Care Quality Commission

Platinum Care Homes Limited

Church View Care 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?	Good
Is the service well-led?	Requires improvement

Overall summary

The inspection of Church View Care Home took place on 30 September 2015 and was unannounced.

Church View Care Home is a care home which provides accommodation and nursing care for up to 78 older people, some of whom are living dementia. At the time of our inspection there were 74 people who lived there. The home is purpose built and set over three floors, with a passenger lift to all floors. The home is divided in to six units with a variety of communal areas including lounges, dining rooms, and quiet areas.

At the time of our visit there was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.'

People were supported by staff that had the necessary skills and knowledge to meet their assessed needs. However during the inspection we identified a concern around how competent staff were when moving and handling people safely in and around the home. Staff did not always adopt best practice in the use of moving and handling people safely around the home.

Summary of findings

Risk assessments in place, however we noted that there were inconsistencies in the recording of risks associated with people using bed rails, covert medicines and developing pressure sores. This meant that people were placed at risk of harm as appropriate guidance and best practice was not always followed.

There were quality assurance systems in place, to review and monitor the quality of service provided, however they were not robust or effective at correcting poor practice.

People told us they felt were safe at the home, one person told us, "I feel safe here and the girls look after me and I do not have to worry about anything." Staff had a good understanding about the signs of abuse and were aware of what to do if they suspected abuse was taking place.

Recruitment practices were safe and relevant checks had been completed before staff commenced work and we found that there were enough staff to safely support people and help keep them safe. Staff worked within good practice guidelines to ensure people's care, treatment and support promoted a good quality of life. People received their medicines when they needed them and the administration and storage of them were managed safely. Any changes to people's medicines were prescribed by the person's GP.

Staff had basic understanding of Deprivation of Liberty Safeguards (DoLS) or the Mental Capacity Act (MCA) or their responsibilities in respect of this. Mental capacity assessments and DoLS applications had not been fully completed in accordance with current legislation. We made a recommendation to the provider to review their documentation in line with current legislation.

People had enough to eat and drink throughout the day and night and there were arrangements in place to identify and support people who were nutritionally at risk. People were supported to have access to healthcare services and were involved in the regular monitoring of their health. The home worked effectively with healthcare professionals and was proactive in referring people for treatment.

Staff involved and treated people with compassion, kindness, dignity and respect. People told us, "The staff are very caring here because they like their job and they are nice people." People's preferences, likes and dislikes had been taken into consideration and support was provided in accordance with people's wishes. People's relatives and friends were able to visit. People's privacy and dignity were respected and promoted. Staff told us they always made sure they respected people's privacy and dignity when providing personal care.

The home was organised to meet people's changing needs. People's needs were assessed when they entered the home and on a continuous basis.

People told us if they had any issues they would speak to the staff or the registered manager. People were encouraged to voice their concerns or complaints about the service and there were different ways for their voice to be heard. Suggestions, concerns and complaints were used as an opportunity to learn and improve the service provision.

People had access to activities that were important and relevant to them. People were protected from social isolation with the activities, interests and hobbies they were involved with. Staff supported people with their interests and religious beliefs in their local community. Religious services were conducted weekly at the home.

The provider actively sought, encouraged and supported people's involvement in the improvement of the service. People's care and welfare was monitored regularly to make sure their needs were met within a safe environment. The provider had systems in place to regularly assess and monitor the quality of the service provided.

People told us the staff were friendly and management were always visible and approachable. Staff were encouraged to contribute to the improvement of the service. Staff told us they would report any concerns to their manager. Staff told us the managers of the home were very good and supportive.

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 back of the full version of this 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 consistently safe.

People were placed at risk as appropriate guidance and best practice was not always followed.

People had risk assessments based on their individual care and support needs. However, there were inconsistencies in the recording of risks to people.

There was a consistent staff team that people knew and they supported the delivery of consistent care. Recruitment practices were safe and relevant checks had been completed before staff commenced work.

There were effective safeguarding procedures in place to protect people from potential abuse. Staff were aware of their roles and responsibilities.

People received their medicines on time and they were administered and stored safely by trained and competent staff.

Is the service effective?

Requires improvement

The service was not consistently effective.

Staff had basic understanding of Deprivation of Liberty Safeguards (DoLS) or the Mental Capacity Act (MCA) or their responsibilities in respect of this. Mental capacity assessments and DoLS applications had not been fully completed in accordance with current legislation.

