Care Quality Commission

Burwood Care Home Limited

Burwood House

Inspection report

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Ratings

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

Overall summary

We carried out an inspection of Burwood House on the 20 and 25 January 2016. The first day was unannounced. This was the first inspection of the service following registration with the commission on 10 April 2015.

Burwood House provides accommodation and personal care for up to 24 people. There were 20 people accommodated in the home at the time of the inspection. The home is an older type property located just off the main road close to the town centre of Bacup, Lancashire. The service is mainly provided to older people with needs relating to old age and for people living with dementia.

The service was managed by 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. The registered manager had been in post since June 2015 and registered with the commission in October 2015.

During this inspection visit we found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to ineffective quality assurance

Summary of findings

and auditing systems, management of people's medicines, infection prevention and control and recruitment processes. You can see what action we told the registered provider to take at the back of the full version of the report.

We also made recommendations about maintaining and developing the environment and developing and improving processes with regards to the Mental Capacity Act 2005 (MCA).

People told us they did not have any concerns about the way they were cared for. They told us they felt safe and were looked after. Relatives told us they had no cause for concerns. One relative said, "I am confident (my relative) is safe here." We observed people were comfortable around staff. We observed staff responding to people in a patient, good humoured and caring manner and we observed good relationships between people.

We looked at how the service managed people's medicines. We found areas where improvement was needed. Staff who administered medicines were undertaking appropriate training. However, regular checks on their practice had not been undertaken to ensure they were competent to manage people's medicines. We were told night care staff did not administer medicines during the night. We were told people did not require medicines during the night but we were concerned they would not receive medicines such as for pain relief during the night. We found processes were in place for the ordering and receipt of medicines although improvements were needed to ensure storage was appropriate and to ensure disposal of medicines was safe.

We did not look at all areas of the home but found some areas of the home were not clean and hygienic. We noted some improvements had been undertaken but other areas were in need of maintenance, redecoration and refurbishment. However, people were satisfied that improvements were being made. One person said, "The layout isn't brilliant although I have noticed other improvements are being made." A development plan was in place for the next 12 months; this was updated following our inspection. People told us they were happy with their bedrooms and some had created a homely environment with personal effects.

The number of shortfalls we found indicated quality assurance and auditing processes had been ineffective as matters needing attention had not always been recognised or addressed. This meant the registered providers had not identified risks to make sure the service ran smoothly. We were told that audits had only recently been introduced to check the quality of the service.

We looked at how staff were recruited and found areas where improvement was needed. We found relevant checks had not been carried out before two staff members started working in the home. This meant a fair and safe recruitment process had not always been followed.

People using the service, their relatives and staff told us there were sufficient numbers of staff to meet people's needs in a safe way. Staff told us any shortfalls due to leave or sickness were covered by existing care staff or by the registered manager. This ensured people were cared for by staff who knew them.

People made positive comments about the staff that cared for them. Comments included, "The staff are marvellous; they will do anything for you" and "I'm treated properly, with respect. Staff are always kind and caring." A health professional said, "The staff are passionate about people's care."

Staff were able to describe the action they would take if they witnessed or suspected any abusive or neglectful practice. We found most staff had not received training on the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). This meant they had limited knowledge of the principles associated with the legislation and people's rights.

People felt staff had skills and knowledge to provide them with effective care and support and were happy with the care they received. There were no records to demonstrate the training that staff had undertaken which made it difficult to determine when and whether staff had received a range of appropriate training. Staff told us their training had been kept up to date under the previous provider and that mandatory training was now booked.

Staff told us they were able to voice their opinions and share their views. They felt there was good communication with the management team and they were supported by a manager who listened to them.

Summary of findings

People told us they enjoyed the meals. One person told us, “The meals are very good; we have a choice.” The menus and records of meals served indicated people were offered meal choices and also alternatives to the menu. People were served drinks and snacks throughout the day. People’s dietary preferences and any risks associated with their nutritional needs were recorded and appropriate professional advice and support had been sought when needed. People’s healthcare needs were met and appropriate referrals had been made to specialist services as appropriate.

All people had a care plan, which had been reviewed and updated on a monthly basis. Information was included regarding people’s likes, dislikes and preferences, routines, how people communicated and risks to their well-being. Additional information was needed to ensure people received the care and support in a way they both wanted and needed. People told us they were kept up to date and involved in decisions about care and support but had not always been formally involved in the review of their care.

