London Residential Healthcare Limited

Belmont Castle Care Home

Inspection report

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Ratings

Overall rating for this service	Requires improvement
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?	Requires improvement

Overall summary

This inspection took place on 4 and 5 November 2015 and was unannounced.

Belmont Castle Care Home is registered to provide accommodation and personal care services for up to 40 older people and people who may be living with dementia or a physical disability. At the time of our inspection there were 35 people living at the home. They were accommodated in a converted and expanded historic building and grounds. There was a variety of shared sitting and dining areas. People had single rooms except for one couple who had a double room.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are "registered persons". Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

It was clear from our discussion with them that people living at Belmont Castle Care Home and their families were very happy with the quality of service they received. We saw examples of care and support that were very good. The registered manager and staff were motivated to make sure people had a positive experience of care. However, we found areas for improvement were needed in record keeping and legal requirements around mental capacity assessments.

Summary of findings

The provider had arrangements in place to protect people from risks to their safety and welfare, including the risk of avoidable harm and abuse. Staffing levels were sufficient to support people safely and in a calm, professional manner. Recruitment processes were in place to make sure only staff who were suitable to work in a care setting were employed. Arrangements were in place to store and administer medicines safely.

Staff received suitable training and support, although training records were not complete. Staff sought people's consent for their care and support. However records of mental capacity assessments did not show that the service always acted according to the legal requirements where people lacked capacity.

The provider had made substantial changes to the décor and fabric of the building to help meet the needs of people living with dementia and to provide an interesting, vibrant atmosphere. Staff made efforts to make meal times an enjoyable experience, and encouraged people to eat and drink enough. Visiting healthcare professionals were complimentary about the service and records showed people had access to healthcare services when they needed them.

Staff had established caring relationships with people. They respected their individuality and dignity. Staff encouraged people to participate in decisions about their care and support.

People's care and support were based on assessments and plans which took into account their needs, preferences and wishes. The provider had processes in place to review people's care and check they received care according to their plans. There was a varied programme of activities and leisure interests which took into account people's individual interests and preferences. There was a complaints process and complaints were followed up and investigated.

There was an open, friendly and positive atmosphere in the home. The registered manager encouraged team work and motivated their staff. Staff responded to their management style and felt empowered to make suggestions. The management system operated effectively apart from in the area of records management where we found inaccurate, incomplete and unnecessary records which meant people were at risk of inappropriate care. Systems were in place to monitor, assess and improve the quality of the service.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the end 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?
The service was safe.

People were protected against risks to their safety and welfare, including the risks of abuse and avoidable harm.

There were sufficient staff to support people safely, and the provider undertook checks to make sure staff were suitable to work in a care setting.

People were protected against the risks associated with medicines, and medicines were stored safely.

Good

Is the service effective?
The service was not always effective.

The provider did not consistently apply the principles of the Mental Capacity Act 2005 where people lacked capacity to consent to their care.

People were supported by staff who had the necessary skills and support to do the job. People were encouraged and assisted to eat and drink healthily, and had access to healthcare services when they needed them.

People lived in an environment which had been decorated and adapted with their needs in mind.

Requires improvement

Is the service caring?
The service was caring.

People were supported by staff who took care to establish friendly relationships with them, who respected their dignity and who treated them as individuals.

People were able to express their views and take part in decisions about their care and support.

Good

Is the service responsive?
The service was responsive.

People received care which met their needs and took into account their preferences.

People could take part in leisure activities according to their interests and wishes.

Complaints were followed up and investigated.

Good

Is the service well-led?
The service was not always well led.

Requires improvement

Summary of findings

People were at risk of unnecessary or inappropriate care because accurate and necessary records were not always kept.

People were supported in an open, empowering environment by motivated staff.

People and their families were able to participate in processes to monitor, assess and improve the quality of the service.

Belmont Castle Care 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 checked whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, looked at the overall quality of the service, and provided a rating for the service under the Care Act 2014.

The inspection took place on 4 and 5 November 2015 and was unannounced. The inspection team consisted of an inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed information we had about the service, including previous inspection reports and notifications the provider sent to us. A notification is information about important events which the provider is required to tell us about by law. Before the inspection, the provider completed a Provider Information Return. 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 spoke with 12 people who lived at Belmont Castle Care Home and nine visitors. We observed care and support people received in the shared areas of the home, including part of a medicines round.

