Care Homes UK Two Limited

The White House Nursing Home

Inspection report

Monkton Lane
Jarrow
Tyne and Wear
NE32 5NN

Date of inspection visit:
19 April 2016
21 April 2016
26 April 2016

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10 June 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 19, 21 and 26 April 2016. The first visit on 19 April 2016 was unannounced. The second and third visits on 21 and 26 April 2016 were announced. We last inspected the service in February 2015 and found the service met the regulations we inspected.

The White House is a care home which provides nursing and personal care for up to 33 people, some of whom may be living with dementia. There were 27 people living there at the time of our inspection.

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

We found the provider had breached Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the registered provider did not have accurate records and procedures to support and evidence the safe administration of medicines. Appropriate codes for the non-administration of medicines were not always used, prescribed creams were not always recorded as administered, there was no specific guidance around 'when required' medicines, and records relating to 'when required' medicines were not always accurate.

You can see what action we told the provider to take at the back of the full version of the report.

People told us they felt safe. One person said, "I'm safe because I'm well looked after here." One relative told us, "I feel [family member] is safe here which is a great help."

The provider made sure only suitable staff were employed. Thorough background checks were carried out before staff started to work with people who used the service.

Staff we spoke with said they had completed safeguarding training and could describe different types of abuse and signs to be alert to. Staff told us they would report any safeguarding concerns immediately.

Risks to people's health and safety were assessed and reviewed regularly. Measures to reduce the risks identified were clearly set out in people's care records. Accidents and incidents were recorded accurately and analysed by the registered manager.

The service was clean, well maintained and felt homely.

People told us they liked the food which was well presented and looked appetising. There were enough staff to support people to eat. People who required specialist diets were catered for. People had access to hot and cold drinks and snacks throughout the day.

The service was working within the principles of the Mental Capacity Act 2005. Deprivation of Liberty Safeguards (DoLS) applications had been made appropriately and contained details of people's individual needs.

The design of the service supported people living with dementia, such as brightly painted doors, old photographs of the local area on display and gardening and household items on the walls.

People were happy with the care and support they received, and told us staff were caring and professional. One person said, "Staff really are caring." A relative told us, "I can't fault the care here. The staff are amazing."

Care records were personalised to each individual and were reviewed regularly. Staff knew people's needs and preferences well.

People and their relatives told us the service was well run. In a recent satisfaction survey 100% of relatives who responded said the registered manager was approachable. There was an effective quality assurance system in place to monitor the quality and safety of the service. People, their relatives and staff had regular opportunities to provide feedback on the service.

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. The provider's procedures did not support the safe administration of medicines.

People and their relatives felt the service was safe.

Thorough checks were carried out on all staff before they started to work at the service, to check they were suitable to care for and support vulnerable adults.

Checks on the maintenance of the premises were carried out regularly.

The accommodation was clean, comfortable and well maintained.

Is the service effective?

Good

The service was effective.

People told us they liked the food which looked appetising and nutritious.

People's healthcare needs were monitored and the service liaised with other health care professionals where appropriate.

Staff received regular supervisions and appraisals.

Staff training was up to date.

Is the service caring?

Good

The service was caring.

People said they were happy with the care and support they received.

People and their relatives told us staff were caring and professional.

Staff knew people and their relatives well.

People's privacy and dignity was maintained.

Is the service responsive?

Good

The service was responsive.

Staff responded quickly and appropriately when people's needs changed.

Care plans reflected the needs of individuals, and were reviewed and updated regularly.

Staff knew people's needs and preferences well.

People and their relatives knew how to make a complaint.

Is the service well-led?

Good

The service was well-led.

People, relatives and staff spoke positively about the registered manager and the management team.

There was a low turnover of staff.

Staff said they felt supported and the service had a good atmosphere.

Feedback was sought from people who used the service, their relatives and staff members.

The White House Nursing 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 over two days. The first visit on 19 April 2016 was unannounced which meant the provider and staff did not know we were coming. The second and third visits on 21 and 26 April 2016 were announced. The inspection was carried out by one adult social care inspector.

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 the PIR and all the information we held about the service, including the notifications we had received from the provider, before the inspection. Notifications are changes, events or incidents the provider is legally obliged to send us within the required timescale. We also contacted the local authority commissioners for the service, the clinical commissioning group (CCG), the local safeguarding team and the local Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We did not receive any information of concern from these organisations.

