Care Quality Commission

Pegmar Limited

St Annes Nursing Home

Inspection report

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Ratings

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

Overall summary

This inspection took place on 23 and 24 January 2015 and was unannounced. The service provides accommodation for up to 58 people who require nursing care, including people living with dementia. There were 24 people living at the service when we visited. The home had 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.

Following a previous inspection in April 2014 when we identified non-compliance with regulations relating to care and welfare of people, infection control, medicines management, staffing, quality assurance and records we added a condition to the homes registration which prevented new people being admitted. This came into force on 11 September 2014. At the last inspection on 26 September 2014, we issued warning notices requiring the provider to make improvements to the care and welfare

Summary of findings

of people, the quality assurance procedures and record keeping by 5 November 2014. On 31 December 2014 the provider sent us an action plan stating they were now meeting the requirements of the regulations.

During this inspection we found the provider had improved the quality of service they were providing and had met the three warning notices issued following the inspection in September 2014. There remain some areas where the provider could further improve including ensuring they fully meet the requirements of the Mental Capacity Act 2005. We have made a compliance action and the provider will have to provide an action plan detailing how they will make these improvements.

People told us they felt safe at the home. Staff had received training in safeguarding adults and knew how to identify and prevent abuse. People, and their families, were involved in assessing and planning the care and support they received. Equipment, such as hoists and pressure relieving devices were used safely and in accordance with people's risk assessments.

People were cared for with kindness and compassion by staff who were aware of their individual needs. Support was provided in accordance with peoples' wishes and their privacy was protected. Daily care records relating to re-positioning, eating, drinking and continence were up to date and confirmed people had received care in a personalised way. We recommend that the provider considers guidance issued by national bodies about creating suitable environments that support people living with dementia.

People were offered a choice of nutritious meals and drinks. They were encouraged to eat and drink well and staff provided one to one support where needed. People were referred to GPs, community nurses and other specialists when changes in their health were identified.

The process used to recruit staff was safe and ensured staff were suitable for their role. Staff received a comprehensive induction and were actively encouraged to attend further training. Staff were supported appropriately and received one-to-one sessions of supervision and appraisals.

The registered manager sought feedback from people and made changes as a result. There was a complaints procedure which was followed. There was a clear management structure in place for all staff who were included in ensuring the quality of the service provided.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 in relation to the implementation of the Mental Capacity Act 2005. You can see what action we have taken at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines were stored securely, administered safely and as prescribed. However, it was not always recorded how much variable dose medicine was administered.

Staff knew how to identify, prevent and report abuse. Risks were managed effectively and equipment was used safely. Plans were in place to deal with foreseeable emergencies.

People were protected against the risk and spread of infection.

There were enough skilled and experienced staff to meet people's needs.

The recruitment process was safe and ensured staff were suitable for their role.

Is the service effective?

Requires Improvement

Where people lacked the capacity to make decisions, the Mental Capacity Act 2005 and how people were supported to make decisions was not correctly documented in care plans.

People were offered a choice of suitably nutritious meals and received appropriate support to eat and drink. The nutritional intake of people at risk of malnutrition was monitored effectively.

Staff were suitably trained and received appropriate support from the registered manager. People had access to healthcare services when needed.

Is the service caring?

Good

The service was caring.

People were cared for with kindness and treated with consideration.

People were supported to express their views and actively involved in making decisions about their care, treatment and support.

People's privacy was protected and confidential information was kept securely.

Is the service responsive?

Requires Improvement

Not all aspects of the service were responsive.

People and visitors praised the quality of care provided to people and their health and personal care needs were met.

Summary of findings

Care plans provided most of the information about how people wished to be cared for and how this should be undertaken. However, the provider had not considered all people living with dementia and the requirement to have a pain assessment.

Although information about the complaints procedure was not available to all visitors, people and visitors were able to make a complaint. These were investigated and where necessary action taken to prevent recurrence of the issue.

Is the service well-led?

Requires Improvement

The service was not always well led.

Quality monitoring systems were in place. These need to be embedded and sustained as the service further develops.

There was an open and transparent culture within the home. People and staff praised the registered manager and said the home was run well.

Feedback from people and staff was sought and the information used to improve the home. There was a system to regularly assess and monitor the quality of service provided although this had not identified the requirement and recommendations we have made.

