M & J Care Homes Limited

Lyme Bay View Residential Home

Inspection report

Old Beer Road
Seaton
Devon
EX12 2PZ

Tel: 0129722629

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out a comprehensive inspection on 1 and 12 June 2017. The first day of our visit was unannounced. The second day was agreed for when the registered manager was available

Lyme Bay View Residential Home is a care home providing personal care to a maximum of 30 older people. They provide care and support for frail older people and those people living with dementia. It does not provide nursing care. The home is a detached house near the town of Seaton in the coastal area of East Devon. On the first day of the inspection there were 23 people staying at the service.

We carried out a comprehensive inspection of this service in May 2016 and rated the service as requires improvement. There were no requirements issued, because the manager at the time who is now the registered manager had identified areas for improvement and developed an action plan. The registered manager has been at the service for 18 months but was registered with the Care Quality Commission (CQC) in March 2017. A registered manager is a person who has registered with CQC 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 was very active within the service. They led by example and had a high level of expectation of the staff to deliver good quality care. They were supported by the owner who worked at the home each day. A new deputy manager position had been developed so there was someone who could undertake the managerial role when the registered manager took some planned leave.

People were not always protected against hazards such as falls, malnutrition, slips and trips and fire. There were not always safe systems in place to assess risks both to individuals and to the environment. People were able to be independent using the main staircase. A generic assessment had been completed and individual mobility assessments for each person to look at them as individuals and identify particular risks.

Flooring on the ground floor outside of the kitchen was in a very poor state of repair. A generic risk assessment had been completed regarding the risk to people and staff but had not looked at each individual in relation to their physical needs and the risk this flooring posed to them.

The provider had started to use a new computerised care system which the staff were getting used to using. Staff were regularly weighing people and recording their weights on the system and in a weights folder. However this was not populating the malnutrition assessment tool on the computer system, so staff might not have been alerted to people at risk of malnutrition. The registered manager confirmed they were aware and that they would revert back to paper assessments while they looked into this issue.

Some fire safety concerns were identified. Two fire doors were held open and would not have closed in the event of a fire. We also identified a fire exit door which had a key lock to exit; this had been agreed with the

fire service. We were unable to open the door; however the owner was able to. It was apparent that the barrel had become worn; they replaced this between the two days of our visit. The registered manager said they would add checks of these locks to the fire checklist.

The provider had several assurance systems in place to assure themselves the service was running safely. However their systems had not identified these areas of concern in relation to safety risks.

People said they felt safe and cared for in the home. Staff had a good understanding of what constituted abuse and how to report if concerns were raised. There were sufficient, suitably qualified staff to meet people's needs although there had been staffing difficulties which the provider was actively recruiting to fill. The registered manager and staff had been undertaking additional duties where there were gaps on the rota and they had been using the services of three local agencies where this was not possible. There were suitable recruitment checks in place.

There was a safe system to ensure the safe management of medicines at the service. Medicines were administered by staff who had been trained regarding medicine management. Staff had received regular supervisions and support with their performance and future development. New staff undertook an induction when they started working at the service. Staff understood their responsibilities in relation to the Mental Capacity Act (MCA) (2005) and Deprivation of Liberty Safeguards (DoLS). They gained people's consent and maintained their rights.

People were supported to have a balanced and variable diet. Where people had specific dietary requirements these were catered for. People's health needs were managed well and they saw health and social care professionals when they needed to and staff followed their advice.

Staff were very caring and kind. They treated people with respect and dignity at all times. There was a friendly atmosphere at the home and a culture led by the registered manager about it being the people's home. People's care plans on the provider's computer system were personalised and guided staff how to meet their needs. These care plans were regularly reviewed.

There was a designated activity coordinator to support people to engage in activities that they were interested in. The registered manager had increased the provision of activities by implementing additional hours for a staff member to be able to undertake individual sessions for people in their rooms.

