Highfields Limited

Highfields Nursing Home

Inspection report

330 Highbury Road
Bulwell
Nottingham
Nottinghamshire
NG6 9AF

Tel: 01159278847

Date of inspection visit:
19 January 2016

Date of publication:
04 March 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an unannounced inspection of the service on 19 January 2016. Highfields Nursing Home provides accommodation for a maximum of 42 people who require nursing or personal care, diagnostic and screening procedures and treatment of disease, disorder or injury. On the day of our inspection 35 people were using the service and there was a registered manager in place.

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.

People were supported by staff who could identify the different types of abuse and knew who to report any concerns to. People told us they felt safe at the home and that there were enough staff to support them. Notifications of potential safeguarding incidents were not always forwarded to the CQC.

Assessments of the risks to people's safety were carried out and reviewed. People had personal emergency evacuation plans (PEEPs) in place, although the content differed from the home emergency pack used when emergency services may need to evacuate people quickly from the home. Where people had been involved in an accident or incident at the home the incident had been recorded and reported to the registered manager and were investigated. The registered manager's recommendations were not always recorded. People's medicines were not always safely managed and recorded. Stock levels were not always correct, a person had not received their medicines when they should have and appropriate guidance to support staff when administering 'as needed' medicines were not in place.

The principles of the Mental Capacity Act (2005) had been applied when decisions had been made for people. The appropriate processes had been followed when applications for Deprivation of Liberty Safeguards had been made.

People spoke positively about the staff and felt they provided them with effective care and support. Staff had recently received supervision of their work but previous supervisions were limited in number. There were some gaps in the training staff had completed but plans were in place to address some of these gaps. The majority of the people we spoke with told us they liked the food and drink provided at the home. Referrals to dieticians were not always made in a timely manner. People had access to external health care professionals; however the care they received from staff was not always recorded appropriately in their care records.

People felt the staff were kind and caring and treated them with respect. We observed some positive interactions between staff and people; however we also saw some examples which were not always respectful. People were provided with information on how to access independent advice about decisions about their care. There was limited space in the home for people to have private time to themselves.

People's care records contained an initial assessment of their needs and care plans were put in place to enable staff to respond to people's needs. However these did not always reflect people's current needs. Opportunities for people to engage in the hobbies and interests that were important to them were limited. People felt able to make a complaint and felt they would be listed to and the complaint would be acted on.

The registered manager's auditing processes were not always used effectively and had not identified the issues raised within this report. The registered manager had not ensured that the CQC were always provided with the appropriate statutory notifications. The registered manager interacted positively with people; however, some staff told us they did not feel valued. There were limited opportunities for people, relatives and staff to give feedback on how to improve the service. A number of statutory notifications had not been sent to the CQC.

We identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see the action we have told the provider to take at the back of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People's medicines were not always safely managed.

People had personal emergency evacuation plans (PEEPs) in place, but the content was not consistent with information that was available for emergency services if speedy evacuation was needed.

Accidents and incidents at the home had been recorded, reported to the registered manager and investigated. However notifications of safeguarding incidents had not always been sent to the CQC.

People were supported by staff who had received safeguarding adults training and knew who to report concerns to.

The risks to people's safety were assessed and reviewed.

There were mixed views as to whether there enough staff available to meet people's needs.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People had access to external healthcare professionals however people's day to day health needs were not always appropriately recorded in their care records.

Staff received supervisions of their work but these were not always conducted regularly enough.

People received support from staff who had the right skills; however some staff required refresher training for some subjects.

The majority of the people liked the food and drink they received.

Staff applied the principles of the MCA and DoLS appropriately when providing care for people.

Is the service caring?

Requires Improvement

The service was not consistently caring.
People felt staff were kind and caring and treated them with respect although we observed some negative interactions.

Information was available for people on how to access independent advice about decisions they may make.

People did not have the space they needed to maintain their privacy.

People were supported by staff to be independent and staff understood people's likes and dislikes.

People felt staff treated them with dignity.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care records did not always reflect people's current care and support needs.

There were limited opportunities for people to do things that interested them.

People felt confident in raising a complaint if they needed to and that would be acted on.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The registered manager's auditing processes were not always effective and had not identified all of the issues raised within this report.

Statutory notifications had not always been sent to the CQC.

The registered manager interacted positively with people, however some staff did not feel valued.

There were limited opportunities for people to give their feedback on the development of the service.

Relatives felt there was a positive atmosphere at the home.

Highfields 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 on 19 January 2016 and was unannounced.