People's care, treatment and support promoted their well-being and there was good communication with healthcare professionals.

People were supported by staff that had the necessary skills and knowledge to meet their assessed needs.

People had enough to eat and drink throughout the day and night and there were arrangements in place to identify and support people who were nutritionally at risk.

People were supported to have access to healthcare services and were involved in the regular monitoring of their health. The service worked effectively with healthcare professionals and was pro-active in referring people for treatment.

Is the service caring?

Good

The service was caring.

Staff involved and treated people with compassion, kindness, dignity and respect.

Summary of findings

Interactions between staff and people who used the service were kind and respectful. Staff were happy, cheerful and caring towards people.

People's preferences, likes and dislikes had been taken into consideration and support was provided in accordance with people's wishes. People's relatives and friends were able to visit.

People's privacy and dignity were respected and promoted. Staff told us they respected people's privacy and dignity when providing personal care.

Is the service responsive?

Good

The service was responsive.

The service was organised to meet people's changing needs.

People's needs were assessed when they entered the service and on a continuous basis. Information regarding people's treatment, care and support was regularly reviewed.

People had access to activities or interests that were important to them and were protected from social isolation through the range of activities available within the home and community.

People were encouraged to voice their concerns or complaints about the service and there were different ways for their voice to be heard.

Is the service well-led?

Requires improvement

The service was not consistently well- led.

Quality assurance checks were not always robust or effective to ensure that the safe practices were followed by staff.

Records were not always kept up to date or contain relevant information for staff.

The provider actively sought, encouraged and supported people's involvement in the improvement of the service.

People who used the service told us the staff were friendly, supportive and management were always visible and approachable.

Staff were encouraged to contribute to the improvement of the service and could report any concerns to their manager who was very supportive.

Church View 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 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 30 September 2015 and was unannounced.

The inspection team consisted of three inspectors, a specialist advisor and an expert by experience. Our expert-by-experience was a person who has personal experience of caring for someone who has dementia.

Before the inspection we gathered information about the service by contacting the local authority safeguarding and quality assurance team. We also reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the home, what the home does well and improvements they plan to make.

During our inspection, we spoke to 27 people who lived at the home, 14 relatives, 13 staff, the general manager and registered manager about the service. We observed how staff cared for people, and worked together. We observed care and support in communal areas and we looked at some of the bedrooms with people's agreement. We also reviewed records about people's care, support and treatment and the provider's quality assurance and monitoring systems.

At the last inspection on 12 May 2014 there were no concerns found.

Requires improvement

Is the service safe?

Our findings

People told us they felt safe at the home, comments made were, "I feel safe here and the girls look after me and I do not have to worry about anything." "I'm very happy here. I feel safe and sound and the company is good, there are always people to see that you are alright. " A relative told us, "I can go to work and know that she is safe."

However during the inspection we identified a concern around how competent staff were when moving and handling people safely in and around the home. Staff did not always adopt best practice in the use of manual handling, when supporting one person to sit up in bed for their meal in a safe way. Staff did not explain to the person what they were going to do and caused the person some discomfort whilst the move was taking place. As this incident could have caused this person serious harm, we asked the manager to make a safeguarding alert to the local authority, which they did. Appropriate action was taken by the management team to ensure that the person was safe. We saw other incidents of inappropriate moving and handling techniques undertaken by staff during the inspection. This meant that people were not always supported by competent staff to conduct safe practices when moving people in the home.

Although there were risk assessments in place, we noted that there were inconsistencies in the recording of risks associated with people using bed rails and covert medicines. Bed rails are used to reduce the risk of falls when people are in bed. Covert medicines is a practice of deliberately disguising medicines usually in food or drink, in order that the person does not realise that they are taking it. This meant that people were placed at risk of harm as appropriate guidance and best practice was not always followed.

Where people were at risk of developing pressure sores there was a plan in place to reduce this risk which were followed by staff. For example by using pressure mattresses or pressure cushions. However when we checked six mattress settings we noted that they were too high for the person's weight. This meant that the optimum level was not always provided to give comfort and relieve pressure on susceptible areas prone to pressure ulcers. We raised these issues with the clinical lead who reviewed the settings and adjusted them.

