Care UK Community Partnerships Ltd

Tiltwood

Inspection report

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Ratings

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

Overall summary

Tiltwood is a residential home which provides care and accommodation for up to 50 older people who are living with dementia. People have varied communication needs and abilities. Some people are able to express themselves verbally; others use body language to communicate their needs. The home is divided into separate areas called bungalows each identified by the name of a tree; for example 'Chestnuts' where up to 10 people live.

Tiltwood also has a day care provision, known as The Club, where people from the home and community can come together to join in activities and where friendships can be made. Tiltwood also benefits from being within close proximity to the village facilities which are easily accessible to people.

On the day of our inspection there were 40 people living in the home.

This inspection took place on 7 November 2015 and was unannounced.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.

There were not always sufficient numbers of staff to meet people's needs. People were left on their own throughout the home which was a risk to their safety. We observed people being left unattended for periods of ten minutes or more. One relative said "One staff is not enough to look after all the needs of 10 people."

People were at risk of not always receiving care from staff who staff did not initiate action when people needed support or recognised when people needed support. Staff did not always take time to speak with the people who they supported. We have made a recommendation about staff undertaking training in dealing with people experiencing anxieties in dementia.

We observed some positive interactions and it was evident people enjoyed talking to staff. However not all staff interacted with people in a social way and addressed people only to provide a task e.g. "It's lunch time, Have a drink etc.

We saw staff had written information about risks to people and how to manage these in order to keep people safe. Tiltwood has all main doors locked to the outside environment. Access could be gained into the garden arranged in such a way as to provide a measure of freedom. An alarm sounds if a person cannot be located, and staff are aware of the procedure to manage a search. During our inspection a person went 'missing' during the inspection, an alert went out immediately the situation arose and the person was found within a matter of minutes. On their return they said, smiling, "I got lost."

Information was displayed for people and visitors on how to raise any safeguarding concerns. Staff had received training in safeguarding adults and were able to tell us about the different types of abuse and signs a person may show. Staff knew the procedures to follow to raise an alert should they have any concerns or suspect abuse may have occurred.

Processes were in place in relation to the correct storage and auditing of people's medicines.

Medicines were administered to people with dignity and disposed of in a safe way.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLs) which applies to care homes. The registered manager and staff explained their understanding of their responsibilities of the Mental Capacity Act (MCA) 2005 and DoLS and what they needed to do should someone lack capacity or needed to be restricted to keep them safe. They had undertaken the appropriate assessments on people who lacked capacity to make certain decisions and the appropriate DoLS had been submitted to the local authority.

People were provided with a choice of cooked meals each day. The meals were not cooked on the premises but provided by an outside catering company. Facilities were available for staff to make or offer people snacks at any time during the day or night.

People were able to see their friends and families as they wanted and there were no restrictions on when relatives and friends could visit.

People and their families had been included in planning and agreeing to the care provided. We saw that people had an individual plan, detailing the support they needed and how they wanted this to be provided. Staff ensured people had access to healthcare professionals when needed. For example, details ofdoctors, opticians, tissue viability nurses visits had been recorded in people's care plans.

People's views were obtained by holding residents' meetings and sending out an annual satisfaction survey. Complaint procedures were up to date and people and relatives told us they would know how to make a complaint if they needed to.

Staff recruitment processes were robust to help ensure the provider only employed suitable people.

The provider had quality assurance systems in place, including regular audits on health and safety, infection control and medication. The registered manager met CQC registration requirements by sending in notifications when appropriate. We found both care and staff records were stored securely and confidentially.

We found one breach 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 always safe.

There were not always enough staff on duty to meet the needs of people. Staff were recruited safely and appropriate checks were undertaken to help ensure suitably skilled staff worked at the service.

There were processes in place to help ensure people were protected from the risk of abuse and staff were aware of the safeguarding procedures.

Medicines were stored, managed and administeredsafely.

Assessments were in place to manage risks to people. There were processes for recording accidents and incidents.

Is the service effective?

Good

The service was effective.

Staff had the skills and knowledge to meet people's needs. Staff received regular training to ensure they had up to date information to undertake their roles and responsibilities. They were aware of the requirements of the Mental Capacity Act 2005 and DoLS.

People were supported to eat and drink to maintain good health.

Staff supported people to attend healthcare appointments and liaised with other healthcare professionals as required.

Is the service caring?

Requires improvement

The service was not always caring.

People were treated with respect but their independence, privacy and dignity were not always promoted.

Staff did not always take time to speak with people and to engage positively with them

People told us they were well cared for. We observed caring staff who treated people kindly and with compassion

People and their families (where necessary) were included in making decisions about their care.

Is the service responsive?

Requires improvement

The service was not always responsive.

Care plans were in place outlining people's care and support needs.

Staff were knowledgeable about people's needs, their interests and preferences in order to provide a personalised service.

Summary of findings

People felt there were regular opportunities to give feedback about the service. People's concerns and complaints were listened to and responded to according to the complaints procedure in place.

Is the service well-led?

Good

The service was well –led.

The staff were well supported by the registered manager.

There was open communication within the staff team and staff felt comfortable discussing any concerns.

The registered manager regularly checked the quality of the service provided and made sure people were happy with the service they received.

Tiltwood

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 4 November 2015 and was unannounced. The inspection was carried out bytwo inspectors 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 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. We asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke withten people,six care staff, fourrelatives, the registered manager and two health and social care professionals. The majority of people who lived at the home had complex needs which meant that we were unable to hold detailed conversations with them. Therefore, we spent time observing the care and support that people received in the lounges and communal areas of the home during the morning, at lunchtime and during the afternoon.