We spoke with five people who used the service and five relatives. We also spoke with the registered manager, the regional manager (representative of the provider), two nurses, one senior care worker, three care assistants, kitchen staff and domestic staff.

We looked at a range of records which included the care records for three people who used the service,

medicine records for 12 people, training and recruitment records for five staff, and other documents related to the management of the service.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific 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

Medicines were not always managed in a safe way. Appropriate codes for the non-administration of medicines were not always used. For example, code X had been used on medicine administration records (MARs), but this was not a standard or correct code for the type of MAR used at this service. Also, staff had written 'R = not required' on some MARs, and this was used on six occasions on one person's MAR in the past four weeks, but code R meant 'refused' on the pre-printed MAR used by the service. This meant accurate records were not always kept when medicines were not administered. Staff told us and records confirmed, that a recent audit by the clinical lead just before our visit had identified the issue of inconsistent codes when medicines weren't taken. The clinical lead had started a daily check of MARs to address this.

Prescribed creams, ointments and gels for topical application were not always recorded as administered. On one person's MAR there were five occasions when there was no staff signature. This meant we could not be sure if the person had their prescribed ointment applied as prescribed.

Unwanted medicines were not returned to the pharmacy in a timely way. They had been returned to the pharmacy most recently on 20 April 2016, but prior to this they had not been returned since 5 January 2016. A significant amount of medicines had built up in this period. When we asked the registered manager about returning excess medicines to the pharmacy, they said the service had recently changed pharmacy provider and they were in the process of setting up a more regular returns process.

People's care plans and medicine records lacked guidance for staff relating to 'when required' medicines. Several people were prescribed pain relief such as paracetamol 'when required', but there was no care plan or guidance in place to assist staff in their decision making about when it could be used. Staff described when they would administer 'when required' medicines but there was no clear guidance for them to refer to.

Records relating to 'when required' medicines were not always accurate as it was not always documented on the back of the MAR why 'when required' meds were given. This meant people's symptoms could not always be monitored by staff.

For the five days before our visit and during our visit, the recorded temperature in the treatment room was above that recommended for the safe storage of medicines. When we spoke to the registered manager about this they arranged for the maintenance person to repair the window so it could be locked open safely. The temperature of the treatment room reduced to recommended limits quickly.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked 12 MARs for the past four weeks and found no gaps or inaccuracies in relation to other prescribed medicines. This meant people received their other prescribed medicines as directed.

We observed one of the seniors administering the morning medicines. They explained to people what their

tablets were for and spoke to people in a respectful and kind way. They were friendly and had a good rapport with people. They were patient and reassuring when administering medicines and said, "Have a little sip of water. Just two more tablets to go now." This meant people were given enough time to take their medicines.

Dates of opening were recorded on prescribed creams, ointments and gels for topical application and body maps advising staff of the specific area to apply prescribed creams were in place. This meant staff had guidance on where to apply prescribed creams in line with the instructions on people's prescriptions.

Dates of opening and expiry were also written on other medicines such as eye drops and paracetamol suspension. This meant medicines were used when they were considered most effective.

Medicines that are liable to misuse, called controlled drugs, were stored appropriately. Additional records were kept of the use of controlled drugs so as to readily detect any loss. The controlled drugs register had been completed accurately which meant the arrangements for controlled drugs were safe.

People who were able to communicate their views told us they felt safe at the service. One person said, "I'm safe because I'm well looked after here." One relative told us, "I feel [family member] is safe here which is a great help." Another relative said, "[Family member] is safe as they need 24 hour care and they get that here."

The registered provider used a dependency tool to determine staffing levels in the service. People's needs in all areas such as mobility, dressing and washing were assessed and given a score between one and five. This contributed to an overall rating of low, medium or high dependency. The registered manager told us people were given a dependency scored based on their individual needs, and this was reviewed monthly. The registered manager said if people's nursing needs increased they could ask for more staff.

The service employed approximately 41 staff, a registered manager and a clinical lead. During our visit one nurse, one senior care worker, and six care assistants were on duty. Staff rotas we viewed showed these were the typical staffing levels for the service. The service also employed an activities co-ordinator, laundry staff, domestic staff, kitchen staff and a maintenance person. Night staffing levels were one nurse and three care assistants. Call bells were responded to promptly and people were supervised appropriately. Staff gave people the time they needed and weren't hurried.

