Barker Care Limited

St Teresa's Nursing Home

Inspection report

Corston Lane
Corston
Bath
Somerset
BA2 9AE

Tel: 01225873614
Website: www.cedarcarehomes.com

Date of inspection visit:
08 June 2016
09 June 2016

Date of publication:
08 July 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 8 and 9 June 2016 and was unannounced. The care home was last inspected on 5 and 12 March 2015. We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 at that inspection. The breaches related to consent to care and the monitoring of care interventions. At this inspection we found actions had been taken to meet these regulations.

St Teresa's Nursing Home is registered to provide nursing and personal care for up to 70 people. There were 68 people living in the home on the days of our visit. The home is divided into two units. The Gainsborough Unit accommodates up to 27 people, most of who are living with dementia. The Bartelt Unit accommodates up to 43 people who need general nursing care.
A third unit is currently being developed within the Bartelt Unit. This is called Austin Unit, and will provide accommodation for people living with dementia. The total number of people accommodated will not change.

There was a manager in post. They had applied and were in the process of completing the registered manager application process. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were assessed before they moved into the home to ensure their needs could be met.

Risks to people were assessed, and where identified, actions were taken to reduce the risks and keep people safe.

When we inspected on 5 and 12 March 2015 we found intervention charts such as fluid monitoring and positional change charts were not always completed. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found sufficient improvements had been made.

We found improvements were required in recording the effectiveness of pain relief, pressure relieving mattress settings, people's dietary requirements and pressure ulcer dressing changes.

People told us they experienced difficulties in their communication with some staff that were not able to communicate effectively because of their English language skills.

People received personalised care that was responsive to their needs. Care plans reflected that people's individual needs, preferences and choices had been considered.

People were supported to have their nutritional needs met. The dining experience was relaxed, and people

received the support they needed.

Governance systems were in place to monitor and mitigate the risks relating to the health, safety and welfare of people.

When we inspected on 5 and 12 March 2015 we found systems were not in place to obtain consent from people. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found improvements had been made. We found the rights of people who did not have the capacity to consent to care and treatment were protected because the service worked in accordance with the Mental Capacity Act 2005.

The provider had met their responsibilities with regard to the Deprivation of Liberty Safeguards (DoLS). DoLS is a framework to approve the deprivation of liberty for a person when they lack the mental capacity to consent to treatment or care and need protecting from harm. Where people were deprived of their liberty this was done lawfully.

People who were supported by the service felt safe. Staff understood how to safeguard people, and knew the actions they would take if they suspected abuse.

We found one breach of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff had been trained and recognised their role in safeguarding people from harm and abuse.

Accidents, incidents, falls, slips and trips were recorded and analysed. Actions were taken where necessary to reduce and minimise people's risks of injury.

Staffing levels were sufficient for the needs of the people living in the home. Robust recruitment procedures were in place. This reduced the risk of unsuitable people being employed.

Risk assessments were completed and risk management plans were in place to provide support to people in the event of an emergency.

People received their medicines safely. The provider had procedures in place to assess and monitor the safety of medicines management. Issues with regard to the supplier of medicines had been identified and were being addressed by the provider.

Is the service effective?

Requires Improvement

The service was not always effective.

People's health care needs were assessed. However, the records did not always evidence the actions taken.

Pressure relieving equipment was supplied and in use, but was not always used correctly to provide the level of protection people required.

People's health care needs with regard to fluid and dietary intake were recorded.

Staff received supervision and training in key areas to enable them to meet people's needs.

The rights of people who did not have the capacity to consent to

care and treatment were upheld because staff acted in accordance with the Mental Capacity Act 2005.

People had access to community healthcare professionals

Is the service caring?

Good

The service was caring.

People were cared for by staff in a kind and caring manner and their dignity and privacy were respected.

People's care was planned in line with their personal wishes and preferences.

People were involved in decisions about their end of life care and this was respected.

Is the service responsive?

Good

The service was responsive.

People received care that was personalised to their individual wishes and preferences. The care plans held personal information about people including their likes, dislikes, preferences and what was important to them.

A complaints procedure was in place and this was easily accessible

Is the service well-led?