The inspection team consisted of two inspectors, an expert-by-experience and a specialist advisor. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The specialist advisor was a registered nurse with experience of caring for older people, some of whom may be living with dementia.

Before the inspection, we reviewed previous inspection reports, information received from external stakeholders and statutory notifications. A notification is information about important events which the provider is required to send us by law.

We spoke with seven people who used the service, three relatives, five members of the care staff, a nurse, the cook, the registered manager and the regional manager.

We looked at all or parts of the care records and other relevant records of 13 people who used the service. We also looked at other records relevant to the running of the service including; audits, training records and policies and procedures.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

People did not raise any concerns with the way their medicines were managed or administered. One person said, "I get my medicine in the morning and evening." A relative said, "[Family member] gets their medication okay. If the medication is altered they will phone me and let me know." However, when we reviewed how people's medicines were managed, which included looking at people's medicines administration records (MAR) and stock levels, we found appropriate processes were not in place to protect people from the risk associated with medicines.

Staff had received training for the safe administration and recording of medicines and the registered manager carried out competency assessments to check whether they did so appropriately. However, we found a number of issues in relation to the administration of medicines which meant the assessments were not effective.

We looked at the MARs for five people who used the service. MARs are used to record when a person has taken or refused to take their medicines. We found gaps on each of these records, which meant we could not be assured that each person had received the right medicine at the right time of day.

We checked the levels of stock of medicines for each of these five people. The stock levels for four of the people were correct. However, for one person we found a medicine in liquid form that contained more than the expected amount if the staff had followed the correct dosage each time they administered medicine. As the person's MAR had not been appropriately completed, we could not be assured that the person had received this medicine, or if they had refused to take it.

There were processes in place to ensure that people's medicines were ordered in time to ensure people had them available when needed. However, these were not always effective. We identified one person where a medicine was not available. This had been followed up by the staff on two occasions but had still not been received. We asked the registered manager to contact the pharmacy to check whether they had the person's prescription, which they did. However the delay meant the person did not receive their medicine when they should have. We were assured the person's health had not been affected, however the registered manager acknowledged more needed to be done to reduce this risk.

People's MARs or care records did not contain protocols to provide additional information for staff to assist them with determining when was the appropriate time to give medicines which were prescribed to be given only when necessary. When staff had decided to administer these medicines, they had not always recorded the reasons why. This could mean staff did not administer these types of medicines in a consistent way which could place people's health at risk.

Where handwritten changes to people's MARs had been recorded these were not always double signed to ensure the changes were correct. This could place the person at risk, due to inadvertent errors being recorded. We also saw the date a person's liquid medicine was opened had not been recorded. Some medicines, once opened, have a limited timeframe by which they can be used so as not to reduce their

effectiveness. By not recording the date of opening this increased the risk of the person receiving ineffective medicine.

People's medicines were stored securely in a locked trolley and locked cupboards; however, the required temperature checks of the storage areas were not always recorded. We found one gap in the past month for the recording of the temperature of the fridge and three gaps for the recording of the room. To ensure the effectiveness of people's medicines is not compromised, they must be stored at the appropriate recommended temperature.

These concerns we identified were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe living at the home. One person said, "I have never felt threatened or nervous around any of the carers or residents. None of them [staff] have been rough with me, they're kind to me." Another person said, "I feel safe, although staff get called away sometimes." A relative we spoke with said, "My [family member] is safe here, I'd talk to the manager if I was worried."

We spoke with staff and asked them how they ensured the risk of people being abused was reduced. The staff could describe the different types of abuse people could encounter. They knew the procedure for reporting concerns both internally and to external bodies such as the CQC, the local authority or the police. However records showed not all staff training for safeguarding of adults was up to date. This meant people could be at risk of receiving support from staff who did not follow best practice guidelines.

Information was available for people if they wished to report concerns externally if they felt they or others were at risk of being abused.

The risks to people's safety were appropriately assessed, recorded in people's care records and regularly reviewed. Risk assessments had been completed to assess people's risks of developing pressure ulcers, falls, moving and handling, nutritional risk and choking. We saw a person had been identified as at risk of falling out of their bed. A risk assessment had been put in place for the safe use of bedrails. We checked to see whether the equipment identified in the risk assessments as needed to support people safely were in place. For the records that we checked the equipment needed was in place.