We spoke with the registered manager, the registered provider, the operations support manager, the head of care and other members of staff, including three care workers and members of the housekeeping, maintenance and catering teams. We also spoke with a visiting GP and district nurse.

We looked at the care plans and associated records of six people. We reviewed other records, including policies and procedures, internal checks and audits, quality assurance survey results training and supervision records, meeting minutes, newsletters and information provided to staff. We looked at the recruitment records for five staff members.

Good

Is the service safe?

Our findings

People told us they felt safe and that there were enough staff to look after them according to their needs and to respond promptly if necessary. One person slept with their bedroom door locked for greater privacy. They said they felt safe because staff also had a key and could open the door in an emergency. They were confident staff would respond quickly if they used their call bell.

One visiting relation said, "Mum is a lot safer here than she was at home because she kept falling over and not telling people." Staff had put measures in place to reduce the risk of the person falling. There had been no recent falls, and the person's relation said, "Mum says they (staff) watch her like hawks."

We saw examples of interactions between staff and people which showed staff were concerned for their safety. When a person wanted to move around the home using their frame, staff made sure their route was clear of obstacles before guiding them where they wanted to go. They did this in a discreet manner to make sure the person was safe.

The provider took steps to protect people from the risk of avoidable harm and abuse. Staff were kept aware of the types of abuse, the signs and indications of abuse, and how to report them if they had any concerns. There were leaflets and posters about safeguarding and whistle blowing in the staff room. The registered manager told us they kept staff's awareness current by discussions at staff meetings with role playing scenarios. None of the staff we spoke with had seen anything which caused them concern, but they were confident any concerns would be handled promptly and effectively by the registered manager. Staff told us they were aware of the provider's whistle blowing policy.

The registered manager was aware of processes to follow if there was a suspicion or allegation of abuse. They had discussed incidents with the local safeguarding authority, but none had been categorised as a safeguarding concern. Suitable procedures and policies were in place for staff to refer to. Visiting healthcare professionals told us they had seen nothing which would have caused them to have concerns about people's safety.

People were kept safe by appropriate risk assessments, for instance with respect to falls or pressure injuries. Staff used a standard tool to assess people's risk of acquiring a pressure injury. Their care plans took account of these risks for instance by specifying an airflow mattress and making adjustments to people's diet. One person was assessed as a high risk for falls. Staff had discussed this with the person and their family and put measures in place including the use of a pressure mat by their bed to alert staff if the person stood up. Staff reminded the person to use their call bell if they wanted to move, and checked on them every 30 minutes to reduce the risk of them trying to move without assistance. Another person was diagnosed with a long term lung disease. Their care plans included an assessment of the risk of them becoming short of breath. There was guidance for staff to avoid this happening, and what to do if the person had difficulty breathing.

Plans were in place to keep people safe in an emergency. People had a personal evacuation plan which outlined the help they would need if the home was evacuated. Staff had guidance in the form of a leaflet of what to do in the event of a fire. There were signs to show escape routes, and the registered manager told us they had installed new fire doors following a recent fire risk assessment.

There were sufficient numbers of suitable staff to support people and keep them safe. People were satisfied there were enough staff, and staff told us their workload was manageable. The registered manager told us staffing levels were based on people's needs and dependency. They had recently increased the number of night staff to improve the safety of people overnight. We saw staff were able to carry out their normal duties and respond to an unexpected event in a calm, professional manner.

The provider carried out the necessary checks before staff started work. Staff files contained evidence of proof of identity, a criminal record check, employment history, and good conduct in previous employment.

Medicines were stored and handled safely. We observed part of a medicines round. Staff observed suitable hygiene practices. They encouraged people to take their medicines, explaining what they were and what they were for. They made sure the person had swallowed their medicine and thanked them before moving on to the next person. Tablets and capsules were administered from blister packs. Medicines in other containers such as bottles and eye drops were kept in containers clearly marked with the person's name. Staff recorded the date bottled medicines had been opened so they could make sure they were used in line with the manufacturer's guidance.

Good

Is the service safe?

People's medicine administration records were accurate and up to date, although duplicate records kept in people's rooms for prescribed creams and ointments were not kept to the same standard. There was a list of staff who had been signed off as competent by the registered manager to administer medicines. Where people were prescribed medicines to take "as required" there were specific instructions for staff. Staff noted the time and dose administered for "as required" medicines which meant there was a full record of what people had taken. Staff checked each other's recording of medicines.

Requires improvement

Is the service effective?