St Annes 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 23 and 26 January 2015 and was unannounced. On the 23 January 2015 the inspection team consisted of two inspectors. On 26 January 2015, there was a specialist advisor and an inspector. A specialist adviser is someone who has clinical experience and knowledge in a particular area, in this case the specialist had experience with frail older people and in particular those living with dementia.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used this information when planning and undertaking the inspection. We reviewed information we already held about the service including notifications. A notification is information about important events which the service is required to send us by law. Before the inspection we spoke with two health and social care professionals who had regular contact with the home.

We spoke with ten people using the service and nine family members. We also spoke with the provider's representative, the registered manager and 12 staff members including nursing staff, care staff, housekeeping and kitchen staff. We looked at records including care plans and associated records for nine people; staff training and supervision records; three staff recruitment files; records of accidents and incidents; policies and procedures; and quality assurance records. We observed care and support being delivered in communal areas, such as the lounge and the dining room, including over the lunch time period.

Is the service safe?

Our findings

During a previous inspection in April 2014 we found medicines, infection control and staffing levels were not safe. We added a condition to the homes registration which prevented new people being admitted. On 31 December 2014 the provider sent us an action plan stating they were now meeting the requirements of the regulations.

During this inspection one person told us "I feel safe here, if I fall I only have to shout and they will come". Other people who were living with dementia and significant health needs were unable to tell us about their experiences. We observed that they were relaxed around care staff indicating that they felt safe.

We observed medicines being administered safely by qualified nurses. They also ensured the security of the medicines trolleys at all times. Information on the medicine administration records (MARs) informed staff how people preferred to take their medicines. If they had any swallowing problems there was information as to how this was managed for the safety of the person. MARs were fully completed showing people had received medicines as prescribed. The registered manager had identified that the MARs did not allow for the amount of some variable dose medicines to be recorded. They had taken action to change MARs to give more space for this to be recorded. For another variable dose prescription some, but not all, nurses had recorded the amount administered. This meant it was not possible to determine how much medicine some people had received.

There were appropriate arrangements to ensure all prescribed medicines were available for people. The procedures in use had ensured medicines were received in a timely way. For example, a GP prescribed antibiotics and these were received the same day allowing administration to commence and the infection to be treated promptly. All medicines including those which needed to be stored at cooler temperatures were stored safely and securely. There were systems and records to ensure medicines no longer used were safely disposed of.

Most people were prescribed topical creams which were applied by care staff. Care staff recorded the application of topical creams on forms held in people's bedrooms which also provided information about the cream and where it should be applied.

The home was clean and people were protected from the risk and spread of infections. People and relatives told us the home was always clean. The home had a dedicated housekeeping and laundry team who were clear about their duties and responsibilities. Housekeeping staff told us they felt they had adequate time to complete all tasks and had undertaken infection control training. They said they had all the equipment required to keep the home clean.

An external infection control specialist had audited the home in June 2014 and made some recommendations. They had subsequently re-audited the home and found their recommendations had been met. Staff had full supplies of personal protective equipment (PPE) and access to hand washing facilities. Records of environmental cleaning were maintained which showed all areas were cleaned on a regular basis. There were clear procedures for the management of laundry which included the safe transportation of laundry around the home and ensured soiled and clean items were kept separate in the laundry room.

The senior housekeeper was responsible for auditing the cleanliness of the home. They monitored this daily and, if they identified any concerns, the action they would take. This included addressing the issue with any staff concerned and informing the registered manager. Staff told us they had completed infection control training during induction with yearly updates. We saw on the training plan that updates were scheduled in 2015. Staff had the necessary knowledge to ensure good infection control procedures were undertaken meaning risks to people were reduced.

Staff had received training in the safeguarding of adults. This was undertaken as part of induction for new staff with update sessions planned for all staff in February and September 2015. Housekeeping and catering staff had also undertaken safeguarding training and along with care staff were clear about reporting concerns to the registered manager. All staff said they were confident the home's management would take appropriate action in response to their concerns. Staff had a good understanding of what safeguarding meant for the people in their care. They described the situations under which safeguarding would be required. For example, one care staff said "safeguarding means keeping people safe from harm, such as abuse, if I found a bruise I would record it and report it. If the senior

Is the service safe?

person did not listen to me I would go higher up even outside the organisation to the Local Authority". Staff had the necessary knowledge to identify a safeguarding concern and knew what action they should take.

Risks were managed safely. All care plans included risk assessments which were relevant to the person and specified actions required to reduce the risk. These included the risk of people falling, developing pressure injuries or being harmed by bed rails. Risk assessments had been reviewed monthly. We observed equipment, such as hoists and pressure relieving devices, being used safely and in accordance with people's risk assessments. Relatives confirmed that hoists were always operated by two members of staff meaning people were safe during the use of moving and handling equipment.

