurately completed. Whilst incidents and accidents were investigated, these sometimes-lacked robustness and learning from these was not yet being consistently applied. We found a small number of gaps in the charts used to document the application of creams. The temperature of the areas used for medicines storage was not being monitored in keeping with the provider's medicines policy. Some mental capacity assessments were incomplete and records relating to the management of legionella were not well documented. This was evidence that the provider's governance and quality assurance systems were not yet being fully effective at monitoring the quality and safety of the service. Following our inspection, the provider sent evidence of the actions being taken to address any shortfalls we found.

Throughout the inspection, the provider was open and honest with us and they demonstrated a good understanding of the areas where further progress was still needed. To support and prioritise improvements within the service, we recommend that the provider develop a structured service improvement plan detailing the areas where improvements were still needed, the resources and timescales needed to achieve these and who would be responsible for each task.