There were opportunities for people to engage in suitable activities both inside and outside the home. People said, “I always have things to do and people here can be very good company” and “We do a few things now and then and sometimes go out.”

People were aware how to make complaints and were confident the manager would listen and take appropriate action. People told us they had not needed to complain and that any minor issues were dealt with informally and promptly.

People living in the home and relatives spoken with made positive comments about the management of the home and were happy about the necessary improvements being made to the service. People told us, “The manager has made a number of changes since she started; things are improving” and “Things are improving week on week.”

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not consistently safe.

Staff were able to describe the action they would take if they witnessed or suspected any abusive or neglectful practice. People told us they felt safe living in the home and did not have any concerns about the way they were cared for.

People's medicines were not always managed safely and checks on staff practice had not been undertaken to ensure they were competent.

We found a number of areas were in need of attention to ensure the environment was clean and a suitable place for people to live in.

There were sufficient numbers of staff available but the provider had not always operated a robust recruitment procedure.

Is the service effective?

Requires improvement

The service was not consistently effective.

Staff told us they received a range of appropriate training. However, records were not available to support the staff team had the skills and knowledge to meet people's needs.

Whilst improvements had been made we found a number of areas in need of attention to ensure the environment was safe and comfortable for people to live in.

People told us they enjoyed the meals and we observed them being given appropriate support and encouragement with their meals. People were supported to access a range of health care professionals to help ensure their general health was being maintained

A number of referrals under the Mental Capacity Act (MCA) 2005 had been made to help ensure people received the care and treatment they need. However, where decisions needed to be made, people's capacity was not assessed.

Is the service caring?

Good

The service was caring.

People told us they were happy with the home and with the approach taken by staff. Staff responded to people in a patient, good humoured, caring and considerate manner and we observed good relationships between people.

Staff took time to listen and respond appropriately to people. Some people using the service told us they were able to make decisions and choices about their daily lives.

Summary of findings

People and their relatives had been involved in ongoing decisions about care and support and information about preferred routines had been recorded.

Is the service responsive?

Good

The service was responsive.

People were encouraged to discuss any concerns during meetings and day to day discussions with staff and management. They told us they did not have any concerns but were confident they would be listened to.

Each person had a care plan that was personal to them which included information about the care and support they needed. Some people were aware of their care plan and they, or their relatives, had been involved in the review of their care. Improvements were being made to the way people's information was recorded.

People were supported to take part in a range of suitable activities. People were able to keep in contact with families and friends.

Is the service well-led?

Requires improvement

The service was not always well led.

People made positive comments about the management of the home.

The number of shortfalls we found indicated quality assurance and auditing processes were not effective. The provider had begun to introduce systems to assess and monitor the quality of the service.

There was a positive and open atmosphere at the home. People were satisfied that improvements were being made.

Burwood House

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 was 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 20 and 25 January 2016 and the first day was unannounced. The inspection was carried out by one adult social care inspector.

The provider sent us a Provider Information Return (PIR). This is a form that asks the provider to give some key information to us about the service, what the service does well and any improvements they plan to make.

Before the inspection we reviewed the information we held about the service such as notifications, complaints and safeguarding information. We contacted the local authority contract monitoring team and social care professionals for information about the service. Following the inspection visit we spoke with a healthcare professional and to the local authority infection control lead nurse.

During the inspection, we used a number of different methods to help us understand the experiences of people who lived in the home. We spoke with the registered manager, three care staff, four people living in the home and three relatives.

We looked at a sample of records including three people's care plans and other associated documentation, three staff recruitment and induction records, staff rotas, training and supervision records, minutes from meetings, complaints and compliments records, medication records, maintenance certificates and development plans, policies and procedures and audits.

We observed care and support in the communal and dining room areas during the visit and spoke with people in their rooms.

Requires improvement

Is the service safe?

Our findings

People living in the home told us they did not have any concerns about the way they were cared for. People living in the home said, "It's a good place. I am looked after very well. I feel safe and content", "Staff are attentive and I'm looked after properly" and "I'm alright here. I get everything I need and everyone is so kind to me." Relatives said, "Staff are very kind" and "I am confident (my relative) is safe here." During the inspection we did not observe anything to give us cause for concern about how people were treated. We observed people were comfortable around staff and seemed happy when staff approached them. In all areas of the home we observed staff interaction with people was caring and patient.

We looked at how the service managed people's medicines. A new system was in place. The registered manager was aware of shortfalls in the management of medicines and was working with the community pharmacist and care staff to improve this area.