Good

The service was well-led.

A range of quality assurance and monitoring systems were in place. Where shortfalls were identified, actions plans were implemented. Most actions were completed.

People who used the service and their relatives were given the opportunity to provide feedback at meetings and in surveys. This enabled the manager to identify areas for improvement and address them.

Staff meetings were held regularly. Staff representatives attended regular meetings with the provider's directors to discuss issues on behalf of their colleagues. Written feedback with agreed actions was provided. This demonstrated that staff views were taken into account in the running of the home.

St Teresa's 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 8 and 9 June 2016 and was unannounced. This meant the provider and the staff did not know we would be visiting. The inspection was carried out by one inspector on 8 June 2016 and two inspectors on 9 June 2016.

Before the inspection we reviewed the information we held about the service. The registered provider had completed a Provider Information Return (PIR). This is a document that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at notifications we had received for this service. Notifications are information about specific events the service is required to send us by law.

We contacted a health professional to obtain their views on the quality of the service provided to people and how the home was managed.

We spoke with eight people who lived at the home and three visitors. We spoke briefly with other people living in the home who were not able to fully communicate their views about the service. We spent time with people in their bedrooms and in communal areas. We observed the way staff interacted and engaged with people. We also spoke with a visiting health professional, the manager, one senior staff member, and nine staff which included nursing, care, housekeeping, administration and activity staff. We observed medicines being given to people. We observed how equipment, such as pressure relieving mattresses and hoists, was being used in the home.

We looked at six people's care records. We also looked at 20 medicine records, staff recruitment files, quality assurance audits, staff and service user feedback surveys, complaints records, compliments records and other records relating to the monitoring and management of the home.

Following the inspection we received further information relating to staff supervision and training, and policies and procedures.

Good

Is the service safe?

Our findings

People living in the home told us they felt safe. One person commented, "I always feel safe and they answer the call bell a lot quicker than they did in hospital, and from another person, "Yes I feel safe in here, day and night." A relative told us, "We come in at different times. We do feel he is safe here. He has settled in now."

Staff had received training and were able to explain their roles and responsibilities for keeping people safe from harm and abuse. All the staff we spoke with told us they would report concerns. They told us they had access to contact details. One member of staff told us, "I would report abuse straight away and if I needed to report to someone outside of the home, there are details of how to do this in the staff room."

Risks to people's safety had been assessed and plans were in place to minimise the risks. These included risks associated with nutrition, mobility, falls, distressed or challenging behaviours, and moving and handling. Risk assessments and risk management plans were reviewed and updated on a regular basis.

Reported accidents, incidents, slips, trips and falls were reported. They were reviewed to establish any patterns, trends or measures that could be implemented to reduce or stop the incidents happening again. The manager had a system to record, monitor and review incidents and we saw that this system had been used effectively. Each individual incident recorded was subject to an 'incident occurrence analysis' which included ensuring the incident had not occurred due to insufficient staffing numbers or staffing skill levels. The review system demonstrated that action had been taken by the manager to ensure people and staff were safe. For example, where a person had displayed behaviour that may be challenging, additional training had been provided for staff and guidance on actions staff could take to reduce the risk of this happening again was recorded. In addition to the incidents being reviewed individually, a management monthly overview of all incidents was completed.

We saw an entry in one accident record that did not follow good practice guidance for record keeping or the provider's policy for accident recording which states 'Staff must only record facts and not opinion'. Staff had recorded what they thought may have happened and not what they actually found. The record stated, "Might have lost his balance and sat on the floor." It was also recorded that staff did not witness what happened and the person was found on the floor.

We recommend staff undertake further training to ensure they comply with the provider's accident management policy.

Safe recruitment processes were completed. Staff had completed an application form prior to their employment and provided information about their employment history. Previous employment or character references had been obtained by the service together with proof of the person's identity for an enhanced Disclosure and Barring Service (DBS) check to be completed. This DBS check ensures that people barred from working with certain groups such as vulnerable adults are identified.