Failure to ensure staff provided safe care to people is a breach in Regulations 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were knowledgeable about people's needs, and how to care for people who were distressed or at risk of harm. Risk assessments detailed the support needs, views, wishes, likes, dislikes and routines of people. Risk assessments and protocols identified the level of concern, risks and how to manage the risks. For example information was recorded about how to provide support to people who were prone to falls, people who needed to be turned and repositioned to alleviate pressure on susceptible areas of the body and people being feed through tubes. The information provided enabled care and treatment to be planned in accordance to people's needs.

Fire safety arrangement and risk assessments for the environment were in place to help keep people safe. The home had a business contingency plan that identified how the home would function in the event of an emergency such as fire, adverse weather conditions, flooding and power cuts. The provider had identified alternative locations which would be utilised if the home was unable to be used. This would minimise the impact to people if emergencies took place.

We observed information displayed regarding the Fire Evacuation plan. We saw in people's care plan a 'Personal Emergency Evacuation Plan' had been completed. This meant that staff had information on how to support people in the event of an evacuation.

Where people had mobility needs or were susceptible to falls or injuries, information was recorded to help minimise these. We noted that handrails were placed throughout the home to support people's independence.

The service had the most recent Surrey County Council (SCC) multi agency safeguarding policy. This provided staff with guidance about what to do in the event of suspected abuse. Staff confirmed that they had received safeguarding training within the last year. Staff knew how to report concerns if they witnessed abuse or poor practice and told us they would feel confident in doing so if necessary. A member of staff told us, "If I saw something going on I would say something and report it. I would never ignore it." We saw incidents and safeguarding had been raised and dealt with and notifications had been sent to CQC in a timely manner.

Requires improvement

Is the service safe?

There was a staff recruitment and selection policy in place and followed. All applicants completed an application form which recorded their employment and training history. The provider ensured that the relevant checks were carried out as stated in the regulations to ensure staff were suitable to work with adults at risk. We saw from the records that staff were not allowed to commence employment until satisfactory disclosure and barring checks and references had been received. All new staff attended induction training and shadowed an experienced member of staff until they were competent to carry out their role.

People had mixed comments about whether there were enough staff on duty, A person told us, "They do their best within the constraints of staffing but at times they are too busy." Another person told us, "It would be better if there were more staff and they had more time to sit and talk to you." A third person told us, "I always have a call bell and they work OK. People usually get to me quickly but there are times when I have had to wait." A relative said, "Weekends are very bad for staffing no management around at all."

However we found there was sufficient number of staff to keep people safe, the consistent staff team were able to build up a rapport with people who lived at the home. This also enabled staff to obtain an understanding of people's care and support needs. The staffing rotas were based on the individual needs of people. The registered manager informed us that staffing levels were determined based on people's assessed needs, if changes in people's needs occurred then staffing levels would be reviewed. This included, supporting people to attend appointments and activities in the community. We noted on the day of our visit, that people's needs were met promptly and they were given support throughout the day.

People told us**,** "I get medication when I expect it.", "They are ask me if I am in pain and do I want any painkillers." and "The staff stop and check I take it."

Only staff who had attended training in the safe management of medicines were authorised to administer them. Staff attended regular refresher training in this area and after completing this training, managers observed staff administering medicines to assess their competency before they were authorised to do this without supervision. When staff administered medicines to people, they explained the medicine to them and why they needed to take it. Staff waited patiently until the person had taken the medicine. Staff knew the importance of giving medicines on time and the reasons why this was important to reduce the risk of side effects. We observed staff asking a person if they were in any pain and would they like something for it. They declined the offer.

A medicines profile had been completed for each person, and any allergies to medicines recorded so that staff knew which medicines people received. The medicines administration records (MAR) were accurate and contained no gaps or errors. A photograph of the each person was present to ensure that they were giving the medicine to the correct person. There were guidance for people who are on PRN [as needed] medicines. Records indicated the amount of medicine people were given. Medicines were stored securely. All medicines coming into the home were recorded and medicines returned for disposal were recorded in a register. Medicines were checked at each handover and these checks were recorded.

The home was clean. One person told us, "It is lovely and clean here. They clean my room every day. I love my room." There were procedures in place for staff to follow cleaning schedules and record cleaning tasks performed. Staff were in uniform and 'bare below the elbow'. This allows staff to wash their hands more effectively which helps reduce the risk of spreading infections. Staff were also seen wearing personal protective equipment such as gloves and aprons and there was hand wash, paper towels and antibacterial gel available throughout the home which also helped prevent cross infection.