We found there were no records to show that staff who administered medicines had received appropriate training, although the registered manager and staff confirmed training had been completed prior to the new provider's registration. All staff who were involved with medicines management were currently undertaking appropriate training. Regular checks on their practice had not yet been undertaken to ensure they were competent to administer medicines.

We were told night care staff had not received any medicine management training and therefore did not administer medicines during the night. This meant people would not be provided with 'as needed' medicines such as for pain relief during the night. Where medicines were prescribed 'when required' or 'as needed', guidance was not clearly recorded to make sure these medicines were offered consistently by staff.

Medication was stored in a trolley which was secured to the corridor wall. Whilst storage temperatures had not been recorded recently we noted the corridor temperature was too high to safely store medicines and action had not been taken to provide more suitable storage. We discussed this with the registered manager who made arrangements to move the trolley to a more suitable, cooler room. We were advised a door lock would be provided and the trolley would be secured to the wall.

Arrangements were in place for the management of controlled drugs which are medicines which may be at risk of misuse. We checked one person's controlled drugs and found they corresponded accurately with the register. However the medicines were stored inappropriately in a cabinet on the corridor wall. We discussed this with the registered manager who arranged for the cabinet to be moved to a cooler and more suitable locked room. We also found one person's medication for injection was stored inappropriately in a cupboard on the corridor wall; this should have been stored in a fridge. The registered manager removed this medicine immediately.

We looked at how people's medicines were disposed of. We found there were no records to support safe disposal of medicines. We noted medicines for disposal had been recorded on the medication administration record (MAR) but without a record of items removed from the premises it was not clear where or who the medicines had been removed by. The medicines for disposal were stored in a locked room but not stored in the recommended tamper proof bin. The registered manager told us the community pharmacist would be providing a returns record following their recent visit.

The provider had failed to ensure people's medicines were managed safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A monitored dosage system (MDS) of medication had been in use for four months. This was a storage device designed to simplify the administration of medication by placing the medication in separate compartments according to the time of day. Policies and procedures were available for staff to refer to and we were told these were being reviewed to reflect current practice. We observed medicine rounds were completed in a timely way. One person said, "I get my medicines on time; the staff make sure of that."

We found records and processes were in place for the ordering and receipt of medicines. People were identified by photograph on their MAR which would help reduce the risk of error. People's allergies had been recorded to inform staff and health care professionals of any potential hazards

of prescribing certain medicines to them. There were generally clear instructions on medicines and on the MARs although we noted 'as directed' had been used for one person and another person's directions for application of creams was not clear. The registered manager told us she would discuss this with the community pharmacist and the person's GP. Appropriate codes had been used for non-administration of regular medicines on the reverse of the MAR.

We noted some external medicines such as creams and ointments were being applied by care staff. Medication charts had been introduced to support them with this. There were records to support 'carried forward' amounts from the previous month and stock amounts were checked each week; this would help to monitor whether medicines were being given properly and ensure adequate stocks were available. Boxed medicines were dated on opening to help make sure they were in date and appropriate to use.

Care records showed people were asked to consent to their medication being managed by the service on admission or whether they were able, or wished to, self-medicate. We were told no one was managing their own medicines at the time of our visit.

There was a system to ensure people's medicines were reviewed by a GP. This would help ensure people were receiving the appropriate medicines. We saw checks on the medication system had not yet been undertaken. We were told there had been a recent compliance visit from the community pharmacy. The registered manager was aware there were areas for improvement but had not yet received a report.

We looked at the arrangements for keeping the service clean and hygienic. During a tour of the home we found communal areas and bedrooms were generally clean and odour free. However we found areas that presented a risk of infection. We found the laundry room was cluttered and dirty, there was no hand wash sink, the flooring was in poor repair, pipes were exposed, cleaning equipment was dirty and stored on the floor. The locked room off the laundry was dirty and cluttered with various bags, equipment and old records. We found communal toiletries in the downstairs shower room although these were removed following our first inspection day. We found the ensuite bath was stained and flooring in bathrooms were not sealed.

The provider had failed to ensure people were protected against the risks associated with poor infection control. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Infection control policies and procedures were available. The registered manager advised us she planned to review them in line with the Department of Health guidance. There were no records to support the staff team had received up to date infection control training. An infection control lead had previously been identified to take responsibility for conducting checks on staff infection control practice and keeping staff up to date. However they had not yet received specific training to help them with this role. The registered manager told us training had been arranged for all staff in June 2016.