On the days of our visit, there were sufficient staff were on duty to provide the support people needed and to

meet their needs. People told us staff responded to their calls for support and assistance when needed. One person told us they thought the staff were very busy, "Especially during the mornings, they seem to have to rush around." They told us if they needed help quickly,"I just need to press my buzzer twice and staff come straight away". Staff told us they usually had enough staff on duty. They told us staffing levels had been increased and they had the support of an activity coordinator on each unit during the day. The manager told us they reviewed the staffing levels on a regular basis to make sure they were sufficient to meet the needs of the people living in the home.

We observed medicines being given to people in a safe way. The Medicine Administration Records (MARs) were signed by staff after they had made sure the person had taken their medicines. Registered Nurses and Associate Nurses administered medicines. Associate nurses are nurses waiting to have their nursing registration confirmed in this country. They were being supported through a programme of supervised practice during this time. Care staff applied creams which were kept in people's bedrooms and signed to say they had been applied. We noted some of the creams were not individually labelled. We brought this to the attention of the manager who told us they would discuss and resolve this issue with the supplying pharmacist.

There were systems for storing medicines, including medicines that required additional security and medicines that required cool storage. People were not looking after their own medicines at the time of the inspection, but systems and policies were in place to allow them to do this, if it had been assessed as safe for them to do so.

There was a system and protocol in place for the use of 'homely remedies'. These are medicines such as laxatives, that can be given for a limited time without an individual prescription. These were recorded when given and the remaining stock balance was recorded. This meant accurate records could be maintained.

We checked the records for two people who were given their medicines covertly by staff. This meant these people received their medicines in a disguised way. There had been discussions with relatives, the GP, the pharmacist and the care home staff. It was agreed this was appropriate and this was recorded. Reviews were completed every six months. This meant people received their medicines lawfully and in their best interests.

There was a record of medicines received into the home and those sent for disposal. This helped to show how medicines were managed and handled in the home.

The environment and equipment were maintained to ensure it was safe. The provider had dedicated maintenance staff that monitored all aspects of the environment and the equipment within the service. For example, there were systems to ensure that water temperatures were safe and that the boilers within the service were operating correctly. There were tests that ensured window restrictors were serviceable to help support people safely and regular fire drills were completed. There were systems that ensured mobility equipment such as hoists, wheelchairs and slings were regularly checked to ensure they were safe. Bed side rails were checked to ensure they were correctly fitted and secure.

Personal protective equipment was provided in sufficient quantities. For example, we saw gloves and aprons used appropriately by staff

Emergency planning had been considered and people had personal emergency evacuation plans. Other health and safety checks on the premises, such as checks on the standard of electrical, gas and water safety had been completed. This meant people could be confident the premises were safely maintained and their needs could be met in the event of an emergency.

Requires Improvement

Is the service effective?

Our findings

Some people in the home used pressure relieving mattresses because they were at risk of developing, or had, pressure ulcers. The mattresses settings should be adjusted according to the person's weight. We checked five mattresses at random and found they were all set incorrectly. For example, one person weighed 63.6kgs in May 2016. Their mattress was set for a person with a weight of 90kgs. Another person weighed 56kgs and their mattress was set for a person with a weight of 90kgs. This meant people were not always receiving the health care support they needed.

We brought the issues above to the attention of the manager. They corrected the settings on the days of our inspection. They showed us the system in place, which had not always been followed, to monitor the pressure settings. They told us they reiterated the required protocol to all staff, during our inspection.

Some people had special dietary needs and preferences. For example, some people needed softened food or thickened fluids where they had been assessed as at risk from choking. Most people received the type of food and drink they needed according to their individual assessment and care plan. However, one person had been assessed by the Speech and Language Therapy team (SALT). Their care plan and records in the person's room stated they needed softened food and guidance was provided about the type of food recommended and not recommended. The person was eating food that was not softened. Senior staff told us the person was no longer at risk of choking and the person had the capacity to decide they did not want to eat softened foods. However, The SALT team had not been consulted and the care records had not been updated to reflect this change. The records did not confirm the risks had been fully discussed with the person. The manager contacted the SALT team during our visit, to request a follow up assessment.