Staff told us and records confirmed they had completed training in safeguarding vulnerable adults. Staff completed this training when they started working at the service, and this was repeated at regular intervals. Staff described various types of abuse and signs to look out for which would alert them to a potential safeguarding issue. Staff told us they felt confident approaching any of the management team if they had any concerns.

A safeguarding file, which was accessible to staff, contained the provider's up to date safeguarding policy and the local authority's 'safeguarding toolkit'. A safeguarding poster which contained contact phone numbers for the local authority was displayed prominently in communal areas and in the reception area. This meant people and their relatives had access to relevant safeguarding information.

Safeguarding incidents had been recorded and dealt with appropriately by the registered manager. For example, one safeguarding incident resulted in the person's family being informed and the community psychiatric nurse contacted to reassess the person.

Thorough recruitment and selection procedures were in place to check new staff were suitable to care for and support vulnerable adults. People's identification and employment history were checked, and a disclosure and barring service (DBS) check had also been carried out before staff started work. These checks help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. The registered manager told us DBS checks were repeated every three years, which was good practice.

Regular planned and preventative maintenance checks and repairs were carried out by maintenance staff. These included daily, weekly, quarterly, and annual checks on the premises and equipment, such as fire safety, window restrictors, bed rails and water temperatures. External contractors also carried out required inspections and services including electrical and gas safety. The records of these checks were up to date.

Accidents and incidents were recorded, dealt with appropriately and analysed monthly. Action following an incident or accident was evident, for example increased observations for people who chose to stay in their rooms who had a history of falls, and referrals to the falls team where appropriate.

Risks to people's health and safety were assessed and recorded in people's care plans. For example, risk assessments had been carried out in relation to people's equipment and behaviour that might challenge others. Control measures to minimise the risks identified were set out in people's care plans for staff to refer to, such as 'ensure the wheelchair is not faulty' and 'two staff to support the person with distraction techniques.'

Risk assessments relating to the environment and other hazards, such as fire, clinical waste and food safety were carried out and reviewed by the registered manager regularly. Each person had a personal emergency evacuation plan (PEEP) which contained detail about people's individual needs, should they need to be evacuated from the building in an emergency. They contained specific guidance for staff about how to communicate and support people in the event of an emergency evacuation. Fire drills were carried out regularly.

The premises were clean, comfortable and well maintained. The service had a homely feel. The register manager told us the provider had a redecoration plan to refresh the service. In a recent satisfaction survey 100% of relatives felt the service was 'tastefully decorated'.

Good

Is the service effective?

Our findings

We observed lunch during our visit. People told us the food was nice. One person said, "Oh yes it's nice. There's always something I like." Meals were served straight from the kitchen into the adjacent dining room. Meals were well presented and looked hot and appetising. People were given a choice of meals. Staff told us if people had limited communication they knew what people's food preferences were from people's support plans as family members had contributed to them.

People had a choice of sausages, mashed potato, vegetables and gravy or soup, salad or sandwiches. One staff member said, "If you don't like it don't eat it. We can easily get you something else don't worry." People were also given a choice of hot or cold drinks and asked if they wanted an apron to protect their clothes. People's drinks were thickened as prescribed and staff knew people's food and drink preferences well such as how people liked their tea.

Tables were set nicely with table cloths, placemats, cutlery, condiments, napkins and flowers. Four care assistants served meals in the dining room and two care assistants took meals to people in their rooms. Staff supported people to eat in a kind and sensitive way, and said things like, "Shall I cut your sausages up?" and "Would you like me to help you with that?" Chocolate cake and custard, tinned fruit and ice cream or fresh fruit was available if people wanted dessert. The atmosphere during lunch was relaxed and there were enough staff to support people to eat. Care staff helped people clean their hands and face after eating in a respectful way, and staff assisted people to leave the dining room when they wished to.

Staff, including kitchen staff, had access to a 'dietary requirements form' which detailed people's religious or nutritional needs, where they preferred to eat, at what time, if special cutlery was needed, swallowing difficulties, food intolerances and likes and dislikes. Where people's care plans noted they needed a particular diet kitchen staff could tell us about this, for example gluten free. This meant staff had access to information about how to support people to maintain a healthy diet.