People knew how to make a complaint if necessary. They said if they had a concern or complaint they would feel happy to raise it with the registered manager. There had been one concern since our last inspection which had been investigated and where issues had been identified these had been learning. The registered manager was aware of their responsibilities in relation to the provider's complaints policy and the action they needed to take. People, relatives and staff were asked their views and these were taken into account in how the service was run.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People's safety was not always protected by effective fire safety and environmental monitoring.

Risk assessment were not always carried out effectively. This put people at risk of not being protected against the associated risks.

People said they felt safe and staff had a good understanding of what constituted abuse and how to report if concerns were raised.

There were sufficient staff on duty to meet people's needs.

There were effective recruitment and selection processes in place.

People's medicines were safely managed.

Is the service effective?

Good

The service was effective.

Staff received training and supervision which enabled them to feel confident in meeting people's needs and recognising changes in people's health.

People's health needs were managed well and they saw health and social care professionals when they needed to and staff followed their advice.

Staff understood their responsibilities in relation to the Mental Capacity Act (MCA) (2005) and Deprivation of Liberty Safeguards (DoLS).

People were supported to maintain a balanced diet.

Is the service caring?

Good

The service was caring.

People and relatives gave positive feedback. They said staff were compassionate, treated people as individuals and with dignity and respect.

Staff knew the people they supported, their personal histories and daily preferences.

Staff were friendly in their approach and maintained people's privacy and dignity while undertaking tasks.

Visitors were encouraged and always given a warm welcome.

Is the service responsive?

Good

The service was responsive to people's needs.

Staff knew people well, understood their needs well and cared for them as individuals.

People's care plans on the provider's computer system were personalised and guided staff how to meet their needs. Their care needs were regularly reviewed and assessed.

People knew how to raise a concern or complaint. The registered manager was aware of their responsibilities in relation to dealing with complaints.

People were supported to take part in social activities. Improvements were being put in place to increase the activity provision at the home to ensure people had meaningful activities.

Is the service well-led?

Requires Improvement

The service was not always well led.

There were quality monitoring systems in place at the home. However the systems had not identified concerns to ensure the safe running of the service.

They registered manager undertook the day to day running of the service supported by a new deputy manager. The staff were well supported by the registered manager.

Everyone spoke positively about communication at the service and how the registered manager worked well with them.

People, relatives and staff were asked their views and these were taken into account in how the service was run.

Lyme Bay View Residential 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 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 1 and 12 June 2017. On the first day an adult social care inspector was accompanied by a Hospitals inspector, who joined the inspection to gain knowledge about observations used in the inspection process called SOFI (Short Observational Framework for Inspection). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. An expert by experience also joined us on the first day of the inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the second day the adult social care inspector completed the inspection.

Before the inspection, we reviewed the information we held about the service from the Provider Information Return (PIR) which we received in May 2017. The PIR is a form in which we ask the provider to give us some key information about the service, what the service does well and any improvements they plan to make. We also reviewed other information we held about the service such as from notifications. A notification is information about important events which the service is required to send us by law.

We met and observed most of the people who lived at the service and received feedback from 12 people who were able to tell us about their experiences. Several people at the home had a dementia type condition. A few people using the service were unable to provide detailed feedback about their experience of life at the home. We spent time in communal areas observing the staff interactions with people and the care and support delivered to them. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people living with dementia. We also spoke with four visitors to ask their views about the service.

We spoke and sought feedback from eight staff, including the registered manager, newly appointed deputy manager, care workers, the activity person, the cooks and housekeeper. We also spoke with one of the owners.

We reviewed information about people's care and how the service was managed. Since our last inspection the provider has put in place a computerised care system. We reviewed two people's care records on these and five people's medicine records, along with other records relating to the management of the service. This included staff training, support and employment records, quality assurance audits, and minutes of residents and staff meetings. We contacted the local authority safeguarding team, health and social care professionals for their views. We received a response from one of them.

Requires Improvement

Is the service safe?

Our findings

People said they felt safe living at the home. Comments included, "Oh yes, I feel safe here, I am local and this is a lovely place, look at the views, my family live near here and they can visit me, they are always made welcome" and "I feel safe here and the staff are very nice." Relatives also said they were happy with the service and felt people were safe. Comments included, "She seems settled here and I think she is safe" and "Very safe and very good here. He has a fall mat and has never been kept waiting".