Requires improvement

Is the service effective?

Our findings

Staff had a basic understanding of their responsibilities under the Mental Capacity Act 2005 (MCA), and the Deprivation of Liberty Safeguards (DoLS). The MCA is a legal framework about how decisions should be taken where people may lack capacity to do so for themselves. It applies to decisions such as medical treatment as well as day to day matters. People whenever possible should be enabled to make decisions themselves and where this is not possible any decisions made on their behalf should be made in their best interests. We reviewed the provider's records and saw that staff had received training in the MCA.

A person told us, "They always ask me before giving me any help and they listen to me." We saw staff obtained consent before carrying out any tasks for the person, for example in relation to care being offered. Staff had a clear understanding for the need to obtain consent for day to day decisions and knew where people lacked capacity who was able to make important decisions in their best interest. However, when we reviewed mental capacity assessments not all of them were completed to see if people could make the decision for themselves or who was able to make decisions on their behalf. This meant that where people lacked capacity they were not fully protected and best practices were not being followed in accordance with the MCA.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people 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 registered manager had completed and submitted DoLS applications to the local authority for most of the people living at the home, but had not submitted any for those who used bed rails or a wheelchair belt. Although bed rails or wheelchair belts were used to prevent people from falling, it could also restrict people's freedom.

Most people were able to move freely around the house; however the stairways and lift could only be accessed by coded key pads. Some people stated that they had been told by staff they could not leave the building unaccompanied. When we spoke to the registered manager they told us that people were able to go out whenever they wanted to and we did not see people being stopped by staff or their movements restricted.

We recommend that the service reviews its MCA assessments and DoLS applications to ensure that people are protected from having their freedom restricted in accordance with current legislation.

We saw that people had photographs on the door to their room so it was easily recognisable to find their room. People's bedrooms were personalised with pictures, photographs or items of personal interest. People's art work was displayed throughout the home integrating it into the home outside of their rooms. All communal areas had large signs on them to describe the room. Although the home was painted in the same colour, the carpets and floorings in the units were different colours which helps those living with dementia to move around the home. It was easy for people living with dementia or who had impaired sight to find their rooms or their way around the service.

People felt that staff were competent. One person told us, "Staff seem to know what they are doing and always ask me about the care I want." Another person told us, "They always ask me about my care before they do anything." A relative told us, "Very competent people. Know what they are doing."

Staff had the appropriate and up to date guidance in relation to their role. The registered manager ensured staff had the skills and experience which were necessary to carry out their responsibilities. New staff attended induction training and shadowed an experienced member of staff until they were competent to carry out their role.

Staff had received training in areas relevant to their roles. However we observed from incidents during the inspection that not all of the training had been integrated into best practice. There were inconsistencies in how staff moved people safely. Conversations with some staff and further observation of transfer techniques confirmed that although staff had received training, not all staff had effectively integrated this knowledge into their practice to move people safely in the home. The registered manager informed us that they have a clinical lead who provided guidance and supervision to the clinical staff in the home.

Requires improvement

Is the service effective?

Staff told us they received dementia training. A member of staff told us, "I have undertaken lots of training, I did moving and handling and this is taken every year" Training covered areas such as: medicines, safeguarding, moving and handling, fire awareness, food hygiene, health and safety, infection control, dementia awareness, Mental Capacity Act (MCA) 2005, and Deprivation of Liberty Safeguards (DoLS).

Staff told us they had regular meetings with their line manager to discuss their work and performance. The registered manager confirmed that supervision and annual appraisals took place with staff to discuss issues and development needs. We reviewed the provider's records which reflected what staff had told us. This meant that staff had received appropriate support that promoted their development.

People we spoke with told us they enjoyed the food and they were given a choice of meals. One person told us, "The food is always very good here and plenty to eat." Another person told us, " I like the food here very much." A third told us, "'There's a good choice of meals and there is usually something on that I like."

We carried out observations at lunchtime and saw staff address each person individually. Staff showed people the menu and talked through it with them to establish what they would like. We saw the environment during the meal was relaxed. People were able to choose who they sat with at meal times. People were involved in the choice of menu for breakfast, lunch and tea. Staff assisted people during mealtimes to ensure that people were supported appropriately to eat. There was a choice of nutritious food and drink available to people throughout the day; an alternative option was available if people did not like what was on offer.