Staff completed the malnutrition universal screening tool (MUST) to identify people at potential risk of malnutrition. Staff told us they monitored people's weight closely and losses of 2kg or more would prompt a referral to the GP, speech and language therapy (SALT) or dietician.

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. 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.

People's care records contained best interest decisions which corresponded to the information contained in the DoLS authorisations. Where people required a DoLS authorisation there was a record of when authorisations had been granted. The registered manager kept a record of DoLS expiry dates so new applications could be made in a timely manner. 11 people in the service were subject to DoLS.

One person chose to have bedrails for their own safety. Staff had explained to them that this was a form of restraint, but they had capacity to make this decision and this was clearly documented. Where a person was not taking their medicines but they didn't have capacity to make this decision, a best interests assessment was done by a psychiatrist and the community psychiatric nurse, and the person's family were involved. This resulted in the person being given their medicines in a different way.

People received effective care from staff that had the knowledge and skills they needed to carry out their roles and responsibilities. The registered manager told us, "Staff are skilled in dealing with people." New staff completed an induction programme which included training on safeguarding vulnerable adults, record keeping and accidents and incidents. Staff completed further training at regular intervals on issues such as food hygiene, moving and positioning, and the Mental Capacity Act 2005.

Staff told us they received "plenty of training", but some staff said they preferred classroom based and practical training to online training. A staff member told us, "We get plenty of training. I've asked for more training in dementia and diabetes which I'm going to get soon." Several staff told us they would like more training on end of life care to increase their confidence in this area.

Staff told us, and records confirmed, they had regular supervisions sessions and an annual appraisal with their managers. The purpose of supervisions was to promote best practice, offer staff support and identify any areas for development. Records confirmed staff had individual supervision sessions six times a year. Supervisions were up to date and covered relevant issues such as infection prevention and control and fire safety. Staff told us they didn't wait for supervisions to raise issues with their managers as they could go to them at any time.

On admission to the service basic checks relating to people's health were recorded, such as their weight, blood pressure, and pulse. These checks were repeated at monthly intervals. Staff told us the purpose of this was to know what's normal for the individual. Where people had specific health needs such as epilepsy, seizure diaries were in place in their care records so the time and duration of seizures could be recorded and monitored. This meant people's health and nutritional wellbeing was promoted and monitored.

People had access to a wide range of health care professionals such as the community nursing team, dentist, GP, tissue viability nurse and community psychiatric nurse. Records of visits by other health care professionals were recorded in people's care plans and in the staff communication diary. Records we viewed were clear and detailed. Where people chose to deviate from advice given to them by health care professionals, where they had capacity to do so, this was clearly documented.

The service had some features which supported people living with dementia. Doors were painted bright colours and memory boxes were outside people's rooms to help people recognise their own rooms. Old photos of the local area provided reminiscence material and kitchen utensils and garden tools provided visual or tactile interest. The dining room had a coffee shop in one corner and a sweet shop in another corner.

Good

Is the service caring?

Our findings

People we spoke with were happy with the care and support they received. People told us care staff were caring, polite and professional. People and relatives told us they had a positive relationship with care staff, and felt that staff knew them well. A relative told us, "I have a good rapport with the staff. They're like our family." A staff member said, "We know people and their families really well. It's homely here."

One person told us, "I'm well cared for and have everything I need. The staff are wonderful." Another person said, "Staff really are caring." One relative said, "Staff go the extra mile including the cleaners. Staff try to give [family member] the best possible care." A relative told us, "I'm pleased with the care [family member] receives. The attitude of staff is good as they have patience with all the residents and have good communication skills." Another relative said, "I can't fault the care here. The staff are amazing."

Some people who used the service were unable to tell us about the care they received, but throughout our visit staff addressed people in a kind and considerate manner, and communicated with people as individuals. For example, by giving people time to respond to questions and keeping sentences short. There were good interactions between staff and people who used the service, particularly those living with dementia. For example, one staff member said to a person whilst supporting them to walk, "There you go my friend. Let's go and have a cup of tea."

Staff spoke fondly of the people who used the service. For example one staff member said, "I love [person] to bits. He's such a gentleman." A 'memory wall' in the dining room contained photographs of people who had used the service but had passed away. Staff spoke warmly about them.

Staff were calm and reassuring to people who were distressed or anxious, and used appropriate touch to comfort people and show affection. Staff took practical steps to ensure people were comfortable such as ensuring they weren't too hot or too cold. People enjoyed a laugh and a joke with staff.