People were not always protected against hazards such as malnutrition, slips and trips and fire. There were not always safe systems in place to assess risks both to individuals and to ensure the environment was safe.

Flooring on the ground floor outside of the kitchen was in a very poor state of repair. This area was used regularly by people and staff and posed a potential trip hazard to people. We discussed this with the owner on the first day; they said they had needed to prioritise funds. By the second day of our visit they had completed a risk assessment for 'the damaged vinyl on the ground floor corridor'. The risk assessment highlighted that there was highly visible tape to mark the sides of the area where the floor begins to ramp and that there were hand rails either side to assist people. They had recorded that they had spoken with staff to ascertain if people had had difficulty with their mobility in the area and they confirmed there had been no occurrences where people had caught their mobility aids on the damaged floor surface. They had then deemed the risk to be low but felt the area was unsightly and had recorded it would be replaced within the next six months. They had not considered people's individual mobility assessments in relation to the damaged flooring and potential hazard. Following the inspection the provider informed us the flooring at the top of the ramp had been replaced.

Some fire safety risks were not being managed. For example, despite a sign telling staff the linen cupboard door must be kept closed, we found the door held open with some webbing. We also found a fire door on the ground floor corridor which was held open with a chair. Both doors had an automatic closure devise in place but this would not activate with the webbing and chair in place, should there be a fire. The owner removed the webbing on the linen door and the registered manager removed the chair when we pointed out our concerns. The linen room automatic door closure required new batteries which were arranged. However the automatic door closure in the corridor was effective so the registered manager could not understand why this was held open. This showed that staff were not following fire safety practice.

The owner and the registered manager said about their frustrations in reminding staff to not wedge fire doors open. The registered manager had already put in place a fire practice plan to increase the fire drills at the home until staff got it right. They said, "going to be more practices until they know in their heads exactly what they are doing."

We also identified one fire door which had a key lock to access; this had been agreed with the fire service. However when both inspectors tried to open the door we found the barrel of the lock had warn and we were unable to open it, however the owner was able to open the door. We discussed this with the owner on the first day; they had a new barrel put into place by the second visit. The registered manager said they would

add checking these locks as part of the fire checks to ensure it was not missed again.

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

Following the inspection we contacted the Devon and Somerset Fire and Rescue Service to make them aware of the concerns we found.

People were supported to take risks to retain their independence, for example, re mobilise freely and using the main staircase. There was a generic risk assessment in place for people using the main staircase and people had individual risk assessments completed regarding their mobility.

Since the last inspection the provider had introduced a new computerised care system. The registered manager and staff were still learning how to use the system fully. The registered manager said, "Still not 100% there." The staff were regularly weighing people and recording their weights on the computer system but this was not populating the risk assessment tool which would help staff identify people at risk of malnutrition. Therefore it was not clear if staff had identified people who had lost weight. We discussed this with the registered manager who was aware of the people who had lost weight. They assured us they had taken action in relation to increasing their dietary intake and involving relevant health professionals. They said they would speak with the software company providing the system to ascertain how to use the risk assessment tool on the computer system. In the meantime they said they would resort back to the paper risk assessments to ensure people were assessed correctly therefore enabling measures to be put in place where someone was identified as being at risk.

The registered manager made us aware that they had been actively recruiting to fill several vacant staff positions. They said several staff had left for different reasons at around the same time. They said they had nearly filled all of the vacant positions; some new staff had started but were still awaiting employment checks for some to be able to start. The registered manager and staff had filled gaps where possible. The provider was also using the services of three care agencies to provide cover for duties. The registered manger said they ensured there was a good balance on each shift of their own staff and agency staff and all shift had been filled except where there was unexpected sickness. They went on to say because of the staff shortages they had stopped admissions. They said "It is too much for staff… we need to ensure we can meet both the residents and the staff's needs. I don't want anyone of them to be stressed."