We observed people were provided with pureed meals, in accordance with their care plan, to reduce the risks of choking. We observed the meals were well presented. People had their dietary needs assessed and specific care records had been developed in relation to this. Where people needed assistance with eating or had special dietary requirements, information and guidelines were recorded to ensure their needs were met. Some people required products to be added to their food and drink to enable them to swallow without harm and instructions were given to staff regarding the dosage and consistency required.

We saw that food and fluid charts were completed for people who needed their nutritional intake monitored. Staff had records of people's individuals requirements in relation to their allergies, likes and dislikes and if people required softer food that was easier to swallow. Staff confirmed that a dietician or speech and language therapy team were involved with people who had special dietary requirements.

We saw a member of staff helping a person to drink a cup of tea as this person was reluctant to take fluids. The member of staff explained why it was important to drink and the person was persuaded to finish their tea. This demonstrated effective care and staff were aware of people's needs. Staff were clear about the need to keep people hydrated. People who were at risk of malnutrition told us they were weighed regularly so that staff could be sure they were getting enough to eat.

People had access to healthcare professionals such as GP, dietician, and speech and language therapist and other health and social care professionals. The management team told us they have a very good relationship with their doctor, who knew the needs of the people living at the home and that people felt comfortable with the doctor. We saw from care records that any changes to people's needs, staff had obtained guidance or advice from the person's doctor or other healthcare professionals. People were supported by staff or relatives to attend their health appointments.

Risk assessments and any healthcare issues that arose were discussed with the involvement of a relative, social or health care professionals such as psychiatrist, community psychiatric nurse, GP or speech and language therapist. A relative told us, "They are very good at keeping in touch and letting us know if anything changes." Outcomes of people's visits to healthcare professionals were recorded in their care records and staff were told what actions they should take to keep people well. This meant staff were given clear guidance from healthcare professionals about people's care needs and what they needed to do to support them.

Good

Is the service caring?

Our findings

People and their relatives told us that staff were kind and caring. The atmosphere in the home was calm and relaxed during our inspection. Staff showed kindness to people and interacted with them in a positive and proactive way. One person told us, "The staff are very caring here because they like their job and they are nice people." Another person told us, "Carers are very good. Anything I need they get it. Good care." A relative told us, "A good home does what is says on the tin. Care and Home."

People are able to make choices about when to get up in the morning, what to eat, what to wear and activities they would like to participate in, so they could maintain their independence. One person told us, "I get up when I like and go to bed when I like there are no constraints."

People were able to personalise their room with their own furniture, personal items and choosing the décor, so that they were surrounded by things that were familiar to them. We noted that people had the right to refuse treatment or care and this information was recorded in their care plans. Guidance was also given to staff about what to do in these situations.

Staff knew about the people they supported. A relative told us, "X came in from hospital not in a good state. She couldn't walk and she needed hoisting. She had good care here and she can walk with a frame. She has come on since she has been here." They were able to talk about people, their likes, dislikes and interests and the care and support they needed. We saw detailed information in care records that highlighted people's personal preferences, so that staff would know what people needed from them. A member of staff told us, "We use different techniques to calm people down such as making them a drink, talking to them or taking them out to places they like." Information was recorded in people's care plans about the way they would like to be spoken to and how they would react to questions or situations.

Staff approached people with kindness and compassion. We saw that staff treated people with dignity and respect.

Staff called people by their preferred names, and personal care tasks were conducted in private. Staff interacted with people throughout the day, for example when preparing for lunch, helping someone to get dressed, listening to music and watching television, at each stage they checked that the person was happy with what was being done. Staff spoke to people in a respectful and friendly manner.

People were involved in making decisions about their care. One person told us, "Staff show me my care planning from time to time and ask if there anything else I would like." We observed that when staff asked people questions, they were given time to respond. For example, when being offered drinks, or going out to the shops. Staff did not rush people for a response, nor did they make the choice for the person. Relatives and health and social care professionals were involved in individual's care planning, and there was detailed information recorded including decisions made for those who lacked capacity. Staff were knowledgeable about how to support each person in ways that were right for them and how they were involved in their care.