We reviewed the registered manager's process for investigating and reviewing accidents and incidents that occurred at the home. We saw they recorded when a person had fallen, whether there had been an allegation of abuse or whether they were at risk of developing a pressure sore. Where needed the registered manager made recommendations to staff on how to reduce the risk of reoccurrence. However, records showed the registered manager did not always check to see whether staff had implemented their recommendations. We also saw examples of potential safeguarding incidents that had been forwarded to the local authority but the CQC had not been notified.

People had a personal emergency evacuation plan (PEEP) in place that enabled staff to ensure, in an emergency, they were able to evacuate people in a safe and timely manner. The staff we spoke with told us they were aware of the support people required. By the front door of the home, details of how to evacuate all people were recorded in one place. This would help staff and emergency services to have the information they needed, quickly, for all people. However, this information did not reflect people's current support needs which could be confusing for staff or the emergency services and result in people being evacuated in a way which increased the risk to their safety.

We raised these issues with the registered manager. They acknowledged that more needed to be done to ensure that all records that could have direct impact on people's safety were reviewed, updated and then regularly monitored.

A business continuity plan was in place which contained contingency plans should there be an emergency such as a loss of electricity, gas, or if there was a major leak in the home. The plans were in place to minimise the impact to people's safety. Regular assessments of the environment people lived in were conducted to ensure that people were safe. Regular servicing of equipment such as hoists and walking aids were also carried out.

After the inspection we were contacted by Nottinghamshire Fire Service (NFS). They had carried out an audit of the home after our inspection to ensure safe fire prevention practices were in place. They raised a number of concerns with us, which included the locality of some bedrooms and how people in those bedrooms would be evacuated in an emergency. We will continue to liaise with NFS to ensure the provider meets all recommendations made by them.

People told us there were no restrictions on their freedom. One person said, "They [staff] ask when you want to get up and go to bed, you have freedom to choose." Another said, "There are no restrictions, although I have to be careful because of my vision."

We received mixed feedback when we asked people, relatives and staff whether they felt there were enough staff working at the home to keep people safe. People told us they did not have to wait long for help from staff. However one person said, "They [staff] don't always seem that bothered to come to me." A relative said, "They sometimes seem quite under staffed, especially at weekends." Another relative said, "It's good here, especially compared with places my [family member] has been. Although they could probably do with some extra staff."

Staff gave us variable views on the adequacy of staffing levels. Generally they felt they could provide the physical care people needed but there was limited time to spend with people.

The registered manager told us, and records reflected, that they carried out a monthly assessment of people's dependency levels to enable them to put in place the number of staff required to meet people's needs and to keep them safe. During our observations we found staff responded to people's needs in a timely manner, this included responding to nursing call bells pressed in people's bedrooms.

The risk of people receiving support from staff who were unsuitable for their role was reduced because the provider had ensured that appropriate checks on a prospective staff member's suitability for the role had been carried out. Records showed that before staff were employed, criminal record checks were conducted. Once the results of the checks had been received and staff were cleared to work, they could then commence their role. Other checks were conducted such as ensuring people had a sufficient number of references and proof of identity. These checks assisted the provider to making safer recruitment decisions.

Requires Improvement

Is the service effective?

Our findings

The majority of the people and relatives we spoke with thought staff were well trained and provided effective care that met their or their family member's needs. One person said, "It's alright here, I came back after I had a trial at home." A relative said, "Staff seem competent to care for [family member], they're generally good staff." Another relative said, "The nurses are very good, on top of the job. Most of them [staff] are very good."

The staff we spoke with told us they had completed an induction that gave them the skills they needed when they first started their role. This enabled them to provide care and support for people in an effective way. The registered manager told us staff who were new to the service would complete 'Care Certificate' training to ensure they had the most up to date skills required for their role. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It gives people who use services and their friends and relatives the confidence that the staff have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support

There was a wide ranging training programme in place for staff to ensure they had the skills required to carry out their role effectively. Records showed staff had completed training in areas such as the safe moving and handling of people, equality and diversity and mental capacity. The majority of staff we spoke with told us they felt well trained. One staff member said, "We can always improve and there is always more to learn." However, others felt more training was required in some areas. One member of staff said, "There could be more training for staff on dementia. Some of the staff haven't grasped it."

Records showed there were gaps in the training that some staff had completed, although we saw training had been booked to address some of these. For example, courses were in place for first aid, medication and fire safety in the two months following the inspection.

Staff were encouraged to undertake external professionally recognised qualifications such as diplomas (previously NVQ's) in adult social care. However records showed that few staff had achieved or were working towards these qualifications.