People, visitors and staff were aware of the staffing issues at the home and this was reflected in their comments. Comments included, "By and large the staff are good but they are often short staffed", "There are not always enough staff", "There are not enough staff and they keep changing but I think that is a common thing in these homes", "They seem to care but they are all so busy and rushing around" and "They don't have sufficient coverage but they just do not have the staff."
We judged there were sufficient staff to meet people's needs, but were aware there had been some issues with retention of staff.

The staff schedule showed throughout the day there was a senior care worker and three care staff. At night two care staff were on duty. The care staff were also supported by two housekeeping staff, a maintenance person, activity staff and cooks who as part of their roles interacted with people. The registered manager said they were being very selective during the recruitment process regarding getting the right staff with the correct aptitude and caring nature. The registered manager had kept people informed of their plans regarding staffing at the residents meetings'.

Safe recruitment procedures ensured that people were supported by staff with the appropriate experience and character. Since our last inspection the registered manager had revamped the recruitment files into a new format with an index. Where they had found gaps they had taken action to put in place the required checks. Staff files included application forms, records of interview and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure people were suitable to work with vulnerable adults. The registered manager said they were being very selective during the recruitment process to get the right staff to work at the home.

Staff had the knowledge and confidence to identify safeguarding concerns and acted on these to keep people safe. The staff were confident the registered manager was aware of their responsibilities and would take the appropriate actions to protect people and report any concerns appropriately.

Staff had a good understanding of how to keep people safe and their responsibilities for reporting accidents, incidents or concerns. All incidents and accidents were input onto the provider's computer system which the registered manager could access to review and ensure appropriate action had been taken. The registered manager was kept informed of accidents, this was demonstrated on the Monday morning we arrived, they were already aware of someone falling over the weekend and were taking action to minimise the risk.

Medicines were well managed and people received their medicines at the time they were prescribed to be given. The medicines storage room was well organised and tidy. Only staff who had completed training, administered medicines. Our observations of staff completing this task showed they followed the home's policy and procedures. The dispensing pharmacist had completed an audit in November 2016 and did not raise any significant concerns. The service completed monthly audits on the medicines and records to ensure practice was safe and people were getting the correct prescribed medicines. The registered manger was in the process of putting in place protocols for medicines prescribed as needed, (known as PRN). This would give staff guidance about when and how they should be used, which is good practice.

The registered manager had also made changes in relation to the administration of topical creams, as previously this had not been on the computer system and was not effective. Cream administration records were being implemented. These were held in a file for care staff to record when they had administered prescribed creams. The senior carer said it was their responsibility to check these were being signed each day and to remind staff were there were gaps.

The home was in the process of a redecoration program and had recently had the dining area decorated. The home felt welcoming and clean throughout. There was a pleasant calm atmosphere throughout the home. We noted that the dining area was quite warm during the lunchtime sitting on the first day. We noted that it was a warm day but raised this with the registered manager they said they would look at ways to make it cooler.

There was a maintenance person employed at the service. They undertook checks which included regular checks of the water temperature and window restrictors. External contractors undertook regular servicing and testing of moving and handling equipment, electrical and stair lift maintenance. Staff were able to record repairs and faulty equipment in a maintenance log and these were dealt with and signed off by the maintenance person. The owner and registered manager monitored the environmental and maintenance records to ensure they had been completed.

Plans and procedures were in place to deal with emergencies. A Personal Emergency Evacuation Plan (PEEP) was available for each person at the service. This provided staff with information about each person

and whether they would understand the fire alarm and what assistance they would require in case of an emergency evacuation of the service. A synopsis of people's needs was also available for the fire services in the event of a fire emergency. This meant, in the event of a fire, emergency services staff would be aware of the safest way to move people quickly and evacuate people safely. Fire equipment such as extinguishers had been serviced and maintained.

Good

Is the service effective?

Our findings

People said, on the whole they were happy the staff had the knowledge and skills they needed to meet their needs. They said there had been a lot of new staff and agency staff at the home during the past six months and it took new staff a little while to know what they were doing.