Our findings

People were satisfied staff were trained and had the necessary skills to support them according to their needs. They said they liked the food and had access to their GP and other healthcare services when they needed them. They told us mealtimes were an enjoyable, social time. One person was particularly complimentary about the food. They were pleased their meal had been kept warm for them when they were late back from a trip out with their family. A visitor told us they were "impressed" by the staff's skills.

The registered manager described the training programme they implemented. They kept their own skills up to date by attending courses and passed the information on to staff. Subjects covered in this way included equality and diversity, dementia care, mental capacity and deprivation of liberty. There were regular refresher sessions for mandatory topics such as moving and handling, food hygiene, first aid, safeguarding and infection prevention and control. If the manager identified a particular training need they arranged a one hour workshop with staff to cover it. All staff had a relevant qualification or diploma.

Staff told us they found the training they received was sufficient to provide them with the skills they needed. However, records of training courses such as certificates of completion were not always kept in their files.

Staff told us they felt supported to provide a service that met people's needs by both informal and informal supervision. The registered manager delegated formal supervisions to senior staff members. There were records of supervisions in staff files. They covered performance, future targets, training needs and other subjects the staff member wanted to bring up. The manager kept in touch with staff members' progress through their annual appraisals, staff team meetings and informal contact.

Staff sought people's consent for care and support. Where people were able to consent, this was documented in their care plans. People signed their consent forms if they were able to do so. We observed staff explaining to people what they were about to do and asking for consent before they went ahead.

The Mental Capacity Act 2005 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 the least restrictive 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 Act. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the Act, and whether conditions on authorisations to deprive a person of their liberty were being met.

We found the service was inconsistent in its application of the Act. Staff used a form provided by the local authority to record capacity assessments. The form guided them to carry out a two-step assessment which was decision specific. They recorded how people were given opportunities to show they had capacity, and their mental and emotional state at the time of the assessment.

The service had applied for authorisation under the DoLS, but the applications were still being considered by the local authority at the time of our visit.

However, we found two cases where a mental capacity assessment was carried out when there was no reason to suspect the person lacked capacity. This was contrary to the principle that people should be assumed to have capacity.

We found one case where the service had applied for authorisation under the DoLS, but had not carried out a mental capacity assessment. One person had two capacity assessments for specific decisions but not for a third, whether to administer medicines crushed and disguised in their food, although this had been agreed with their GP and documented in their care plan. The provider did not always assess people's capacity before making a decision in their best interests.

Failure consistently to apply the principles of the Mental Capacity Act 2005 was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

Staff took care to make meal times a positive experience for people. There were set meal times, which helped people living with dementia understand the time of day, but

Is the service effective?

people could eat at any time they wanted to. The registered manager told us one person preferred to have five small meals a day, and they were able to accommodate their preferences.

The day's menu was available on the tables in the dining area, and offered a wide range of choice. When served, lunch was as described, and the food looked and smelt appetising. People were offered a choice of drink, including lemon or blackcurrant juice or a small sherry. There was a lot of conversation which made the meal an enjoyable, social time. Tables were decorated with flowers and condiments were available, which contributed to the homely atmosphere. Staff served dessert from trolleys, which made it easy for people to make a choice at the time. Between meal times, cakes, biscuits, sweets, fruit and drinks were freely available and enjoyed by people.

Staff helped people to eat and drink enough. Where staff assisted people to eat, they sat at the table and ate the same meal or assisted the person more discreetly in a quieter area of the home. The registered manager told us this was according to people's preferences. The kitchen had information about people's food preferences, any allergies and the sort of assistance they needed at meal times. When one person had started to lose weight and lost their appetite, staff had tried encouraging them with recipes from their native country, and had used translation cards and a language dictionary to help the person understand their menu choices.

In order to maintain their good health, staff helped people access healthcare services. The registered manager told us the service had a good relationship with the community mental health team and the local GP practices. Records showed people had appointments with and visits by their GP, district nurse, dentist, dental hygienist and other healthcare providers.

Visiting healthcare providers found the service to be cooperative. They said they were called appropriately, and staff listened to their advice and carried it through into people's care plans..

The provider had adapted the home to support the needs of people living with dementia. Signs to help people orientate themselves used words and pictures. There were items and pictures to promote reminiscence at various points through the home and there were reminiscence boxes outside people's rooms. Jigsaw puzzles in a games room were kept complete because the subject of the picture could trigger memories for people.