People were supported to express their views about their care, support, treatment or the home in different ways such as: day to day conversations, questionnaires, meetings and social activities.

Relatives and friends were encouraged to visit and maintain relationships with people. People were able to attend various activities taking place inside the home and outside in the local community, for example attending afternoon tea and memory sessions. People confirmed that they were able to practice their religious beliefs, because the provider offered support to attend the local religious centres and people from the religious community visited the home.

People could be confident that their personal details were protected by staff. There was a confidentiality policy in place. Care records and other confidential information about people were kept in a secured office. This ensured that people such as visitors and other people who were involved in people's care could not gain access to their private information without staff being present.

Good

Is the service responsive?

Our findings

People told us they were happy with the support they received. One person told us, "The care is lovely. Relaxed about the care here no worries about it at all." A relative told us, "Can't complain about the care. It is very good. Carers make a real fuss of Mum."

We saw that pre assessments were carried out before people moved into the home and then were reviewed once the person had settled into the home. The information recorded included people's personal details, care needs, and details of health and social care professionals involved in supporting the person such as doctor and care manager. Other information about people's medical history, medicines, allergies, physical and mental health, identified needs and any potential risks were also recorded. This information was used to develop care and support in accordance to people's needs to ensure staff had the most up to date information.

The care records had detailed information which identified individual's care and support and any changes to people's care was updated in their care record, however the information recorded was not always up to date or in accordance with people care needs. The managers confirmed that they involved people, health care professionals and relatives in the decisions and planning of care.

We noted that information about people's care and support was also provided if a person require hospitalisation. This enabled hospital staff to know important things about people's medicines, allergies, medical history, mental and physical needs and how to keep them safe.

Staff told us that they completed a handover sheet after each shift which relayed changes to people's needs. We looked at these sheets and saw, for example information related to a change in medication, healthcare appointments and messages to staff. Daily records were also completed to record each person's daily activities, personal care given. This showed us that the staff had up to date information relating to people care needs.

People told us, "People are around so if I ask I don't have to wait very long for any care." Care given was based on an individual's needs, care and treatment. For people whose behaviour may be challenging, guidance was provided to staff to minimise risk, whilst ensuring people were safe. Staff were quick to respond to people's needs. For people who had mobility needs, guidance was given to staff about how to stop pressure sores developing. The manager told us by having a consistent staff team they were able to build up a rapport with people and that people were cared for by staff they knew and who understood their needs.

We saw there was a call bell system in place; the system was easy to use. We saw that the information displayed on the call unit indicated in which room the call button had been activated. We observed there were call bells in communal areas as well as in people's bedrooms. We observed that the call bells or requests for help were responded to quickly.

The home was kept in good decorative order. All bedrooms were clean and decorated to accommodate people's choice. There was a small lounge for people to have some quiet time or socialise with family members, there were quite areas throughout the home where people could sit away from their room and there a separate room for people to have their hair and manicures done. There was also a main lounge where most of the activities took place and separate dining room.

People were provided with the necessary equipment to assist with their care and support needs. We saw items such as lifting equipment, wheelchairs, bath seats, specialist mattresses and beds, which were used in accordance to people's care needs and support.

People confirmed that they took part in the activities in the home, such as games, arts and crafts, reminiscence sessions and trips out in the community. One person told us, "It's lovely outside. Plenty of space we have games outside when the weather is good." Another person told us, "There is quite a bit going on here if you want to join in." People also confirmed that friends, relatives and people from the local community visited them at the home.

The activities at the home consisted of bingo, craft activities, indoor skittles, quiz, reminiscence, board games and trips out. People could also take part in chair based exercises. Entertainment, including Flamenco dancing, music and magic shows were provided by outside agencies. People, who did not want to take part in the group activities, could do jigsaw puzzles, play games or read a book. Those who were bed bound were offered one to one time with the activities co-ordinator. There was an

Good

Is the service responsive?

activities programme which was displayed throughout the home and each person received a copy of the activity programme, in a format which supported their needs to identify relevant activities they were interested in.

People were made aware of the complaints system. There was various ways that someone could voice their opinion about the service. For example completing a form or discuss issues with the manager. People had their comments and complaints listened to and acted upon. We looked at the provider's complaints policy and procedure which was displayed at key points around the service. When people first moved in there was a copy provided in the resident's guide which people kept in their rooms.