People were supported by staff who were able to provide effective care and support. This included support to new staff. For example, staff had completed an induction when they started work at the service. They completed an induction checklist which included the use of equipment, care or people and systems at the home. The induction required new members of staff to be supervised by more experienced staff to ensure they were safe and competent to carry out their roles before working alone. The induction process enabled the senior staff to assess staff competency and suitability to work for the service. The registered manager was working with the deputy manager to implement the 'care certificate' programme for new staff who had no care qualifications, which was introduced in April 2015 as national training in best practice. The registered manager had agreed with the owner to have a new training system for staff as they felt the previous one did not cover all areas. Staff completed training which included safeguarding, fire safety, infection control and moving & handling. They had recently undertaken Dementia training. This had included a 'virtual dementia tour' where staff had experienced what a person with dementia might be seeing and feeling. Staff were very excited by this training and said it had made them reflect and change the way they supported people.

People were supported by an effective staff time. This was because staff had supervisions (one to one meeting) with the registered manager. Staff said supervisions were carried out regularly and enabled them to discuss any training needs or concerns they had. Staff said they felt supported by the registered manager, and other staff. Comments included: "(The registered manager) is fabulous, she is always there, we can ask her anything."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who 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 authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the home was meeting these requirements. The registered manager had spoken with the local authority deprivation of liberties safeguarding team to identify people who they believed were being deprived of their liberty. They had made the required DoLS applications to the supervisory body.

The registered manager had a clear understanding about the principles of the MCA. Long term staff had received training on the MCA and they demonstrated an understanding of people's right to make their own

decisions. Staff had completed capacity assessments for people and considered people's capacity to make particular decisions. Best interest discussions and meetings had taken place with relatives and GPs but these had not always been formally recorded as a best interest decision, although they had been added to people's daily notes. The registered manager said they would review them and formally record them. When people arrived at the home, they or their legal representatives were involved in care planning and their consent was sought to confirm they agreed with the care and support provided.

The cook was very knowledgeable about different people's dietary needs and who required a special diet and how they accommodated these requirements. Staff gathered information about people's dietary requirements, meal sizes, likes and dislikes when they first arrived at the home. Staff went around the previous day to ask people for their meal choice. There was a new picture menu board in the lounge advising people the meals for the day.

People said they liked the food and were able to make choices about what they had to eat. Comments included, "The food is good by and large", "We have a choice of food, sometimes I eat in my room, if I don't feel so well they bring it here for me. I have coffee and biscuits and tea in the afternoon", "When my wife is not here they help me to eat and drink. I have it in my room. Snacks are here if needed", "The food is lovely here I have already recommended this home!", "I enjoyed lunch but I don't like it here. I think the staff are good", The food is good and we do get choices", "I like the food but I am not a very big eater. We get snacks in the morning with our tea or coffee and in the afternoon." One relative said how they had themselves required a specialist diet. They explained how when they had eaten at the home at Christmas staff had ensured they had a meal which was appropriate for them.

People had the option of a cooked breakfast on Tuesday and Saturdays and on other days as requested. We met one lady who had just had poached eggs on toast for breakfast. They said how much they had enjoyed it and said they could have what they wanted. We observed a lunchtime meal. People had wine or sherry with the meal; however one man said they would prefer a pint of mild and another said they liked cider. We made the registered manager aware of these comments and they said they would look into offering alternatives. People appeared to enjoy their meals and staff interacted with them.

In July 2016 the service was inspected by an environmental health officer in relation to food hygiene and safety. The service scored four with the highest rating being five. They had actioned all of the concerns identified and the registered manager said they were hopeful of a five when they returned. This confirmed good standards and record keeping in relation to food hygiene had been maintained.

People had access to health and social care professionals. The registered manager recorded in the Provider Information return (PIR) "We have the involvement of outside professionals helping us such as GP's, district nurses, chiropodists, funeral directors to help with end of life and many more." Records confirmed people had access to a GP, dentist and an optician and could attend appointments when required. One relative said, "They got an optician in recently but I do his feet they do offer to do them but it would cost extra as we are council funded." Care plans were in place to meet people's needs in these areas and were reviewed monthly or more regularly if people's needs changed. People's changing needs were monitored to make sure their health needs were responded to promptly. Health professionals said they were contacted promptly if required. Comments included, "They are very good at contacted us, if anything over cautious." They went on to say they were happy their advice was followed.