Staff were aware of what they should do in an emergency. First aid update training had been booked for staff who were encouraged to attend. Staff attended fire drills and Personal Emergency Evacuation Plans (PEEPS) were in place for all people. Staff described what action they would take in the event of an emergency meaning they would be able to take appropriate immediate action if required.

The recruitment and selection process was safe. We saw evidence that all necessary pre-employment procedures and checks had been completed before new staff commencing employment. New staff confirmed the procedures described by the registered manager had occurred meaning safe recruitment procedures had taken place.

There was sufficient staff available to meet the needs of people although they were dependant on long term agency qualified nurses. One new nurse had recently started working and a further two qualified nurses were in the process of being recruited. This would reduce the reliance on agency nurses. A dependency assessment tool was used to determine staffing levels. This meant the registered manager would be able to identify when staffing levels would need increasing. Staff said they had sufficient time to meet people's needs. Staff were busy but they went about their work in an unhurried manner. Call bells were responded to promptly and staff had time to support people individually when required. Ancillary staff were also employed in appropriate numbers, these included catering, administration, housekeeping and maintenance staff. Therefore nursing and care staff were not having to undertake other tasks taking them away from meeting people's needs.

Is the service effective?

Our findings

During a previous inspection in April 2014 we found people had not always received effective care. People had not received appropriate catheter and wound care or the correct type of diet and fluids. We added a condition to the homes registration which prevented new people being admitted. At the last inspection on 26 September 2014, we issued warning notices requiring the provider to make improvements to the care and welfare of people by 5 November 2014. On 31 December 2014 the provider sent us an action plan stating they were now meeting the requirements of the regulations.

Care plans contained a lack of clarity about mental capacity and the person's ability to make specific decisions. Care plans contained a mental capacity assessment. For one person this concluded they were unable to make decisions relating to their care. However, when talking with care staff, and reviewing the person's care plan and records of care provided, it was evident they were making day to day decisions and staff were respecting these.

In January 2015 twenty-five staff had attended Mental Capacity Act (MCA) 2005 training. This included housekeeping and catering staff as well as care staff. The MCA provides a legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision should be made involving people who know the person well and other professionals, where relevant.

We were told by the local authority that Deprivation of Liberties Safeguards (DoLS) applications had been received for people living the home. These safeguards protect the rights of people using services by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm.

The concerns about the documentation and correct implementation of the Mental capacity Act 2005 was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The environment was safe and suitable for older people, and had all the necessary equipment such as passenger lift, assisted bathrooms and toilets, hand rails of a contrasting colour and level access into the home. However, signage was limited and contrasting colours to help people identify important rooms such as toilets was not in place. This did not support people living with dementia to navigate their way around the home. There were also minimal pictures or items of interest on corridor walls or around the home to stimulate memories of people living with dementia.

We recommend that the provider considers guidance issued by national bodies about creating suitable environments that support people living with dementia.

People were able to access healthcare services. A visitor told us that when their relative went to live at the home they were physically unwell and the staff worked really hard to get them well. The visitor said "I cannot fault what they did". Family members told us their relatives always saw a doctor when needed and were admitted to hospital promptly if investigations or treatment were required. Care records showed people were referred to GPs, community nurses and other specialists when changes in their health were identified. Records for a person who had recently been receiving end of life care were detailed and complete and showed the person had regular and routine care which met the person's end of life support needs.

People received appropriate support to eat and drink enough. People spoke positively about the meals and they were happy with the quality and the quantity. One person said, "The food is good here – no complaints". Another person said, "The food is beautiful; if I don't like what I get, they take it away and bring me something I do like". A relative told us, "the food always looks good". One of the nine relatives we spoke with raised some concerns about the quality of some evening meals. However, they said they had not raised this with staff or the registered manager. We heard staff offering and providing people with condiments with their meals.

Meal times were organised and there were sufficient staff to provide people who required support in a relaxed way. Staff were aware of people's individual needs where food and drink were required in an alternative format. Records were maintained which showed people were provided with the correct meals and drinks were regularly offered. The chef was aware of people's individual preferences and requirements which were met. People's nutritional needs

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were assessed and their weight was monitored. Where concerns were identified action was taken to seek external health professional's guidance which was followed. This meant people had their nutritional needs met.