The staff told us that they were aware of the complaints policy and procedure as well as the whistle blowing policy. Staff we spoke with knew what to do if someone approached them with a concern or complaint and had confidence that the manager would take any complaint seriously. The service maintained a complaints log and these were dealt with in a timely manner, in accordance to their complaint policy. We noted that there were 11 complaints made in the last twelve months. We noted that responses to the complaints contained action to be taken and offers of apology. We saw information about the complaint procedure displayed in the home, which provided people with the information about the process, contact details for the registered provider, CQC, and Local Government Ombudsman.

Requires improvement

Is the service well-led?

Our findings

People told us the service was "Managed well", and "The teamwork is very good here." However we found that the systems and arrangements that were in place to monitor the quality of the service and ensure safe practices were not always robust or effective.

It was clear that not all staff and management had a clear working knowledge of the current changes in legislation to protect people's rights and freedom and that staff did not always follow best practices which put people at risk of harm. For example staff did not always use the correct techniques when assisting or supporting people to move safely in their bedroom or around the home.

Management observed staff in practice and any observations were discussed with them. We noted that poor techniques were identified and actioned. For example additional training was provided; however, staff's competencies were not always monitored or observed. Hence we observed incidents of poor practice during our inspection. This meant that although there were arrangements in place to observed staff's practice techniques, the monitoring was not robust enough to stop poor practices from taking place and putting people at risk of harm.

Records held were not always correct or up to date which meant new or agency staff who did not know people might not be working to the most up to date information. The records were completed in an inconsistent way. For example information about how to monitor and review wound care or, diabetes management was not robust. This meant that up to date information was not always available to staff to ensure that people were receiving the appropriate care in accordance to their needs.

When discussing our findings with the management team they confirmed that they did not have a copy of CQC's Guidance for Providers on meeting the regulations and the Fundamental Standards and that all guidance in place referred to old regulations. This meant that staff did not have access to up to date information about current legislation. During our inspection, the manager obtained a copy of the current legislation.

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

People's care and welfare was monitored regularly to make sure their needs were met within a safe environment. There were a number of systems in place to make sure the service assessed and monitored its delivery of care. We saw there were various audits carried out such as care plans, medicine administration records, health and safety, room maintenance and housekeeping. We saw accident records were kept which contained a description of the accident, time it occurred and if people required hospital treatment. Each accident had an accident form completed, which included immediate action taken. We noted that the manager conducted an analysis of the accidents occurred at the home, identifying trends and patterns for example the number of time people used the call bell and the reasons why. We noted that fire, electrical and safety equipment was inspected on a regular basis.

The provider had a system to manage and report incidents and safeguarding. Members of staff told us they would report concerns to the managers. We saw incidents had been raised and dealt with and notifications had been received by the Commission. Incidents were reviewed which enabled staff to take immediate action to minimise or prevent further incidents

People told us that the management team were approachable and visible throughout the service. One person told us, "I always see the manager around. She is approachable and she is prepared to sort thing out." A relative told us, "My family member was becoming very poorly and they wanted to visit a relative, it was important to them. The manager personally sorted them out and got them ready. She is a wonderful person."

There was an open door policy as we saw people come into the office to share information about their activities, if there was any concerns or if they required assistance. The managers of the service promoted an open culture.

People told us, "There are resident's monthly meetings." People were involved in how the service was run in a number of ways. We noted that there were 'residents' and relatives meetings for people to provide feedback about the service. We saw minutes of the meeting where people discussed issues regarding catering, health and safety, staff levels, safeguarding, complaints and care provided.

Staff told us that managers were open and approachable and that they could discuss any issues they had with them. Staff told us that team meetings were held regularly and

Requires improvement

Is the service well-led?

that they could raise any concerns they had at these meetings. Staff told us that they met their managers on a one-to-one basis for supervision and that notes of these sessions were recorded. Staff told us "I am happy here, there is a good team of staff and we support each other."

We looked at a number of policies and procedures such as environmental, complaints, consent, disciplinary, quality assurance, safeguarding and whistleblowing. The policies and procedures gave guidance to staff in a number of key areas. Staff demonstrated that they were knowledgeable about aspects of this guidance.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered provider failed to ensure safe care to people in the home. 12 (1) (2) (a) (b)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The registered provider had not ensured good governance in the home.**