Good

Is the service caring?

Our findings

Staff treated people with kindness and compassion in everything they did. Throughout our visits staff were smiling and respectful in their manner. They greeted people on their first encounter with affection and by their preferred name and people responded positively. The atmosphere at the home was calm and pleasant. The registered manager recorded in the provider information return (PIR) "Each member of staff know our residents as an individual, show them respect and dignity. Staff try to promote independence and give our residents support where and when required."

We found where people required support with their personal care they were able to make choices and be as independent as possible. For example, if they wanted to go to the lounge; like to watch television, had they finished their lunch or did they require more. People told us, "I wash my face myself usually and do my hair and they let me choose my clothes. I feel fairly well cared for … They are polite and help me if I need the toilet" and "I do wash myself and brush my hair myself and we can sit in the garden if the weather is nice".

Staff supported people to be as independent as they wanted to be. People were active in the communal areas and throughout our visits people were using the outside balcony, patio area and some went out into the garden.

People and visitors were very complimentary about the staff. Comments included, "The care is excellent here", "They are all lovely" and "Yes it's very nice here, the views are lovely and the staff are kind."

Staff were proactive and made sure that people were able to maintain relationships that mattered to them. People's relatives and friends are able to visit without being unnecessarily restricted. Throughout our visits visitors were coming and going freely. We observed family visiting and being offered refreshments. One person said, "My relatives are welcome here". It was evident the registered manager knew people's relatives well. They greeted them when they arrived and took a genuine interest in them and what they had to say.

People's diversity was celebrated. For example people were encouraged to personalise their rooms. People's rooms were tidy and quite homely with personal touches like family pictures. The registered manager had recorded in the PIR, "All residents are encouraged to bring anything into the home which may make them feel at home this is their own pictures, photos ornaments etc."

The registered manager had received a lot of thank you notes from relatives of people who had stayed at the home. These included, "Thanks to all of you she was passed away in familiar surroundings and was looked after by those who knew and cared for her", "Thank you to everyone for the care shown. Mum said the was food was excellent", "Thank you; Mum could not have been better looked after than she was by those very good folk at Lyme Bay View. A big thank you to everyone for doing such a wonderful job. The devotion showed by the staff was greatly appreciated and I thank you all very sincerely", "It's impossible to thank you and express our appreciation of your loving care. We have felt you have all become part of the family" and "I want to thank you for handling dad's illness and death with such professionalism and sensitivity, you have looked after them so well and we are so grateful. We have never found anything to grumble about. they are

all welcoming and cheerful every time I visit."

People were asked about where and how they would like to be cared for when they reached the end of their life. Any specific wishes or advanced directives were documented on the computer system, such as the person's views about resuscitation in the event of unexpected collapse.

Good

Is the service responsive?

Our findings

People received personalised care and support specific to their needs, preferences and diversity. Care plans reflected people's health and social care needs and demonstrated that they or their relatives were involved in developing their care, support and treatment plans. Before people came to the service a member of the management team visited them. They discussed their requirements with them to assess if the home could meet their needs. One relative said, "I was involved in the care plan and its all fine."

Each person had care plans on the provider's new computerised system which staff all had a unique login's to be able to access. The care plan clearly set out how people would like to receive their care, treatment and support. Care plans included information that enabled the staff to monitor the well-being of the person. Where a person's health had changed it was evident staff worked with other professionals. For example one person had fallen a couple of times; staff were liaising with the person's GP and family. Care files included personal information and identified the relevant people involved in people's care, such as their GP, optician and chiropodist. They included information about people's history, likes and dislikes.

People's needs were reviewed monthly and as required. Every six months a full review would be undertaken which people's family and friends could attend if the person chose and if appropriate. The registered manager said it was important to go through the care files to ensure they reflected what people wanted and was an accurate description of the support required.