Care staff were responsible for the laundry and a recently employed domestic person worked five days each week. We were told there was no cleaning schedule for them to follow. However on the second day of the inspection a cleaning schedule had been introduced and would be monitored each week. We were told sufficient cleaning products were available. We were told people who needed to be moved using a hoist had their own slings to prevent cross infection.

We noted staff hand washing facilities, such as liquid soap and paper towels were available in the majority of bedrooms and waste bins had been provided. Additional items were ordered following our inspection visit. This ensured staff were able to wash their hands before and after delivering care to help prevent the spread of infection. Appropriate protective clothing, such as gloves and aprons, were available. There were contractual arrangements for the safe disposal of waste.

A recent hand wash audit had been completed. Other audits in relation to infection control had not been completed. The registered manager showed us a monthly audit that would be used to support good practice and to help improve standards of cleanliness. Following the inspection we discussed our concerns with the local authority infection control lead. A support and advice visit was arranged.

We looked at the recruitment policies and procedures. We found they needed to be updated to reflect current legislation. We looked at the recruitment records of two recently employed members of staff. We found a number of

Is the service safe?

checks had been completed before they began working for the service. These included the receipt of a full employment history, an identification check and a Disclosure and Barring Service (DBS) check. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions. However we found only one written reference on each file. We also noted records of the interview and selection process had not been maintained and health questionnaires were completed prior to the offer of employment. This did not support a fair and safe recruitment process had been followed.

The provider had failed to operate safe and robust recruitment and selection processes. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how the service managed risk. Environmental risk assessments were in place and kept under review. Each person had a personal emergency evacuation plan which recorded information on their mobility and responsiveness in the event of a fire alarm. We noted these were not recorded in people's individual care plans for reference. We also noted the fire risk assessment had not been reviewed for some time and noted a number of bedroom doors were wedged open. The registered manager assured us she would address this as a matter of urgency. Individual risks in relation to pressure ulcers, nutrition, falls and moving and handling had been identified in people's care plans and kept under review. There were contingency procedures to be followed in the event of emergencies and failures of utility services and equipment.

There were safeguarding vulnerable adults procedures and 'whistle blowing' (reporting poor practice) procedures for staff to refer to. Safeguarding vulnerable adult's procedures provide staff with guidance to help them protect vulnerable people from abuse and the risk of abuse. We noted the contact information of local agencies and information about how to report abuse was available in the office although was not included with the whistleblowing and safeguarding vulnerable adults procedures for staff to refer to. The registered manager told us she would address this. There was information about recognising and reporting abuse displayed in the hallway for people living in the service and their visitors to read.

There were no records to support staff had received any safeguarding vulnerable adults training. However staff told us they had undertaken training under the previous provider. The staff we spoke with had an understanding of abuse and were able to describe the action they would take if they witnessed or suspected any abusive or neglectful practice. Records showed training for all staff had been booked for April 2016. The management team was clear about their responsibilities for reporting incidents and safeguarding concerns and had experience of working with other agencies.

We looked at the staffing rotas. It was difficult to determine the designation of staff as this was not recorded on the rotas. The registered manager assured us she would review this. Three care staff worked 7:30am – 9:30pm and two care staff were on duty during the night. There was a cook available 8am – 1:30pm who would prepare a light tea before leaving. The domestic worked five mornings and activities organiser worked 10am – 2pm three days each week.

People using the service, their relatives and staff told us there were sufficient number s of staff to meet people's needs in a safe way. People said, "There is always someone around" and "I pull the alarm if I need help and they come." Staff told us any shortfalls due to leave or sickness were covered by existing care staff or the registered manager. This ensured people were cared for by staff who knew them. However, we were concerned people would be left unattended for periods during the night when staff were providing care and support in other areas of the home or behind closed doors. We discussed this with the registered manager and were told staffing numbers would be reviewed if people's needs changed or if the occupancy numbers changed. The registered manager did not currently use a recognised staffing tool which would help her to determine the required numbers of staff but assured us she would look into this.

We saw equipment was safe and had been serviced. The provider had arrangements in place for ongoing maintenance and repairs to the building and we saw records of the work completed. We were told training had been given to staff to deal with emergencies such as fire safety. The registered manager had booked update training for all staff. There was key pad entry to the home and visitors were asked to sign in and out which would help keep people secure and safe.

Requires improvement

Is the service safe?

Staff spoken with told us they had received mandatory moving and handling training under the previous provider. They told us they felt competent when using moving and handling equipment.