Shared areas gave people a wide choice of decoration and atmosphere. There was a quiet room or library with books and a larger shared lounge with a television. The registered manager told us the television in this room was only used at breakfast time and in the evening if people wanted to watch a particular programme.

There was a small kitchen and dining area decorated with a collage of famous movie stars. We saw people helping to lay the tables and clear up in this area. Another area of the home had been decorated to look like the terrace of a café and had a CD of bird song playing. The main dining area had a corner furnished with domestic laundry equipment. Another area was decorated with a nautical theme. The registered manager told us this prompted people to reminisce about their holidays.

The grounds of the home had been adapted. There was an aviary and a fish pond. One area was designated a relaxation garden, and there was another area where people could have a small allotment to grow plants if they wished. One person with a room on the ground floor had plants on a terrace outside their room which they looked after. There was an area of decking with shade where people told us they sat out when the weather was better. This overlooked another area which was being adapted to look like a beach with brightly coloured beach huts. The registered manager said they had been aware that there was not much to look at from the decking, so they were developing the area to provide more interest.

Good

Is the service caring?

Our findings

There were caring relationships between people and staff who supported them. A family member visiting their relation said, "Mum settled in really quickly. She always says how nice the girls are. She likes the food. She has not complained about one thing. When we take her out she is always glad, relieved, to get back". Another visitor said, "My mother is always pleased to see [care worker's name] or any of the other girls." Other visitors said the service was "amazing, individual like home" and "Mum adores the carers."

People told us they treated the staff as friends. They could have a joke and banter with them. One said they could ask for anything they wanted and "they don't make you feel like a nuisance". Staff were aware of people's families and life histories, and used this knowledge to have meaningful and relevant conversations with them.

We saw examples of positive interactions between staff and people. Staff used an appropriate level of voice and made sure the person they were talking with could make eye contact. During our visit a person was taken unwell. Staff dealt with the incident calmly and professionally. They used temporary screens to maintain the person's dignity. One member of staff stayed with the person to reassure them, while other staff reassured other people and helped them move away. Staff made sure nobody else was disturbed by the incident, and they could carry on with their own activities.

Staff were attentive to people and their moods. A staff member noticed a person had not drunk their tea. They checked whether it was strong enough for the person's taste and replaced it with a stronger cup. Another staff member noticed a person was not wearing their glasses, and they went and found them. Another person did not want to speak or interact with a member of staff. The staff member went away for a period of time and tried again. The person still did not want to speak with them. We later saw the same staff member sat with the person and chatting with them. During lunch we saw a staff member offer to help a person eat. They declined the offer, which the staff member respected, and after explaining what was on the person's plate, they left them to eat at their own speed.

Staff involved people in decisions about their day to day care. There was key worker system in place which meant people and their families had a named person to talk with about any aspects of their care. A "champions" system meant there were identified members of staff who people and their families could talk to about specific topics such as dignity or nutrition.

If they needed to move furniture around, for instance to make room for a particular activity, staff explained what they were doing and checked if it was all right with the people sat nearby. People brought their own furniture and belongings to personalise their rooms, and one person told us they had been able to choose the colour when their door was repainted.

When staff reviewed people's care every month, they involved the person and their family if appropriate. There was a section in the review form to record the person's own thoughts about their care. The registered manager told us people were "in control" of their own care, and gave us examples of where people could make choices. These included choices about how many meals they had each day, what time they ate, and how soon after one meal they could have another.

People's privacy and dignity were respected. There were a number of areas in the home in addition to their rooms where people could sit quietly with visitors. Staff told us they considered themselves to be visitors in people's home. We saw interactions that were always polite and considerate. When people said certain things, staff did not contradict them, but continued the conversation on the same terms. For instance, when a person said they had cooked the dessert at lunch, a staff member went on to talk with them about what they liked to cook, and which dishes their children liked most. Another person was comforted by carrying a doll around. The registered manager said they had the doll in their room at night and slept better as a result. If there was a risk a person's behaviour might upset other people, staff distracted the person and led them away to do something else. We heard one staff member asking a person advice about gardening, which showed they valued them for their knowledge and experience. Staff respected people's individuality and listened to them. The manager said, "Nobody is the same."

One person told us they were a theology teacher and were registered to take religious services. They said, "I do not do it now, but I can attend services and communion when I

Good

Is the service caring?

want." The registered manager confirmed people were able to attend religious services, but nobody living at the home had particular needs arising from their religious or cultural background.