People were able to choose to take part in group activities and go on outings to local attractions with the activity coordinator employed at the home. There was no clear program of activities on display although people had been involved in gardening sessions, group exercises, massage therapies and bingo. The registered manager had recognised improvements were needed in relation to activities. They had recorded on the Provider Information Return (PIR) "More activities within the home to stimulate our residents every day if they like to be involved. Some of these will be one to one' activities." Because of this they had allocated additional hours for a staff member to undertake activities. This staff member's role was to undertake more one to one activities with people who were unable due to health needs or chose not to come out of their room. This would help reduce the risk of social isolation

People and visitors were not dissatisfied with the activities at the home. Comments included, "They always take him on trips but it is hard as he can't get in and out of the car very easily, they are getting a new vehicle soon suitable for a wheelchair", "We do go on outings sometimes but I don't know of any other activities", "He does not like to join in …he is always invited though" and "They don't seem to have a lot of activities here but they sometimes have things going on in the lounge and we do have outings sometimes which is nice, especially if it is a sunny day like this one. I would recommend this home to anyone".

On the first day of our visit a person was celebrating their birthday. The activity coordinator made special arrangements for their family to join them and refreshments were provided on the patio. There was a designated vehicle at the service which was used to take people on outings and appointments. The registered manager said they were looking at outings they could take people on.

Complaints and concerns were taken seriously and used as an opportunity to improve the service. There was a complaints procedure which included information about the external agencies people could contact if they were not satisfied with the response from the service. People and visitors said they would be happy to raise concerns with the registered manager and would be confident they would take action. One person said, "I had a couple of complaints but can't remember what they were, only little things and the office soon sorted it out" and "I would talk to the manager if I had a problem, she is lovely." Others said they would tell staff and were confident they would inform the management team. Comments included, "Yes the staff are really helpful, if I had to complain I would talk to the (staff member role)" and "If I had to complain I would go to the (staff member)."

One person raised with us that when they visited their relative had often been incontinent. We discussed this with the registered manager who told us about the plan which had been put into place to undertake regular toileting which had varying levels of success. The relative also said laundry had been causing some difficulties. They had raised this with the registered manager who had taken action by introducing 'snappy tags' (personalised plastic tags). This had improved the problem and clothes were being allocated to the right people.

There had been a concern raised with the Care Quality Commission (CQC) since the last inspection. We brought this to the registered manager's attention. They treated it as a complaint and fully investigated the concerns raised and where there was learning this had been put into place. This was the only complaint there had been at the service since our last inspection. The registered manager was aware of the provider's complaints policy and the action they needed to take.

Requires Improvement

Is the service well-led?

Our findings

There were quality monitoring systems in place at the home. However the systems had not identified concerns to ensure the safe running of the service. The provider had a schedule of audits and risk assessments to review of quality monitoring systems in use which were used to review and improve the service. For example, falls analysis, monthly; care plans, six monthly, environmental, kitchen, fire risk assessment, deep fat fryer and control of substances hazardous to health (COSHH) annually. However these audits had not always been effective and had not identified areas of concern found during the inspection in relation to safety risks, which included fire doors being held open and risk assessments which were not being fully effective. This showed the quality monitoring systems in use at the home were not fully effective.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were some effective systems in place to monitor the quality and safety of the service. These included a six monthly room audit completed by the provider. Where they identified concerns they had taken action to rectify the issue. For example where they found thermostatic valves used to control water temperatures in sinks used by people were not getting water to the required temperature they took action to have these replaced before they became ineffective and put people at risk of scalds. The kitchen audit identified new kitchen extraction was required this had been actioned.

The provider had displayed the summary of the last inspection which showed their previous rating in the main entrance of the home. However they had not displayed their rating on their website. We raised this with the registered manager who said she would make the owner aware on their return from holiday and were sure this would be addressed. Following the inspection the provider confirmed the rating was displayed on their website which we checked to confirm.

There was a registered manager at the service. The registered manager understood their role and responsibility and had been working hard with the provider to action improvements they had identified.