We saw people were supported safely and appropriate, safe moving and handling techniques were used to minimise the risk of injury to themselves and the person they supported.

Requires improvement

Is the service effective?

Our findings

People said, “I have everything I need in my room” and “It’s not home but it’s comfortable enough.” Visitors told us, “The home is in need of improvement but it’s just fixtures and fittings; what is important is the care is good” and “The environment has improved since (my relative) came.” One person said, “The layout isn’t brilliant although I have noticed other improvements are being made.”

Burwood House is located on a main road close to the town centre facilities of Bacup. Burwood House is an older type property with facilities on three floors, which could be accessed by steep staircases or a number of chair lifts and a passenger lift. There was a car park area with seating available outside; the seating area was not secure and the main road could easily be accessed. A dining room and two lounges were available on the ground floor with quiet seating areas around the home. Bathroom and toilet facilities were available. One bedroom had ensuite bathroom facilities and others were located near to toilet facilities or were provided with commodes. Aids and adaptations had been provided to help maintain people’s safety, independence and comfort.

We looked around the home and found some areas were in need of improvement. We did not enter all areas of the home. We found damp areas to some ceilings and were told the roof had been leaking but repair work was due to commence within two weeks. We found curtains and curtain poles were not secure in some rooms and one person’s blinds were broken. A number of carpets were stained, frayed or were uneven. Bedroom furniture in some rooms was mismatched and damaged and was in need of replacement; we were told nine bedroom sets had been ordered. Flooring in bathrooms was damaged. There were rooms that did not have a purpose and were being used for cluttered storage. The room designated as a treatment room had a locked area for medicines but did not have a lock on the entrance door.

We noted some improvements had been undertaken or were underway. We noted the lounge and dining areas had been partitioned to make smaller more comfortable rooms and a ramp and additional chair lifts had been provided to improve people’s access around the home. A number of areas had been redecorated. A member of staff said, “Changes are being made to the environment; the home is improving.”

There was a maintenance person who visited the home once each week or when repairs or maintenance were urgent. A system of reporting required repairs and maintenance was in place. There was a development plan for the next 12 months. However, a number of the shortfalls noted during our inspection had not been recorded. Following the inspection the registered manager had undertaken an audit of all areas of the home and had forwarded a more detailed improvement plan to the commission. We were told this had been shared with and approved by the directors.

People told us they were happy with their bedrooms and some had created a homely environment with personal effects such as furniture, photographs, pictures and ornaments. This helped to ensure and promote a sense of comfort and familiarity.

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. The service had policies in place to underpin an appropriate response to the MCA 2005 and DoLS. The registered manager expressed an understanding of the processes relating to MCA and DoLS. The registered manager and two senior staff had received training in this subject although other staff had not. This meant they had limited knowledge of the principles associated with the legislation and people’s rights.

We found the registered manager had submitted DoLs applications for three people whose liberty needed to be

restricted for their safety. The registered manager told us other applications needed to be made. This would help to ensure people were safe and their best interests were considered.

From looking at records and from our observations we were aware some people were unable to make decisions for themselves. We saw some information in the care plans regarding people's ability to make some choices but noted assessments of people's capacity had not been completed. This meant it was not always clear whether people lacked capacity to make decisions for themselves and whether a best interest decision would be needed.

During our visit we observed people being asked to give their consent to care and treatment by staff. Staff spoken with were aware of people's capacity to make choices and decisions about their lives although this was not always clearly recorded in the care plans. People's consent or wishes had been obtained in areas such as information sharing, involvement and medicine management but not yet with regards to gender preferences around support with personal care. The registered manager gave assurances this would be reviewed as part of the care plan audit. This would help make sure people received the help and support they needed and wanted.

The service did not have a policy in place with regards to resuscitation (DNACPR - do not attempt cardiopulmonary resuscitation). We noted one person had a DNACPR decision recorded in their records. Whilst the decision and the reason behind the decision had been recorded we found no information to support this had been discussed with the person's family. or that the decision had been reviewed appropriately. The registered manager told us the family were aware of the decision but that a clear record would be maintained.

We looked at how the service trained and supported their staff. People felt staff had the right level of skills and knowledge to provide them with effective care and support. They were happy with the care they received and told us that it met their needs. The registered manager told us there was no records to demonstrate the training that staff had undertaken under the previous provider. This made it difficult to determine when and whether staff had received a range of appropriate training to give them the necessary skills and knowledge to help them look after people properly. Staff told us they had not received any recent mandatory training but that this had been kept up to date under the previous provider and certificates had been displayed in the home but since removed.