Some people assessed as at risk of choking had their fluids thickened. Plastic lidded containers were available to store these products in people's rooms. We saw some thickening powders were left unsecured in people's room and in the dining room. Recent NHS safety information was provided about the safe storage of these products, following a serious incident. Whilst these products need to be accessible, they also need to be out of easy reach of people who may be confused. This meant people were at risk of harm because the thickening powders could be accessed by people who may use them inappropriately.

We looked at the care records for a person who had a pressure ulcer. This was being treated and cared for appropriately. The tissue viability nurse had provided advice and guidance and we saw their instructions had been followed. However, we did note some inconsistency about where the updates and confirmation of wound dressing changes were recorded and reported on. Sometimes updates and reviews were recorded in the daily records and sometimes they were recorded in the pressure ulcer care plan in the 'wound management evaluation' record This meant it was difficult to obtain a clear and consistent picture of the progress of the progress of the pressure ulcer, because the detail required in the wound management record was not completed. This was brought to the attention of the manager and senior staff at the time.

We checked the care records for people who received pain relieving medicines. One person had regular pain relief, was cared for in bed and was checked regularly by staff. However, the effectiveness of the pain relief

and the time staff spent with the person was not recorded. This meant there was a risk of the person's pain relief not being adequately controlled and not having sufficient time spent with them because the records were not fully completed.

The above examples of failures to accurately record care and treatment are breaches of Regulation 17 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

People had access to healthcare professionals. People had received support from chiropodists, opticians, community psychiatric teams, dieticians, occupational therapists and GPs. The feedback we received form healthcare professionals was positive. One professional commented, "As a team I believe we are confident when placing at the home and have a good working relationship with St Theresa's." Another health professional told us, "The staff are good, they recognise changes and act on instructions and guidance." They gave examples of how the home worked well with them and responded to their advice and guidance.

Staff received training to carry out their roles. Staff had received training in a variety of relevant topics to meet the needs of the people who used the service that included moving and handling, safeguarding, dementia, challenging behaviour and equality and diversity. The manager demonstrated how staff completed regular on-going training by producing the training forecast for the next three months. This showed staff that required updating training would receive it to ensure the needs of people were met. Nursing staff received role specific clinical training in subjects such as syringe drivers and skin care management to meet the needs of people.

The provider had an induction process which encompassed the Care Certificate. This was introduced in April 2015 and is an identified set of standards that health and social care workers should adhere to when performing their roles and supporting people. The Care Certificate is a modular induction and training process designed to ensure staff are suitably trained to provide a high standard of care and support. At the time of our inspection there were newly employed staff completing the certificate.

In addition to the Care Certificate new staff completed an internal induction relevant to the service. The internal induction for new staff was completed over nine days. It consisted of a combination of training in a classroom environment, observing senior staff members providing care and support and then being observed themselves to ensure they were providing effective care. Within the induction folder, we saw that new staff completed training in subjects such as health and safety, moving and handling, nutrition and hydration, safeguarding and dementia care.

The provider had a system to support staff through regular performance supervision. Staff received supervision approximately every three months and this consisted of both individual and group supervision. Where required, we also saw that individual 'supportive supervisions' were completed if the need was identified due to a concern being identified with a specific staff member. Group supervision records showed that matters such as the Mental Capacity Act 2005, safeguarding, infection control and general home matters were discussed. Individual supervision focused on the staff member's performance and if they required any support in their roles, together with people's individual care needs.

Staff received an annual appraisal. This was completed with staff and included a discussion about the provider's code of conduct and how the staff member applied this to their work. The staff member's compliance with their job role and the health and safety standards the staff member achieved were also discussed. We observed that the annual appraisal and objective setting was role specific for staff, for example the document differed slightly for nursing staff and care staff to reflect their different job roles within the service.

A senior member of staff told us they also received support and guidance from the multi-disciplinary team. They told us the support was very helpful. They gave an example of the discussions they had and the guidance they received to support a person with distressed behaviours that may be challenging to others.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Staff had received training and staff demonstrated an understanding of the Mental Capacity Act. They told us they understood they needed to obtain consent from people before they provided care and support. One member of staff told us, "People are lucky here, we ask and we give good care. We do not have anything like this in my country." We did hear staff asking people before they provided support and assistance. For example we heard people being asked, "Do you want to go back to your room…that's no problem I'll take you now" and "Are you ready to get up now?".