Staff received training and were supported to carry out their roles and responsibilities. New staff received a comprehensive induction which included five days of formal induction training provided by an external training provider. This covered all key areas and additional relevant topics such as care of people living with dementia and end of life care. Staff were positive about the formal induction stating it gave them lots of knowledge and information helpful to their role. Staff then undertook shadow shifts where they worked additional to other staff. The induction system ensured new staff had the necessary essential skills before commencing working with people.

The home also contracted with the external training provider for other training including yearly updates where these were required. The training plan showed these were arranged throughout 2015. Specific training, such as wound care or the support people required at the end of their lives was organised via professional experts in these areas. This included the local hospice staff and NHS tissue viability nurses.

Staff said training was provided and felt this was of good quality. Staff who had been working at the home for a longer time had completed care qualifications. Staff had regular supervision and most had received an appraisal. One staff member said "we get supervision every month and we talk about the issues we worry about and the ways we could do things differently, I look forward to it". Other staff told us they felt supported and could raise any issue they needed during staff meetings or at any time in an informal manner. The registered manager was completing appraisals throughout January 2015 and we saw the list of those completed and those outstanding. Care staff were supervised by the senior nurse and nurses by the registered manager. We saw records in staff files confirming these were occurring. Staff were therefore supported to attend training and received regular supervision and an annual appraisal.

Is the service caring?

Our findings

People were cared for with kindness and compassion. One person told us "it's all right, I get on very well with the care staff". Another person said that if staff did not get to them "within a minute or so" of them using their call bell staff "would say sorry". A third said "I like the day staff, they are good, (name of staff) likes helping me to bed as we have a good natter. She brought me a present back from her holiday". Visitors also commented that staff were nice and friendly adding they "always offer us a drink".

Staff spoke fondly of the people they cared for and treated them with consideration. One said "we provide a loving family. Doing what needs to be done in a caring way". Staff were aware of people's preferences and these reflected the information in care plans. Staff also spoke fondly of people's relatives and we saw older visitors were welcomed and supported to their relative's bedroom. Staff were chatting pleasantly with people whilst supporting them with meals and afternoon drinks. Staff clearly understood people's needs and wherever possible met these. When people asked for assistance staff provided this promptly and pleasantly. We observed some sensitive interactions when staff demonstrated caring skills delivered in a kindly manner. Staff sat with people speaking with them about their lives in ways that implied staff had a good knowledge of the people they were caring for. When it was necessary to discuss a person, staff did so discreetly in ways that were inclusive. For example, when a senior member of staff enquired about what a person had eaten, the staff involved the person in the discussion. This demonstrated sensitivity and tact by the care staff member.

When a person became upset, care staff responded warmly towards then in spoken terms but also held their hand providing reassurance. They stayed with the person until they had recovered providing them with tea and biscuits. Once the person seemed to feel better the staff member returned to them shortly afterwards and read the newspaper to them. This showed kindness, sensitivity and an in-depth knowledge of how best to support the person through an uncomfortable situation. We observed catering staff asking people what meal they would prefer. Whilst many people would be able to make these decisions other people would have been able to express their views if they had been provide with an alternative method of communication such as pictures of the various options.

People were treated with respect and in ways that protected their dignity. The induction completed by all new staff included dignity and communication. We saw care staff made sure people's dignity was preserved and promoted during the use of moving and handling equipment by ensuring clothing was properly arranged. Staff knocked on doors and waited before entering and closed the door when any kind of personal care was being provided. Confidential information, such as care records, was kept securely and only accessed by staff authorised to view it. A dignity champion had recently been appointed. They described how they viewed their role. This included challenging other staff where they felt a person may not have been treated with dignity and respect. Staff encouraged people to be as independent as possible. One relative said "they bend over backwards to meet her needs. They respect her independence".

People and their families, where appropriate, were involved in assessing and planning the care and support they received. People's preferences, likes and dislikes were known, support was provided in accordance with people's wishes and staff used people's preferred names. A family member told us "I've seen and discussed [my relative's] care plan and staff contact me when anything needs changing". For example, one person liked to keep their curtains open at night and they told us staff knew this and met their wishes. A person told us how staff met their individual wishes saying "I'm not a great water lover. Staff said they would make me coffee if I wanted, so I asked and they did". This showed staff knew about, and were responsive to people's individual needs.