Good

Is the service responsive?

Our findings

People received care and support that met their needs and took into account their wishes and preferences. One person said, "I meet people at breakfast and lunch time. It is a nice community, like a hotel." Another person said, "I like it here because we are under no pressure to do anything."

When asked, people could not think of anything they wanted to change about the home. They told us they had no reason to complain, but if they did they "would talk to one of the girls".

People's families were equally positive about the care and support their relations received. One visitor said, "Everything is now sorted out, like personal care etc." They went on to say, "Because [Name] is happy here, she eats well." Families gave us examples of people who had regained weight lost before they came to live at the home, and of people whose behaviours indicated they had become more settled since moving in.

People's care and support were based on assessments and plans that took into account their preferences, needs and medical conditions. Care plans took into account people's individual personality. They contained information about the person in a preferences questionnaire and their preferred daily routine. Standard tools were used to assess people's risks associated with activities of daily living and of acquiring a pressure injury. Where risks were identified, this was translated into the person's care plan, for instance by using an airflow mattress to relieve pressure areas. Where people were unable to describe if they were in pain, a standard tool was used to assess this. We saw that people were offered pain relief when it was indicated as required. Records were in place to show where people had made advance decisions about their care.

Staff completed daily logs of care delivered and records of activities people took part in. Where individual care plans required regular interventions, for instance where a person was at high risk of falls and should be checked every half hour, staff kept appropriate records. There were monthly reviews of people's care and support which covered 16 aspects of care, including medication, pain and comfort, skin integrity and breathing. The reviews noted if planned outcomes were achieved, and recorded people's satisfaction with their service, where possible in their own words. The registered manager checked the daily logs and monthly reviews were completed regularly.

People had positive outcomes from their care and support. One person's records showed they had once experienced nine falls in a month. Following the implementation of their care plan, this had reduced to one fall in the previous month. Visitors told us they found people's care was tailored to them as individuals and where people were living with dementia, their care took into account their individual response to their dementia. One family member said, "I can't speak highly enough" of the care their relation received. Another visitor said they would put the home in their top five, and that they observed staff "handled dementia well".

People's relations said there were a variety of activities and excursions designed to stimulate people. One visitor said, "There is more variety, places to go." The home had a library, magazines and daily papers available. There were activities throughout the day both individual, for instance puzzles and colouring, and group activities, for example people making Christmas cards.

People could maintain interests such as gardening or by looking after the home's minibus. One person told us they liked to help the housekeepers keep their room clean and tidy. People helped prepare dining areas for meals and clear up afterwards. Where people could no longer actively participate in certain activities, such as horse riding, there were photographs of them to help them remember.

There were frequent conversations and interactions between people and between people and staff. Staff used planned activities, such as a quiz, to stimulate conversation and reminiscences. There was a programme of planned activities displayed on a wall, which included external services such as a visiting hairdresser and a Pets as Therapy dog. However, staff told us this was used as a guide only, and activities depended on what people wanted to do on a particular day. A person's relation confirmed this. They said, "There is no fixed routine. It is all about Mum." Their mother enjoyed musical activities, walking in the garden and having their hair done. Another visitor said, "We often struggle to get [Name] out of activities because she enjoys them so much. She looks younger than when she first arrived here."

Good

Is the service responsive?

There was a complaints process in place. The registered manager told us they had an “open door” policy, and preferred to handle concerns informally before people felt the need to make a formal complaint. They came into the home at weekends so they could meet people’s relations who could not visit during the week.

Records were available to show complaints were followed up and investigated, including copies of records during the investigation, for instance staff rotas, care records and communications from the registered manager to staff. Although the records were available in different locations, the manager did not have a single complaints log or file on the first day of our inspection. However, they were able to pull all the records together into one file before the end of the inspection. This would allow them better to identify any trends or patterns that might arise from complaints.

Requires improvement

Is the service well-led?

Our findings

There was an open, friendly atmosphere at the home. Among the comments made by visitors were: "It is very relaxed here." "The staff are always happy to talk and are always cheerful." "I can come and go as I please. If I am here at lunch, I am offered some." and "I do not want to go home."

The registered manager was aware they depended on their staff to deliver the standard of care people experienced. They had a philosophy of "the resident comes first", and were proud of the staff team they had developed. They told us of various techniques they used to keep staff morale high. These included an employee of the month scheme and treats, such as a takeaway food evening. The manager said they tried to involve staff, people and their families in "one team". They invited family members of people no longer living at the home to stay in touch and comment on the service. They said, "Everything is open. There is no blame." Staff told us they found the manager "took things seriously", and was "always available" and "open to ideas".