The provider had met their responsibilities with regard to the Deprivation of Liberty Safeguards (DoLS). DoLS is a framework to approve the deprivation of liberty for a person when they lack the mental capacity to consent to treatment or care and need protecting from harm. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). 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.

At the time our inspection there were people living at the home who had a DoLS authorisation in place and where required the manager had acted in accordance with conditions within these DoLS. We saw for one person the condition noted that one to one time should be recorded. This was recorded. However, the amount of time spent was not recorded which meant the effect of the intervention may not be accurately determined.

Multiple applications had been submitted to the local authority and the relevant assessments and authorisations for some people were pending. It was highlighted to the manager that records relating to people's DoLS were in different files and this made it difficult to instantly ascertain the current status for people in the service. This resulted in the manager having to call the local authority DoLS team during the inspection and send us information following the inspection to confirm the current DoLS status for two people. The manager told us a review of the current system would be undertaken.

People were supported to eat and drink. One person said, "They bring in my breakfast at about nine o'clock, when I wake up." Another person commented, "The food's really nice. I just tell them (the staff) if I don't like anything and it's changed."

The catering team were informed about people's specific dietary needs, and were also provided with written updates about people's likes and dislikes. The chef told us they spoke with people and received feedback from staff to help them provide what people liked and wanted to eat.

We observed meals served to people in their rooms and in the communal areas. People had chosen their main meals in advance. Staff offered people choices of drinks and provided support and encouragement to people. One person was assisted with their pureed food. The staff member gently encouraged the person to eat. They asked, "Go on, please try, just a little bit." The person responded and slowly ate most of the meal.

The chef told us they anticipated some people may change their mind at the last minute, or may not remember what they had chosen. They made provision for this and we saw when people did change their mind, they were offered an alternative.

Good

Is the service caring?

Our findings

People and relatives told us staff were kind and caring and our observations confirmed this. Comments included, "They (the staff) are all good from what we've seen," "We are cared for beautifully" and "The staff are all lovely and kind, day and night."

Several people were not able to express their views. We watched interactions with staff and people looked relaxed and comfortable in their presence. We did note there were instances where people had difficulty understanding what staff said to them. Some people, relatives and health professionals acknowledged there were communication challenges because most of the care staff did not speak English as their first language. We spoke with one member of staff who told us their English speaking was improving and they were attending a course to improve their skills.

Staff were aware of people's preferred names. The atmosphere in the home was calm and pleasant. There was chatting and appropriate use of humour between staff and people living in the home, throughout the day.

People were treated with dignity and respect by staff and they were supported in a caring way. Staff ensured people received their care in private and staff maintained their dignity. Staff were aware of the importance of this. One member of staff told us, "We always knock on doors before we go in. I would remind other staff too if I noticed they didn't do this." Another member of staff commented, "I try to put myself in their (people who use the service) shoes. It's really important to get to know the person and treat them with respect, even things like closing the curtains."

People were involved in decisions about their end of life care and this was recorded. For example, one person had a do not attempt cardio pulmonary resuscitation (DNACPR) order document in place. We saw the person had made this decision and it was recorded appropriately to ensure it would be known to other people and respected. The person was receiving end of life care. Their relatives had been consulted and were involved in the decisions about the person's care. We saw that care assessments were reviewed each day and pain relief was increased as their condition changed. Staff checked the effectiveness of the pain relief when they visited the person regularly. We saw the person was sleeping and looked comfortable.

We reviewed the compliments folder held at the service. This contained cards and letters from people and their relatives giving praise and thanks to the management and staff at the service for the care and support that had been provided. We reviewed a sample of the cards and letters and recorded some extracts. One relative said, '[Relative name] and I really appreciate all the support and kindness that you and the staff gave to our Mother.' Another said, 'Thank you for the kindness and care taken with [service user name] in the final weeks of life.' A further note said, "I thought I would let you know how pleasantly surprised I was to see the very good care home [service user's name] was in. The staff were most accommodating and helped move her to her room when we wanted more privacy to talk.'

Good

Is the service responsive?