The staff we spoke with told us they had recently received supervision of their work. Records showed that almost all staff had supervision in January 2016. However staff also told us that before this date, the number of supervisions they had received was limited. Records showed that some staff had received three supervisions in the last year, whereas others had received as few as one. Regular supervision and assessment of staff's work enables the registered manager to identify good performance, but also to identify where staff may not be carrying out their role effectively.

We observed staff give people choices and then act on the decisions people made. This included where people wanted to sit or if they wished to be alone. People's care plan records contained documentation that was designed to reflect that people had, where able, given their consent to decisions about their care. For

example we saw a document where people were asked for their consent as to whether their photograph could be used in their records. We saw examples where this had been signed, but not for others, with no explanation why. This meant people's photographs could be used without their consent.

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. We checked whether the service was working within the principles of the MCA.

When people were unable to make some decisions for themselves, mental capacity assessments had been completed and best interests decisions documented. This documentation also included the names of people who were involved with making these decisions. Some people had 'Do not Attempt Cardiopulmonary Resuscitation' (DNACPR) documentation in place. These had been completed by the person's GP. Some of the documentation had not been appropriately completed, which could mean in an emergency people's wishes would not be adhered to. We raised this with the registered manager who told us they would review all of these forms and would contact people's GP to ensure any errors were amended.

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 are called the Deprivation of Liberty Safeguards (DoLS). Records showed that applications to the authorising body had been made for people that required them.

People care records contained guidance for staff to support people if they presented behaviours that may challenge. We observed staff support people effectively with this throughout the inspection.

The majority of people and their relatives spoke positively about the food provided at the home. One person said, "There's plenty of good food and you can always ask for more." However they also said, "You can't depend on the food being on time. It's a nuisance." Another resident said, "I find the food very good. They will always give me a choice or get me something I want." Relatives thought their relations had a good choice of food. One relative said, "[Family member] eats well, there's a varied menu."

We spoke with the cook who had detailed dietary information for each person who used the service. This included information about allergies and food intolerances, food likes and dislikes, preparation of food [e.g. soft or pureed diet] and any assistance they required with eating and drinking. The kitchen was stocked with a variety of fresh fruit, vegetables and snacks. People had access to fresh water and juices throughout the day.

Records showed people being referred to a dietician when they had lost or gained a significant amount of weight. However, in one person's record we noted they had lost 8kg in a four month period. The person's care record indicated some weight loss had been identified; however there was no evidence of additional action being taken in response to this. Another person's records stated they had been referred to a dietician in April 2015, however between September 2015 and December 2015 they continued to lose weight and there was no evidence of a further referral. The lack of professional intervention to support people with high levels of weight loss could have a negative impact on their health.

People and their relatives told us they felt their on-going health care needs were met by the staff. A relative gave an example where their family member was at risk of choking and they had been referred to a speech and language therapist (SALT). The result of this referral and the subsequent guidance being implemented

by staff, had reduced the risk to their health. People told us they were able to see their GP when they needed. One person also said, "The foot man [chiropodist] is good, he comes here." Another person told us they were supported with their hospital appointments.

Where people required daily assistance with maintaining good health, the staff supported them in doing so. However we did see some examples where people's records did not always reflect the care and support that was provided. For example when people were identified as at risk of developing a pressure sore, care plans were in place to ensure staff frequently repositioned them. However, we found the frequency of the repositioning recorded in people's records was not always in line with the guidance. For example we saw one person was due to be repositioned every two hours, but we found several examples where this had increased to four and four and a half hours respectively. We were assured by the registered manager that this person did not have a pressure sore, but they acknowledged there needed to be a more consistent approach to recording.

Requires Improvement

Is the service caring?

Our findings

The majority of people told us they thought staff were kind and caring. One person said, "They're [staff] kind to me, they will go and get something from my room for me if I've forgotten, I like that." Another person said, "I like them [staff] all. They are easy to talk to and friendly and caring in their own way." A relative said, "I've been happy with what I've seen. The care is good."
However one person told us staff could be a little impatient with them at times. A visiting professional said staff knew the people well and were always helpful. They said, "It's a nice care home."

We observed some positive interactions between staff and the people they cared for. Staff were friendly and polite. However many of these interactions were task led and we saw few examples of staff taking the time to sit and talk with people, if they were not providing some element of care or support. One member of staff said, "There is no time to talk to people and communication is important to people particularly when they have dementia."