One relative we spoke with said, "The White House has been [family member's] saviour. They were in and out of hospital before they came here. This is their home now. The staff love [family member]. I didn't know if I could trust other people to look after [family member], but it soon became apparent that every member of staff has a vocation." Another relative told us, "This place is a revelation. Since coming here my [family member] has put weight back on and has calmed down. They're nowhere near as anxious and they have more interaction with the staff than other places they were in. For the first time in years I've had peace of mind."

People told us they felt their dignity and privacy were upheld by care staff. Staff knocked on people's doors and asked permission before carrying out care tasks such as helping people to cut up their food or helping people with personal care needs. This was done discreetly and sensitively. 'Care in progress' signs were used on people's doors to help maintain people's privacy.

People's choices were respected. For example where people liked to eat their meals and at what time. One

person liked to have their door closed when they were in their room and this was respected.

The representative of the provider said, "This is a kind place. Staff have built up good relationships with people." The registered manager told us, "We take pride in treating people with respect and maintaining their dignity."

Two relatives visited the service during our inspection whose family member had recently passed away. The registered manager and care staff spoke kindly and sympathetically to them. The relatives said to the registered manager and the staff, "Thanks for all you've done over the years."

The service had received several thank you cards from relatives of people who used the service. Comments included, 'Our thanks for looking after [family member] so well and making them feel comfortable and safe', 'I would like to thank you for the love and care that you gave [family member]', and 'We will be forever grateful for your care, love and compassion.' Another relative wrote, 'In the short time [family member] was in The White House they could not praise the staff enough. The care and attention you showed them was amazing and the family cannot thank you enough.'

The registered manager told us staff asked people about their preferences for end of life care when they first moved into the service. Where people and their families had been able to discuss their preferences, this was included in people's support plans. The registered manager showed us end of life care plans they used for people receiving end of life care and associated guidance. This meant staff had access to personalised information so they could support people in the way they wanted and needed at the end of their lives.

Each person who used the service was given a residents' guide (an information booklet that people received on admission) which contained information about all aspects of the service. This included the service's statement of purpose, how to make a complaint, and how to access independent advice and assistance such as an advocate. The residents' guide was also available in other languages and formats, and was available in the reception area so it was accessible for family members, along with other guidance on issues such as the Mental Capacity Act 2005 and safeguarding.

Good

Is the service responsive?

Our findings

People's needs were assessed before admission to the service. People had been included in their own care planning, where capabilities allowed. Some people had limited involvement in their care planning because they could not always communicate their needs fully. Relatives we spoke with said they felt involved in planning and reviewing their family member's care. One relative said, "Staff involve me in all decisions and discussions about [family member's] care. Staff are so helpful and always keep me informed what's going on."

Care plans were detailed, well written and contained information about people's family background, likes and dislikes, nutritional needs, communication, mobility, spiritual needs and general support needs. This information was person centred and specific to the needs of the individual. For example, there was precise detail around daily tasks, '[Person] is able to choose which clothes they would like to wear, but is unable to remember to change their clothes. Staff to encourage them to change their clothes.' Another care plan we viewed stated, '[Person] likes to go to bed around 8pm and have two pillows.' Care plans were reviewed and updated regularly or when needed, which meant staff had access to up to date information about how to support people in the way they wanted and needed.

Risk assessments were completed and were specific to the needs of the individual where appropriate, such as risk of isolation, pressure damage, falls, and malnutrition or dehydration. Where risks were identified measures to reduce the risk were clearly documented. For example, one person's care plan stated, 'Staff to include [person] in activities so they do not feel isolated'.

There were clear examples of the service responding to and acting on people's changes in needs. For example, staff noticed a person was unsteady on their feet and had experienced a few falls, so they referred them to the falls team. Appropriate advice was sought and recorded in the person's care plan and a sensor mat was obtained to alert staff when the person got out of bed. Also, a person's family had requested a different room for their family member. Staff identified there was a vacant room with views of the garden as they knew the person liked to watch the birds in the garden. This room was being redecorated for this person during our visit. When a person became unsettled and presented with behaviour that may challenge others staff contacted the person's practice nurse and psychiatrist to reassess them. This meant staff could identify and act on people's changes in needs promptly and appropriately.