By the second day of our inspection the registered manager had booked moving and handling, fire safety, infection control, safeguarding and first aid training for all staff. A training plan was available. Training would be undertaken by staff mainly by e learning from February to June 2016. Medicines management training, moving and handling training and customer service training was currently underway for some staff. We were told all staff had achieved or were working towards a recognised qualification in care although certificates were not available on all staff files to support this. The registered manager assured us she would address this as part of the new audit system.

We looked at the records of two recently employed staff. We found both staff had received a basic induction into the routines and practices of the home. The induction included an overview of key policies and procedures such as fire, moving and handling and safeguarding vulnerable adults. We were told the induction would take up to six weeks to complete and would include additional hours shadowing a more experienced member of staff. We discussed the effectiveness of the induction system with the registered manager as we noted the induction topics had been completed and signed off in one day. The registered manager assured us this would be reviewed.

We noted new staff had commenced the care certificate induction training but had not yet received a review of their performance or competence during this period. The registered manager advised us that existing staff would be enrolled onto the care certificate to refresh their knowledge and skills and that assessments of performance would be in place following completion of mandatory training.

Staff told us they felt supported by the registered manager and by other members of the team. However, we were told staff had not received regular formal one to one supervision sessions. This meant shortfalls in their practice and the need for any additional training and support may not be identified. The registered manager was aware of the gaps in the provision of supervision sessions for staff and a plan to ensure these were completed had been put in place.

Requires improvement

Is the service effective?

Staff told us handover meetings, handover records and a communication diary helped keep them up to date about people's changing needs and the support they needed. Records showed key information was shared between staff and staff spoken with had a good understanding of people's needs. Staff told us communication was good although we were told that visiting professionals felt communication could be improved. One professional said, "The home will action what is requested but this may take some chasing and may not always be done in the timeliest of manners."

We looked at how people were protected from poor nutrition and supported with eating and drinking. People told us they enjoyed the meals. They told us, "The meals are very good; we have a choice", "I enjoy what I get and the portions are good; I can ask for a bit more if I feel like it" and "I have supper; I never go hungry." A relative said, "My relative is well fed; the meals are okay."

The menus and records of meals served indicated people were offered meal choices and also alternatives to the menu had been provided on request. The daily menus were displayed in the dining room. We observed people being served drinks and snacks throughout the day.

During our visit we observed breakfast and lunch being served. The dining tables were appropriately set and condiments and drinks were made available. People were able to dine in other areas of the home if they preferred and equipment was provided to maintain their dignity and independence. The meals looked and smelled appetising. The meals were hot and the portions were ample. The atmosphere was relaxed with chatter and friendly banter throughout the meal. We saw people being sensitively supported and encouraged to eat their meals.

Care records included information about people's dietary preferences and any risks associated with their nutritional needs. This information had been shared with kitchen staff. Records had been made of people's dietary and fluid intake when needed. People's weight was checked at regular intervals and whilst appropriate professional advice and support had been sought when needed, we found one person's weight record did not reflect this. However records showed appropriate action had been taken.

We looked at how people were supported with their health. People's healthcare needs were considered as part of ongoing reviews. Records had been made of healthcare visits, including GPs and district nurses. We found the service had links with health care professionals and specialists to help make sure people received prompt, co-ordinated and effective care. A health professional told us how there had recently been a number of poorly people in the home. They said people's care had been managed well and full discussions had taken place with staff enabling people to stay at the home.

We recommend that the service complies with the dates on the improvement plan and keeps the plan under review to ensure people live in a comfortable and suitable environment.

We recommend that the service seeks advice and guidance from a reputable source about the provision of training and development of procedures to guide staff with making appropriate referrals and recording appropriate and clear information with regard to the MCA 2005 and DoLS code of practice.

Good

Is the service caring?

Our findings

People spoken with were happy with the care and support provided. People told us, “The staff are marvellous; they will do anything for you”, “Staff are great, very friendly” and “I’m treated properly, with respect. Staff are always kind and caring.” Relatives said, “The staff are great, (my relative) doesn’t want for anything” and “The care is very good.” Health and social care professionals said, “The staff are passionate about people’s care”, “My client was very happy residing there and had no complaints about the care received”, “Staff care for people” and “Staff are attentive to people.”