We observed the lunchtime meal being served in the two dining areas on each floor of the home. In the dining room upstairs the tables were not laid until the residents were sitting down. There were no table mats, cloths or condiments on the table to enhance people's lunchtime experience.

We observed staff sitting with people and assisting them to eat. We saw some positive interactions with staff showing genuine warmth and interest in the person they were supporting. However, we also saw some negative interactions in both dining rooms. We observed one staff member assisting a person with eating. They did not engage with the person in anyway other than saying, "Open your mouth." They rarely looked at the person and appeared uninterested in them. In the other dining room we observed two members of staff respond to people's conversation rather than initiating conversation with them. This meant some people had a negative lunchtime experience.

The staff we spoke with had an understanding of people's likes and dislikes and personal preferences, although we saw limited examples of staff engaging people in conversation about their interests. Staff made cheerful comments as they passed through each area of the home. They took the time to say hello to people but this was rarely followed up with any meaningful and engaging conversation. The staff team appeared rushed and busy throughout the inspection.

People's care records contained guidance for staff to communicate effectively with people. We observed staff use various communication techniques to communicate with people in a caring way. We also observed staff patiently interact with people living with dementia.

Staff responded to people in a timely manner if they showed signs of discomfort or distress. We observed a person tell a member of staff they felt unwell and had become upset. The staff member showed warmth and kindness and bent down to the person's level, listened to them carefully and held their arm to soothe and reassure them. The person responded positively to this.

People's care records contained information which showed when people had been involved with decisions made about their care. Some of the people we spoke with were aware they had a care plan in place whilst others did not. Relatives we spoke with told us they felt involved with decisions relating to their family member's care.

People told us they felt able to speak with the staff about their care. One person said, "I enjoy it here, they do listen to your comments." A relative we spoke with felt able to talk to staff about their family member's care.

Information to support people if they wished to speak with an independent advocate was available. Advocates support and represent people who do not have family or friends to advocate for them at times when important decisions are being made about their health or social care.

People told us they felt staff treated them with dignity and respect. One person told us they felt staff maintained their dignity. A relative said, "[Family member] is happy here. I'm 99.9% satisfied. I am happy with the way they are treated. [My family member] is always clean, looks clean and has clean clothes."

When staff spoke about people's care they did so in a way that protected their privacy and dignity. They lowered their voice or went to another part of the room to ensure others could not hear. The staff we spoke with told us when providing people with personal care, they made sure people were covered as much as possible and encouraged them to do as much for themselves as they wanted to.

Staff told us they respected people's privacy. They told us before entering a person's bedroom they knocked on the door before entering and we observed this during the inspection. Apart from people's bedrooms there were no private spaces for people to sit alone or with friends and family. The regional manager told us they were in the process of renovating some bedrooms that were not in use in order for private meeting space to be made available.

People did not raise any concerns with us in terms of staff treating them in a disrespectful way and we saw some positive, respectful interactions. However we also saw interactions that could have a negative impact on people staff were supporting. We observed two staff members safely moving a person using a hoist. They explained to the person what they were doing. However they did not engage the person in a conversation. The staff members continued their unrelated conversation between themselves, only stopping to talk to the person when part of the tasks of moving the person required it. The staff members did not show the person the respect they were entitled to.

Many of the people living at the home required staff support to enable them to move around the home. This included the use of wheelchairs and walking aids. We observed staff supporting people with doing so in a patient and encouraging way, supporting them to be as independent as they wanted to be.

The registered manager told us that people's relatives and friends were able to visit them without any unnecessary restriction. We observed relatives visiting people throughout the day.

Requires Improvement

Is the service responsive?

Our findings

People's care records included a pre-admission assessment and admission assessment to identify their care and support needs. Care plans were then put in place with guidance for staff on how to meet those needs. Some of these records were detailed and contained relevant, up to date information about people's current support needs. For example, records showed that one person had variable ability to stand. There were two care plans for supporting them with their mobility, with clear instructions of how to assist the person when they tried to stand and when they could not stand. This would enable staff to respond appropriately to the person's changing support needs.

However some care plans contained inconsistencies between the support needs recorded in the care records and the care actually being given. For example, a person at risk of developing pressure sores had a pressure relieving mattress in place but there was no indication of this in the care plan. The frequency the person needed to be re-positioned at was also not recorded in the care plan. This meant the person was at risk of receiving inconsistent care from staff.

People's care records were regularly reviewed. However not all records were reviewed in line with the recommended frequency recorded within the care records. For example a person's care plan for mobility stated it should be reviewed weekly but had not been reviewed for over a month.