Staff knew people's needs and preferences well. For example one staff member told us, "[Person] needs time to respond when you ask them a question so you have to be patient and ask basic questions."

A relative told us how staff arranged for a comfortable chair and small table to be placed in the corridor as their family member liked to sit there. The relative told us, "[Family member] has improved a lot since they came here. They are not as anxious and they are eating a lot better as staff know what they need."

One relative told us, "Staff ring me anytime there's a problem with [family member] and even text me if [family member] is in hospital."

The service employed an activities co-ordinator who organised a range of entertainment, activities and social events such as board games, pamper sessions, indoor bowls, movie afternoons and gardening. Although the activities co-ordinator was absent during our visit care staff organised activities such as cake making. Photos of people enjoying activities such as afternoon tea or a visit by a miniature pony were on display throughout the service, which made it feel homely. The registered manager told us the service was a member of the National Activities Providers Association (NAPA) which is an organisation which promotes person-centred activities for older people.

The service had its own mobile tuck shop which contained sweets, chocolate, crisps and drinks. The maintenance person, who had a good rapport with people who used the service, took this around people's rooms several times a day. People told us they liked to buy treats for themselves and their visitors. The money that the tuck shop generated was put into the residents' fund for outings and activities.

The provider had a clear complaints policy which was up to date. There was information about how to make a complaint in the residents guide. The registered manager kept records of any complaints including the nature of the complaint, actions taken and the outcome. Three complaints had been received in the last 12 months which had been investigated and dealt with appropriately. For example, the registered manager had met with family members and the pre-admission process had been improved. The registered manager also analysed complaints to check if any emerging trends could be identified to improve the service overall.

People and relatives we spoke with said they knew how to make a complaint. In a satisfaction survey conducted in February 2016, 100% of family members who responded said they were aware of how to make a complaint. Nobody we spoke with had ever needed to complain. One relative said, "I've never needed to make a complaint but I wouldn't hesitate speaking to the manager or the clinical lead as they are so helpful and understanding." Another relative told us, "I've got no complaints at all, but I would happily speak to any of the staff."

Good

Is the service well-led?

Our findings

The service had a registered manager who had been registered with the Care Quality Commission since 2014. The service also employed a clinical lead, but they were not present during our visit. The registered manager said they felt supported by the provider. The representative of the provider told us, "I want to empower my managers. I've got a good working relationship with the registered manager here and we've got a good clinical lead."

The staff team were stable which the registered manager said helped with consistency, and one care assistant had recently been employed. One staff member told us, "I've worked here for 10 years and I love it. It's a lovely little home."

People and their relatives told us the service was well run. Feedback from relatives in a recent satisfaction survey was positive. For example, 100% of relatives who responded said the manager was approachable.

People and their relatives could also give their views on the service at regular residents and relatives meetings. Recent meetings had not been well attended. When we asked the representative of the provider why this was the case, they said they had an open door policy so relatives and people who used the service could approach them or the clinical lead at any time. People and relatives we spoke with confirmed this was the case.

Staff spoke positively about the registered manager and the service, and how they felt supported. One staff member said, "I feel supported by the management team. The registered manager is great, very approachable." A second staff member said, "They're a great manager. They're so calm and always pleasant." A third staff member said, "There's a great atmosphere here."

Staff meetings were held monthly. Staff told us they didn't wait until staff meetings to raise issues as they would go straight to the registered manager or the clinical lead. Staff surveys were carried out annually, the most recent one was completed in February 2016 and responses were positive.

There was an effective quality assurance system in place to monitor the quality and safety of the service. The regional manager, registered manager and clinical lead carried out regular audits of areas such as infection control, care plans, health and safety and complaints. The representative of the provider told us they visited the service monthly to carry out a provider audit, but that they also did unannounced 'pop ins'.

Records of audits showed areas of improvement were identified and acted upon, and had a timescale for completion. For example, a recent health and safety audit identified the gas safety of the service needed re-testing and this was done in line with the timescale identified. Also, a recent audit of care plans identified some care plans which hadn't been signed by people, their representatives or staff and a plan was in place to rectify this.

The service had links with a local church and two pastoral visitors attended the service during our visit to

administer communion to people who used the service. Staff told us how important this was to people.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who use services were not protected against the risks associated with unsafe or unsuitable care and treatment because records and systems operated by the registered provider did not support the safe management of medicines. Regulation 12 (2) (g).