People confirmed there were no restrictions placed on visiting and they were made welcome in the home. We observed relatives visiting throughout the days of our inspection and noted they were treated in a friendly and respectful way.

During our visit we observed staff responding to people in a patient, good humoured, caring and considerate manner and we observed good relationships between people. People who required support with their personal care needs received this in a timely and unhurried way. The

atmosphere in the home was calm and relaxed**.** One member of staff told us, “We all do our best to look after people properly. The care is good.” From our observations staff knew people well and were knowledgeable about individual needs, preferences and personalities.

From our discussions, observations and from looking at records we found people were able to make choices and were involved in decisions about their day. Examples included decisions and choices about how they spent their day, the meals they ate, activities and clothing choices. There was information about advocacy services which could be used when people wanted support and advice from someone other than staff, friends or family members.

There were policies and procedures for staff about caring for people in a dignified way. This helped to make sure staff understood how they should respect people’s privacy, dignity and confidentiality in a care setting. Staff were seen to knock on people’s doors before entering and doors were closed when personal care was being delivered. We observed one person was taken to a private area when being visited by a healthcare professional. Staff spoke to people in a respectful way and used people’s preferred titles and names and we saw most people were dressed smartly and appropriately. However, we noted most of the ladies were not wearing stockings or tights; it was unclear whether this was their choice or not. We discussed this with the registered manager who assured us she would look into this.

We observed staff supporting people in a manner that encouraged people to maintain and build their independence skills. For instance people were encouraged to maintain their mobility. One person told us they regularly went out of the home to visit places in the nearby town.

People were encouraged to express their views during day to day conversations, residents’ and relatives’ meetings and care reviews. The residents’ meetings helped keep people informed of proposed events and gave people the opportunity to be consulted on a variety of topics.

We found people or their relatives had been involved in ongoing communications and decisions about care and support. A visitor said, “Staff keep me up to date with any changes in my relative’s condition.” The care plans included information about people’s preferred routines and preferences which would help to ensure people received the care and support they both wanted and needed.

Good

Is the service responsive?

Our findings

People who used the service and their relatives were encouraged to discuss any concerns during meetings and day to day discussions with staff and management. People told us they could raise any concerns with the staff or managers. One person said, "I would tell staff if things weren't right." Visitors said, "I feel we can speak up if we need to" and "I have no complaints. Things here are good." People spoken with told us they had not needed to complain and that any minor issues were dealt with informally and promptly.

There was a complaints procedure displayed in some people's rooms and in the entrance advising people how to make a complaint although this did not include the contact details for external organisations including social services. The registered manager assured us this would be reviewed. Clear records had been maintained of people's concerns. Records showed the service had responded in line with procedures. People's concerns and complaints were monitored by the provider and used to improve the service.

We noted before a person moved into the home an experienced member of staff had carried out a detailed assessment of their needs. Information had been gathered from a variety of sources and covered all aspects of the person's needs, including personal care, likes and dislikes, mobility, daily routines, social and leisure interests and relationships. People were able to visit the home and meet with staff and other people who used the service before making any decision to move in. This allowed people to experience the service and make a choice about whether they wished to live in the home. A relative confirmed they had been involved in this process and had found it very useful.

We looked at the arrangements in place to plan and deliver people's care. People had an individual care plan which was underpinned by a series of risk assessments. The registered manager told us a new format had recently been introduced. The care plans were organised and clearly written however, there was no information about people's ability to make safe decisions about their care and support or information about people's preferences in respect of receiving personal care from male or female staff. The registered manager gave assurances this would be clearly recorded in each person's care plan.

Information was included regarding people's likes, dislikes and preferences, routines, how people communicated and risks to their well-being. Additional information was being collected about people's lives prior to being admitted to the home. This would help to ensure people received the care and support in a way they both wanted and needed. Daily records recorded how each person had spent their day but were not always completed in detail.

We saw evidence to indicate the care plans and risk assessments had been reviewed and updated on a monthly basis or in line with changing needs. A visitor told us they were kept up to date and involved in decisions about care and support. However, people living in the home and their relatives had not always been formally involved in the review of their care. The registered manager assured us this would be reviewed.

There were systems in place to ensure staff could respond quickly to people's changing needs. This included a handover meeting at the start and end of each shift where staff were able to discuss people's well-being and any concerns they had. This helped to ensure staff were kept well informed about the care of people living in the home.