Our findings

People who lived at the home and their relatives were generally positive about the service and felt it was responsive to their needs. For example, one person commented, "The staff help us with whatever we need". Feedback from relatives was positive and complimentary. One relative told us, "I'm really happy with the care they give to Mum and they let me know if they're any changes." Relatives told us they were made to feel welcome when they visited. We saw that relatives were involved in care planning and reviews of care and this was recorded in the care plans.

The staff we spoke with had a good understanding people's individual needs and preferences. They told us they tried to make sure people who couldn't always say what they wanted were cared for in the way they would have chosen. One member of staff told us, "I read the small care plans (there were two care files for each person, one for day to day care records and monitoring charts, and one with more detailed information) to make sure I am up to date and to remind me what the resident wants."

Separate weekly activity programmes for Bartelt Unit and for Gainsborough Unit were displayed in reception and in the units. The programmes reflected the different needs of people living in each unit. Where people were able, they chose the activities they wanted to join in. For example, during the inspection, a game of scrabble was organised. One person commented, "I've not played before but I'll give it a go."

A member of staff told us that relatives had commented positively to them about the improvement in the activities provided for people in the Gainsborough Unit. People were given the choice about where they spent the day. Some people preferred to spend time in their rooms and this was respected by staff. The member of staff told us, "We try, [to encourage people into the communal areas] but some residents don't find it comfortable being with others in the lounges so we spend time in their rooms with them, even if it's just looking through books or stroking their hands." A new system of recording had been started where the activity coordinator recorded the individual visits with people in their rooms.

An evening entertainment had been arranged and was taking place on one of the inspection days. Another event was planned for the weekend. The manager told us they had a good relationship with the local parish council who were helping to provide food and refreshments for the event.

There were systems to ensure that monthly care audits and the reviews of people's risk assessments were completed. The manager completed monthly reviews of care records to ensure that care provided was in line with people's needs and preferences. We saw that these reviews and audits ensured the service were responsive to people's changing needs. The audit encompassed a review of all people, recording if they currently had any infections or were on a course of antibiotics.

The audit identified if the person had received a visit from the GP or other health professional or if they had an accident or fall. Further information showed if the person was at risk of malnutrition, had any skin damage, if they had suffered a weight loss or gain or if they were currently receiving end of life care. This demonstrated that regular reviews were completed to monitor and manage people's health and be

responsive to their changing needs if the requirement was identified.

The provider had a complaints procedure available for people and their relatives. The policy was displayed in the foyer of the service and the manager had a system to monitor complaints received. The current complaints record within the service showed that one written complaint had been received during 2016. This had been responded to and resolved for the complainant within two days and in accordance with the provider's policy. We reviewed the complaints log audit used by the manager that showed when required, a record of the complainant, the reason for complaint and the outcome was recorded. This would support identifying any common trends or individuals involved in complaints.

The provider had produced a hospital transfer form for people. This record ensured that if a person was admitted to hospital or when they returned from hospital, key information would be available for staff and the relevant healthcare professionals to help them support the person. Whilst in hospital, this could reduce the person's anxiety or distress whilst being in an unfamiliar environment, in particular if the person was living with dementia. The record contained personal details such as how the person communicated, if they had difficulty hearing or understanding certain things. Additional information such as the person's personal health conditions and medication was recorded together with any identified risks, for example a falls or mobility risk.

Where required, the provider had been responsive to people and their relatives following feedback of areas that could be improved. For example, within the most recent survey mixed feedback was received about the meals at the service and negative feedback had been received around people feeling involved in their care planning. As a result of this there had been a consultation with people and a menu change. This was further complimented by a monitoring system that ensured people were satisfied with the changes. In relation to being involved in care, the manager had introduced a consultation audit that ensured people's views were sought and they were involved in care planning. Additional improvements had been made in following feedback in relation to the laundry system which had received positive feedback.

Good

Is the service well-led?

Our findings

We spoke with people living in the home and with relatives. They all commented positively on the management of the service and told us the service was well led. Comments such as, "She's [manager] great, everything I have raised has been done. I have so much confidence in her, I feel I could go to her about anything" "The manageress pops her head round the door and asks how I am" and "We're always made to feel welcome."