People were supported to express their views. Throughout the inspection we heard staff seeking and respecting people's views and opinions. Care staff were able to detail the day to day decisions people made and discussions showed they respected these decisions. For example, in care records and food and fluid charts when people refused care or nutrition this was recorded. Care staff stated if a person regularly refused care and this may be detrimental to the person they would inform the nurse in charge. We observed catering staff asking people what meal they would prefer. Whilst many people would be able to make these decisions other people would have been able to express their views if they had been provide with an alternative method of communication such as pictures of the various options.

Is the service responsive?

Our findings

During a previous inspection in April 2014 we found people had not always received responsive care. Key processes for assessing and monitoring people's care and welfare had not always been followed and associated records were inaccurate and incomplete. We added a condition to the homes registration which prevented new people being admitted. At the last inspection on 26 September 2014, we issued warning notices requiring the provider to make improvements to the care and welfare of people by 5 November 2014. On 31 December 2014 the provider sent us an action plan stating they were now meeting the requirements of the regulations.

People praised the quality of care and told us their health and personal care needs were met. One person who preferred to stay in their bedroom said, “when I’m sitting up here they pop in to see if I’m ok and have a natter”. Another person said “Oh, it’s lovely here, I really like it”. A relative told us “The care is excellent”. Another visitor said they felt their relative was well cared for and gave examples of how staff had provided individual care that met their relative’s needs. We observed staff taking time to assist a person to put on perfume and made sure they had their handbag and hearing aids in place before going down to the lounge.

We observed seven moving and handling processes, which involved the use of a hoist or stand aid. These were carried out efficiently and competently. However, we noted in two situations that the staff provided very little interaction with the person being supported to move other than saying “going up” and “going down”. The two people were holding on very tightly to the lifting equipment and looked tense and worried. This meant there was a period of time when the people were most vulnerable but staff were not providing reassurance. The care plans for these people included “(the person) is very anxious and needs lots of reassurance and encouragement when transferring”. The person’s needs had been identified but either staff were unaware of it or were not following the care plan.

Care plans were written in a personalised way, were clearly about people as individuals and in a format where information was easy to find. Additional mini care plans in bedrooms enabled care staff to have quick access to all essential information. Care staff told us they used the care records as a source of information when necessary however, one told us “we rely most on the handover and looking in the daily records as we do not always have time to look in the main care plans but can always ask the nurses who use them several times per day”. This meant staff caring for people had the information they required about people’s needs.

Care plans were reviewed each month, risk assessments carried out and new care plans created when necessary. However, there were some gaps in the records, for example, when people had an infection, their records did not contain short term care plans, which would have provided instructions for staff about how to support them to assist recovery and increase comfort. For one person we identified there was a need for additional information about their sitting position and care they required. Their care plan stated “because of their leaning to the left, this will cause backache”. There was however, no further reference to this in the person’s records or how they should be supported to sit correctly or what actions should be taken to manage the identified risk of backache. The person’s records showed they had scratched their left arm, the arm they were leaning onto. This included a body map showing the scratches however, scratching the arm may have been an indicator that the person was experiencing pain and staff had not investigated the possibility of pain which the person may not have been able to tell staff about.

There was a basic ‘as and when (prn)’ medicines protocol which included the name of the product and what it was used for but this was not personalised to the individual person. This meant the unique signs a person might display when they were in pain were not recorded. As a consequence, agency or new staff may not realise the person was in pain and offer appropriate pain relief medicine. The registered manager showed us a new prn document which they told us would be shortly introduced. It included some references to good practice. However, the National Institute for Clinical Excellence (NICE) guidance “medicines in care homes 2014” had not been included. We found a pain assessment tool was in use for some of the people who were living with dementia. However, other people in the home were living with dementia and they may not be able to express any pain they experienced.

It is recommended the provider should consider the latest best practise guidance on pain assessments.

A person told us they had “made cakes in the dining room with chocolate”. Staff told us how the activities person was

Is the service responsive?

able to take people out to the local shop when they required small items of personal shopping. There was information about people's activities preferences in care plans and a recording sheet was used to record daily the activities people had taken part in. Some formal activities were organised, such as visiting entertainers and informal and ad hoc activities. Discussions with staff showed they were aware of people's activity interests and aimed to meet these.

People and relatives were provided with information about the complaints procedure within their contracts. There was no information advising other visitors as to how they may complain although there was a concern and compliments box in the entrance hall if people wanted to raise concerns anonymously. Visitors said they would raise any questions or concerns with the manager or staff and were confident these would be sorted out.