We observed staff respond to nursing call bells and people's requests for support in a timely manner. For example when a person asked to be assisted with moving from the dining room to the lounge the staff did so quickly.

People raised concerns with us about the lack of activities at the home and the opportunity to engage in the things that interested them. One person said, "I play the odd game, it would be nice to do something, although I do go out with my friend." Another person said, "We had someone come in and do some exercises, that was good. We don't do much, would be nice to do things." A relative we spoke with felt their relative was, "Left sitting all day."

We observed the activities coordinator engaging with people on a one to one basis, playing board and card games. They used large versions of the games to aid involvement. However the care staff we spoke with felt there could be more activities for people. They said the activities coordinator tried to do individual activities for people, but there could be more group activities and activities for those who stayed in their bedrooms. We saw people sat for long periods of time with limited social interaction other than the television or radio. The radio station which was playing in the main dining area of the home, where many people sat throughout the day, did not reflect the musical taste or era of the people in the room. The registered manager acknowledged more needed to be done to ensure people were able to take part in individual or group activities that interested them.

People's care records contained some elements of person centred care planning. Documents included people's likes and dislikes and personal preferences and what made them 'happy or sad'. People's choices

about how they wanted their personal care provided and whether they wanted a male or female member of staff were included. One person said, "I can choose a male or female carer, but I am happy with whoever comes to help me."

People were provided with the information they needed to raise a complaint. The people and relatives we spoke with told us they felt able to make a complaint if needed and were confident that it would be acted on. One person said, "I would raise a concern, but I don't like to. I would speak to the manager, she'd listen." Another person said, "I would talk to someone, one of the girls." A relative told us they had raised a complaint with the manager and felt they had been listened to and the complaint was resolved. Another relative said, "My [family member] would feel comfortable raising concerns."

Records showed that the registered manager recorded people's complaints and acted on them in a timely manner.

Requires Improvement

Is the service well-led?

Our findings

The registered manager had auditing processes in place to assess, identify and manage the risks to people who used the service. A representative of the provider also carried out audits of the service.

However these auditing processes were not always used effectively. They had not identified all of the issues raised in this report. These included concerns regarding the management of people's medicines, the failure to submit statutory notifications relating to potential safeguarding incidents and when people had passed away, the inconsistencies regarding people's personal emergency evacuation plans, limited supervisions conducted in the past year and the variable quality of people's care records. We discussed these issues with the registered manager. They acknowledged that more needed to be done to identify these concerns and then to address them. They also advised us they would put a plan of action in place to address them immediately.

These were examples of a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The relatives we spoke with told us they thought there was a positive atmosphere at the home. One relative said, "I like the atmosphere here, it's the little things, they know whose glasses are whose. [My family member] is well looked after." Another relative said, "On the whole it's very good. To move [my family member] somewhere else it would have to be quite exceptional."

The staff we spoke with told us they enjoyed their job and gained satisfaction from helping people. One staff member said, "Sometimes if we can get [people who use the service] walking with a frame when they have not been able to previously; it is so satisfying. I love my job." Another staff said, "We always try our best and a lot of staff go the extra mile, and come in on their days off to do things with people."

However some staff told us they did not always feel valued and supported by the management team. Some felt the registered manager was approachable, whereas others felt their views were not welcomed. We raised this with the registered manager who told us they would review the way they interacted with all of the staff to ensure there a positive atmosphere amongst the staffing team.

We observed the registered manager interact with people during the inspection. They appeared to know people well and people responded positively to her.

However there were limited opportunities for people, relatives and staff to give their views about the quality of the service provided. There had been no staff meeting since July 2015. People who used the service and their relatives told us they could not recall being asked to give any formalised feedback by the way of a questionnaire. One relative said, "There have been no surveys, questionnaires or meetings."

The registered manager told us they were aware of their responsibilities to meet the conditions of their CQC registration. The CQC must be informed via a statutory notification if a person receives a serious injury or if

an allegation of abuse had been made. We found examples where these had not been sent to us. The submission of these notifications is important as it enables the CQC to assess whether a service is taking, or has taken, appropriate action when there is an allegation of abuse or if a person has been seriously injured. We discussed this with the registered manager. They could not explain why they had not been sent. We were notified by the registered manager after the inspection that these had now been sent.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not ensure the proper and safe management of medicines. Regulation 12 (2) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not always; (a) assess, monitor and improve the quality and safety of the services provided, (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users, (c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. Regulation 17(2)(a)(b)(c)