When people were admitted to hospital they were accompanied by a transfer form containing a summary of their essential details, information about their medicines and a member of staff or a family member. In this way people's needs were known and taken into account when moving between services.

The service employed an activities person who worked three sessions each week. This meant the provision of daily activities was not always reliant on staff availability. Activities included nail care, shopping, external entertainers, dominoes, art and crafts, bingo, music and reminiscence. People living in the home said, "I always have things to do and people here can be very good company", "There's not a lot going on but there is always someone to talk to", "They do things to keep us occupied" and "We do a few things now and then and sometimes go out."

People told us they were able to keep in contact with families and friends. Visiting arrangements were flexible. One person said, "My visitors can come anytime I think."

Requires improvement

Is the service well-led?

Our findings

People living in the home and relatives spoken with made positive comments about the management of the home. People living in the home told us, "The new manager is very nice" and "The new manager is making improvements." A relative said, "The manager has made a number of changes since she started; things are improving." Staff commented, "Things are improving week on week" and "Changes are being made for the better." Health and social care professionals said, "The staff and the manager have been very welcoming and easy to work with" and "The manager is trying to make a difference."

The ownership of the home had changed in April 2015. The manager had been employed since June 2015 and was registered with the commission in October 2015. The registered manager was able to describe her achievements so far and her development plans for the next 12 months.

The registered manager was supported by a mentor (a registered manager from another service in the organisation) and by the directors of the organisation. She was able to meet with other managers to discuss the operation of the service and share best practice. One of the directors visited the home on a regular basis and was available if people, their relatives or staff wished to discuss any issue relating to the home. In addition, the registered manager completed a weekly report for the directors which would help to monitor her practice.

The registered manager had completed a nationally recognised qualification in management and was seen to interact warmly and professionally with people living in the home, relatives and staff. During our inspection we spoke with the registered manager about people living in the home. She was able to answer all of our questions about the care provided to people showing that she had a good overview of what was happening with staff and people who used the service.

The number of shortfalls that we found during this inspection indicated quality assurance and auditing processes had not been effective particularly in areas such as management of medicines, infection control and standards of the environment. We were told that a schedule of audits had only recently been introduced and the directors and the registered manager had begun to carry out audits in the home to check the quality of the service. We saw copies of recently completed audits in relation to a small number of care plans and personnel files and staff hand washing practices. We noted action plans had been devised to resolve any identified shortfalls. However, not all the shortfalls that we found had been recognised or addressed.

The provider had failed to operate effective quality assurance and auditing systems. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a positive and open atmosphere at the home. We noted the registered manager had an 'open door' policy to promote ongoing communication, discussion and openness.

Staff meetings were held regularly and we were told minutes of the meetings were displayed. Staff were provided with job descriptions, a staff handbook, contracts of employment and policies and procedures which would help make sure they were aware of their role and responsibilities.

Staff were aware of who to contact in the event of any emergency or concerns. If the registered manager was not present, there was always a senior member of staff on duty with designated responsibilities. The provision of a team leader to work on nights was currently being reviewed.

Staff told us they were able to voice their opinions and share their views. They felt there was good communication with the management team and they were supported. Staff spoken with felt they could raise their concerns with the directors or with the registered manager and appropriate action would be taken. One member of staff told us, "The manager is approachable; she listens to what we have to say." All staff spoken with felt communication had improved and that the care was good.

People were encouraged to be involved in the running of the home. We saw meetings had been held. The minutes of recent meetings showed a range of issues had been discussed, such as activities, food and the forthcoming events for Christmas. The registered manager told us a customer satisfaction survey would be sent to people using the service and their relatives. This would help to monitor the quality of the service offered

There were procedures in place for reporting any adverse events to the Care Quality Commission (CQC) and other

Requires improvement

Is the service well-led?

organisations such as the local authority safeguarding and deprivation of liberty teams. Our records showed that the provider had appropriately submitted notifications to CQC about incidents that affected people who used services.

The organisation had achieved the Investors In People award. This is an external accreditation scheme that focuses on the provider's commitment to good business and excellence in people management. A review was planned for 2016.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider had failed to ensure people's medicines were managed safely. This was a breach of Regulation 12 (2) (g)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **The provider had failed to ensure people were protected against the risks associated with poor infection control. This was a breach of Regulation 12 (2) (h)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **The provider had failed to operate safe and robust recruitment and selection processes. This was a breach of Regulation 19 (2) (a)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider had failed to operate effective quality assurance and auditing systems. This was a breach of Regulation 17 (2) (a)**