One person did comment they would like the opportunity to talk with the nurses more often. The person told us, "They give out my pills a couple of times every day and ask how I am, but don't really spend time talking about my care."

Staff were mostly positive about the support and direction they received. They told us, "The manager is great, I feel really well supported, it's a lovely role so far" "I think we are a good team, we support each other and can talk if we have worries" and "This place has improved during the last year, we have more regular supervisions."

We also received some feedback that was not so positive. Staff commented they were not thanked enough for the work they did. They told us they were criticised by senior staff when they did something wrong, but not praised when they worked hard or covered extra shifts. We spoke with the manager who told us they were disappointed at this feedback and would take action to make sure feedback to staff was balanced and fair.

Messages were communicated to staff through meetings. Different levels of meeting were held frequently at the service. For example, we saw minutes relating to 'heads of department' meetings, domestic meetings and general staff meetings. We reviewed the meeting minutes for the meetings involving all staff which showed matters such as policy acknowledgement, staff uniforms, budgets, record keeping and activities were discussed. During these discussions, if actions were required they were noted. For example, from the most recent minutes for the meeting in February 2016 we saw that actions relating to the providers policies were required.

People and their relatives were actively involved in meetings and we saw that when feedback was given, action had been taken by the manager. Meetings were held periodically and general matters within the service were communicated to people and their relatives. For example, the previous meeting minutes from the meeting held in March 2016 showed that people were involved in discussions about activities, new menu choices, the current recruitment at the service and care planning. Where suggestions had been made we saw that action had been taken. For example, one relative asked for a day and a date board to be placed into one of the dining areas of the service and this had been completed.

People and their relatives had been given the opportunity to complete an annual survey. The most recent survey had been given to people in November and December 2015. The results were displayed in the entrance foyer of the home. In general the response to the survey was positive. In total the service received

15 responses. All of these responses said they would either definitely or likely recommend the service to others. Most people said they could spend the day as they pleased and commented positively about staff seeking their consent prior to providing personal care. Everyone said that their choices were either always or usually respected and positive feedback was received about people feeling safe and the cleanliness of the service. Where areas had been identified as requiring improvement, for example meals and care planning, this had been completed as reported in the 'responsive' section of this report.

There were governance systems to monitor the health, safety and welfare of people. For example, there were monthly care management audits that ensured risks within people's care records were recorded correctly and foresight was given to any matters that may arise. For example, within one person's record it showed the audit had highlighted the prescription should be checked for accuracy in relation to end of life medication as the person's health had deteriorated. The audit had also identified the service needed to contact a person's GP for advice and for another that a Deprivation of Liberty Safeguards (DoLS) assessment was needed.

Governance systems completed on admission to the service ensured that documents were completed correctly and that appropriate documentation was in place for people. We saw this system had been effective as it had identified where documentation relating to a person's nutritional risks had not been completed. There were infection control audits completed and medicine audits completed. These had also identified where improvement was required. For example, the medicine audit had identified that a person's PRN (as required) medicine was being given routinely and as a result the person's GP was contacted. Infection control audits had identified minor improvements required within the service that were being addressed.

There was a business continuity plan in place should the service suffer a temporary or permanent loss of key supplies to ensure a contingency plan could be implemented. The plan showed what action should take in the event of the loss of accommodation, any heating, gas, water or electric supply loss or catering disruption. The business continuity plan also showed how the service intended to manage in the event of natural occurrences, for example a flood or other severe weather conditions.

The manager was supported by the provider through performance supervision and regular meetings with other managers from within the provider's group were held. The manager told us they received sufficient financial support from the provider and where required funding was available for equipment and decorating the service.

The manager was aware of their obligations in relation to the notifications they needed to send to the Commission by law. Information we held about the service demonstrated that most notifications had been sent when required. During a review of the DoLS authorisations it was evident that some authorisations had been granted prior to the current manager having an active role in the DoLS application process. As a result of this, the number of DoLS authorisation notifications sent to the Commission was not consistent with the number of authorisations identified as being in place. The manager followed this up during the inspection.

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 17 HSCA RA Regulations 2014 Good governance Accurate and complete records were not always maintained