The registered manager was a role model who led by example. The registered manager undertook care duties and were very hands on supporting staff and speaking with people and visitors. Because the registered manager regularly worked alongside staff this gave them an insight into what was happening in the home and staff practices. Therefore they could deal with concerns quickly. People and staff had confidence the registered manager would listen to their concerns and they would be received openly and dealt with appropriately. Comments shared with us included, "The lady manager is a doer, she is excellent and often asks me how I am. I wanted a Wi-Fi connection so we can skype and she got it sorted" and "The manager is very nice and if I had any issues I would talk to her or one of the carers."

The registered manager knew each person's needs and was knowledgeable about their families and health professionals involved in their care. They promoted a positive culture and was aware of the ability of staff and was working with staff to develop them and was also willing to challenge poor practice.

A new role of deputy manager had been put into place since our last inspection. This was to support the registered manager and to cover their managerial duties when they took some planned absence. The deputy manager had started three weeks prior to our visit. They had a good understanding and qualifications in health and social care and dementia to undertake the role. One of the owners had their office at the home and were available to discuss concerns and support the registered manager and staff. They undertook responsibility for audits and checks regarding the environment. They was also very visible in the home and spoke with people, staff and visitors to ascertain their views.

The registered manager had notified CQC about significant events. We used this information to monitor the service and ensure they responded appropriately to keep people safe.

People and those important to them had opportunities to feedback their views about the home and quality of the service they received. The registered manager recorded in the providers Information return (PIR), "Resident meetings and one to one's for feedback. Listen to our residents and family members to ensure we take on board any suggestions to help with being more caring." A relatives survey had been completed which had been responded to positively and was waiting to be collated. The recent resident's survey had been collated and showed people were happy with the care they received. People had been asked about whether they were happy with the meals provided, activities, support they received, cleanliness of the home and whether their privacy was respected. People had responded positively to all of these areas. They had recorded comments "I love it here", "It's lovely" and "yes very happy." Where one person had raised concerns the registered manager had spoken to them regarding their concern.

Residents meetings were also held to keep people informed. At the last meeting in May 2017, people were advised about staff leaving and told about the new deputy manager and how the owners and registered manager were working to recruit new staff. The owner had made the decision to have CCTV installed in some areas of the home; people were consulted regarding this at the meeting. The CCTV was being installed during our visit. We gave the owner the guidance produced by CQC in relation to using surveillance to monitor services. One person told us, "I have been to a couple of residents meetings but think they are regular; I have not asked to see the minutes."

Staff meetings were held regularly where staff were able to express their views, ideas and concerns and to be kept informed. A staff meeting held in March 2017 recorded that there had been a lot of staff sickness due to a 'bug going around' and staff were thanked for helping with covering. The minutes of the most recent staff meeting held on the 6 June 2017 the registered manager updated staff in regards to new staff starting and said they were looking to build a strong caring staff' and that they were aiming for 'high standards'. The registered manager said staff supervisions were scheduled for every three months but staff felt this was too frequent so they were looking to have one every four months.

Staff had a staff handover meeting at the changeover of each shift where key information about each person's care was shared. Senior staff had a handover document which they completed to ensure important information was passed on to the next shift. This included any new medicines, care records had been completed, any appointments or if someone required a health professional. The new computer system enabled messages to be sent to all staff where changes to people's needs had been changed. This meant staff were kept up to date about people's changing needs and risks.

All accidents and incidents which occurred at the home were recorded and the registered manager was kept well informed. The registered manager completed a report each month which looked at the time and place of accidents to establish patterns and monitor if changes to practice needed to be made. The registered manager also discussed the findings with the provider and looked at whether anything further could have

been done.

Following our last inspection the registered manager had been in touch with the local authority Quality Assurance and Improvement Team (QAIT) to access some support and guidance to help improve the service further. The registered manager also attended manager's meetings arranged by another provider and had signed up to CQC alerts to keep updated about changes.

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 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 was not ensuring people received safe care and treatment. Risks were not being managed safely. Reg 12 (1)(a)(b)(d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's quality assurance systems had not identified areas of concern. (1)(2)(a)(b)