The registered manager told us that when reviews were held relatives and people were specifically asked if they had any worries or concerns. The complaints record showed two formal complaints had been received since our previous inspection in September 2014. The registered manager had received a complaint about the meals, which had related to the temperature at which the meal was served. They described how the chef now ensured the person's meal was "piping hot" when served and the person was happy with the outcome of the complaint. We saw the complaints had been appropriately investigated and there was a record of the action taken to address the concern including providing a formal response to the person who had raised the complaint.

Is the service well-led?

Our findings

During a previous inspection in April 2014 we found records and quality assurance systems were not well managed. We added a condition to the homes registration which prevented new people being admitted. At the last inspection on 26 September 2014, we issued warning notices requiring the provider to make improvements to quality assurance systems and records by 5 November 2014. On 31 December 2014 the provider sent us an action plan stating they were now meeting the requirements of the regulations.

People were supported to express their views. Throughout the inspection we heard staff seeking and respecting people's views and opinions. Some people choose to spend their time in their bedrooms and this was supported by staff. One person said "I like the view from my bedroom so I stay up here". A relative told us the staff "bend over backwards" as their relative "would only drink hot water and staff provided this". This showed staff acted on people's decisions and that people felt able to make individual requests to staff on a day to day basis.

While the staff were not able to explain their understanding of the provider's values and visions they told us "we always talk about what is most important, like residents first, always residents first at meetings, so that is the value I think". Another staff member told us "the manager is always saying we want to provide outstanding care so that people have the best care in the world and we are all working hard doing our best towards it". Other staff were also clear that their role was making sure people were "happy and we've achieved their needs". Staff also spoke of the need for a "homely relaxed experience". Staff said they felt confident to make suggestions to the manager and that these would be listened too. This indicated that the home had an open and inclusive culture which placed the needs and welfare of people first.

Staff told us the registered manager was approachable and available. One told us "they are always around the home, she knows the staff and all the residents really well and talks to the relatives all the time, and she is liked by everyone". Another said the registered manager "is a really good manager, she really cares about us but she is no push-over and can be firm when needed just like any good boss should be". Staff also said they felt supported by the registered manager. The registered manager knew all people, relatives and staff and was able to answer questions about the care individual people required. This showed they were actively involved the day to day running of the home and care people received.

All staff described how they were included in monitoring the quality of the service. Staff told us this made them "even more careful" about fully completing records. Senior care staff told us that they monitored the care given by less experienced staff and that if they felt a person had not received adequate care they would address this with the care staff concerned and ensure correct care was provided. All staff were therefore involved in quality monitoring and promoted a culture of self-monitoring.

The quality assurance system included audits, which were analysed, and stated action taken and how this would be followed up, such as at the next staff or resident meeting. Audits were being completed and we saw copies of these. These included medicines audits, which had identified a need for clarity of how long opened topical creams should be safe for use. An activities audit had been completed in January 2015. Other general audits including infection control and specific audits, such as the Kings fund "is your care home dementia friendly" which considered how the environment may support people with dementia had also been undertaken although action to make the home more "dementia friendly" had not been taken. We saw the meals audit had identified people were not routinely being offered the opportunity to wash their hands prior to eating. This had been addressed and we saw staff offering people the opportunity to wash their hands before lunch. The mealtime audit had also identified the action to ask people about the environment and noise at mealtimes at the next resident meeting. A range of audits were therefore occurring however, they had not identified some of the issues we found and recommendations made.

A care plan audit had been completed and we saw that this was comprehensive and identified what information was missing or required updating within each care plan. There were plans to change the way care plans were reviewed by ensuring that the whole care plan was reviewed by the same senior staff on one day. This would help reduce inconsistencies between different parts of the care plan which were resulting from parts of plans being reviewed when needs changed but other parts not being updated to reflect the person's new care needs. We were told this would then mean the registered manager would only need

Is the service well-led?

to sample care plans to ensure senior staff had completed a thorough care plan and risk assessment review. This demonstrated that there had been action taken to change procedures when audits had identified a need.

Training and staff knowledge had been audited by the use of a quiz which also invited staff suggestions for improvements. Staff meetings were held and we saw the minutes of these. People and relatives were involved in care reviews during which they were asked if they had any concerns or requests. A compliments and comments box was provided in the entrance of the home for anonymous views and suggestions. We observed the registered manager was available for people or relatives and they approached her to discuss any issues. People and visitors told us they felt able to raise questions or concerns with the registered manager or staff and that these were sorted out.

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 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. The registered person must ensure the Mental Capacity Act 2005 is correctly used to ensure people's legal rights to make decisions are supported.