The registered manager was supported by a head of care, a head team leader and care team leaders. Their management system included daily checkpoints with these senior staff and those responsible for catering, housekeeping, activities, administration and maintenance. There were more formal clinical review monthly meetings with the head of care and head team leader. Other monthly meetings, for instance with housekeeping and catering heads of department were not always formally minuted. Staff told us they in turn had regular communication meetings with their team leaders and the head of care. This was supplemented by a staff newsletter which was used to communicate trends in the service and to prompt staff about relevant policies. A recent increase in the number of falls had led to a review of the provider's prevention of falls policy.

There was not an effective management system for records management. The registered manager had an overview record of staff training status, but it was not kept up to date. Individual records, such as course completion certificates, were not always kept in staff files. This meant the registered manager could not be certain staff had attended mandatory refresher training to keep their skills up to date.

In two cases where people had prescribed creams and ointments there were duplicate and incomplete records. Records kept in the medicines file were up to date and complete. However, records kept in people's rooms were incomplete and not up to date. In one room there were forms for a medicine the person was no longer receiving. People were at risk of not receiving their creams and ointments as prescribed because the records were inconsistent.

In four cases, records of people's food and fluid intake were incomplete. There were gaps in recording, the records did not make clear the person's target intake and total amounts were not recorded. Where there was a variation in a person's recorded intake, there were no records to show this information had been used to assess if a change to their care plan was required. When we discussed this with staff they told us they were not aware of any continuing clinical need for people to have their food and fluids monitored. The records had been kept in place when they were no longer necessary, which meant the records did not reflect decisions made about people's care and people were at risk of inappropriate care.

Failure to maintain accurate records was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider supported the registered manager through regular visits by the operations support manager and other senior management. The managing director visited every three months to meet with people and their relations. Feedback from these meetings had led to the provision of a computer to enable people to contact their families using an online video application. This was being installed during our visit.

The registered managers within the provider's organisation had both formal and informal support networks. These consisted of regular face to face meetings every three months and less formal contact through conference calls and learning from each other's experiences.

There were monthly meetings with people using the service. The minutes of a recent meeting showed 12 people had attended, and items discussed included people's care, consent, safety, food and drink, laundry, maintenance, complaints and activities. All of the feedback from people

Requires improvement

Is the service well-led?

was positive and satisfactory. The registered manager told us these meetings had been used in the past to raise concerns about noise at night and problems with the laundry which had been addressed.

Systems were in place to monitor, assess and improve the quality of service provided. The registered manager made a monthly report to the provider. They told us this had, for instance, led to an increase in staffing levels when there had been an increase in the number of falls reported.

There were regular checks and audits undertaken by the registered manager and senior staff. These covered care plans, medicines management, infection control, catering, and health and safety. Recent records showed these had identified no actions to follow up. The manager said they carried out an informal check by walking round the home every day, and minor items discovered were dealt with straight away.

The internal checks were supplemented by reviews by other registered managers in the provider's organisation and regular monitoring visits by the operations support manager. These covered occupancy, any issues, staffing, care plans, medicines, kitchen, mealtimes, infection control, grounds and gardens, complaints and safeguardings. Any actions were followed up via the registered manager and checked at the next visit.

The provider surveyed people's families regularly and made the outcome of the survey known to the registered manager. The most recent report had shown a slight drop in the home's overall satisfaction percentage, and the manager was taking steps to improve communications with people's families, particularly by email. The surveys covered reception, environment, cleanliness, staff, leisure time and activities, diet, attention to needs and overall quality of service. In the most recent survey, two respondents had given a score of "good", eight "very good" and nine "excellent".

People and their families were encouraged to use a public online facility to record their satisfaction with the service they received. The registered manager read these and was aware there had been almost 100 reviews posted. We sampled some and found they were all positive. One person had commented, "I am a contented resident. The staff are miraculous."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Where service users lacked capacity to consent, the registered person did not act in accordance with the Mental Capacity Act 2005. Regulation 11 (1) and (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person did not maintain accurate and contemporaneous records in respect of each service user. The registered person did not maintain other records necessary to be kept in relation to persons employed in the carrying on of the regulated activity. Regulation 17 (1) and (2) (c) and (d)(ii)