We reviewed a variety of documents which includedfour people's care plans, seven staff files, training programmes, medicine records,four weeks of duty rotas, maintenance records, all health and safety records, menus andquality assurance records. We also looked at a range of the provider's policy documents. We asked the registered manager to send us some additional information following our visit, which they did.

We last inspected the service in January 2014 where there were no identified breaches.

Requires improvement

Is the service safe?

Our findings

Relatives felt there were not enough staff deployed to keep people safe. One relative said; “People are on their own for periods of time.” And “How can one staff meet everyone’s needs, if they are attending to one person, everyone else gets left on their own.” One person said; “I don’t think there are enough staff about.”

The registered manager said that one care staff looked after each bungalow and there were two floating support staff throughout the home. There are five ungalows in total. In which up to 10 people require care and support in each bungalow. These 10 people are supported by one member of staff.

The registered manager said that the staff numbers were worked out a numerical calculation of how many care hours per person per day were needed. We checked the rotas for a four week period and confirmed that there were five staff were on duty in the morning with two floating supplementary in morning and one floating in afternoon, there were five waking staff overnight. One per bungalow, which meant that if another area of the home, required support during the night people were left unattended. On the day of our inspection one of the floating staff had called in sick and they were unable to be replaced.

Staff were not deployed around the home to ensure people’s safety. We had been alerted to an increased number of people falling and sustaining injuries. We requested a falls audit which showed the majority of falls people had were unwitnessed by staff. The clinical commissioning group (CCG are NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England) quality audit had also identified a high number of hospital admissions following falls. A lot of falls had been unwitnessed by staff as there was not enough staff deployed to monior people at risk of falling.

On another occasion a person’s health deteriorated and they had to go to hospital. One relative told us, “My relative was once sent to hospital at 10pm on her own at night as there were no staff available to go with her.” The relative explained that the person had advanced dementia and would have not been able to communicate their needs to the ambulance or hospital staff. We were told by the acting manager that this was an unplanned admission to hospital and that the persons hospital passport was sent along with care plans, risk assessments and medicine charts.

We saw that people were not being attended to promptly. We observed in one of the bungalows, a relative assisted the care worker to enable another person on the unit to go to the toilet asthere no other staff available to support them. Staff told us that they sometimes could not meet peoples needs in a timely way as there were not enough of them . One person needed to be repositioned regularly however staff told us this did not always happen due to having to wait for other staff to help them as there were other people that needed their support. This increased the risk of this person developing pressure sores.’

One person had been identified as being at high risk of falls, their care plan stated that they should be checked every half an hour and their whereabouts logged. The person was actively mobile. Staff did not have the time or capacity to check on this persons whereabouts every half an hour or to document the person’s whereabouts. This increased the risk to the person of not being supported in a timely manner should they have had a fall.

There were not enough staff to meet the needs of people. This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff recruitment records contained the necessary information to help ensure the provider employed people who were suitable to work at the home. Staff files included a recent photograph, written references and a Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Staff members confirmed they had to provide two references and had a DBS check done before starting work. The provider had ensured that qualified staff had the correct and valid registration.

Most of the risks to individuals and the service were managed so that people were protected and their freedom was supported and respected. One person said; “I move around with a walking frame in my room, around the home I freely use my wheelchair.” However although people had

Is the service safe?

access to the garden, hand rails and other aids to manage peoples risk of falling had not been put in place. Subsequently the falls record showed that a number of people had fallen whilst in the garden.

The registered manager spoke of environmental risks attributed to the design of the building which had many places in which residents could be unseen and how the gardens posed a risk where uneven surfaces could potentially cause a fall.

We recommend that best practice guidance is sought and implemented for safety equipment to be available for people in the garden area.

The registered managerensured staff assessed the risks for each individual and recorded these. Incidents and accidents were reported appropriately and in a timely manner, the registered manager described to us the action they took to analysis each incident. They showed us examples of outcomes of investigations; this included an accident where a person had fallen. The registered manager had reassessed the risk and implemented new strategies such as alarm mats to alert staff sooner to the person moving about their room. Staff were able to describe risks and supporting care practices for people. For example people with specific health care conditions and at risk of pressure wounds had individualised risk assessments which staff were able to describe. One staff described to us how they acted within the provider's guidelines to inform relevant professionals for example, to inform the GP if a person had lost weight, or if a person had an infection.

We checked a sample of risk assessments and found plans had been developed to support people's choices whilst minimising the likelihood of harm. The risk assessments included people's mobility risk, nutritional risk or specific health risks. One person's risk assessment detailed their assessed skin breakdown risk. The action plan detailed pressure mattress settings, repositioning frequency and nutrition support which should reduce the risk to the person of their skin breaking or them acquiring a pressure wound. Although the documents were in place to minimise the risk. The lack of staff meant that actions could not always be undertaken in a timely way.

The registered manager and staff had taken steps to help protect people from avoidable harm and discrimination. The registered manager and staff were able to describe what they would do if they suspected someone was being abused or at risk of abuse. Staff told us they had received safeguarding training and were able to describe the procedures to be followed if they suspected any abuse. Staff and relatives told us they would approach the registered manager if they had any concerns. Prior to our inspection the registered manager formally notified us and the local authority of a safeguarding incident in line with their legal responsibilities. The information supplied demonstrated that appropriate action was taken to safeguard people from harm and abuse. This also demonstrated that the registered manager understood their responsibilities in relation to safeguarding. Spome people we spoke to said they would talk to the registered manager if they had concerns about anything.

Staff told us they were aware of the provider's whistleblowing policy and procedure and we observed the provider had details of the whistleblowing policy in a prominent position for staff to know where to access it.

People's medicines were well managed and they received them safely. One person said; I do get my medication when they are due" and "They give me painkillers when I ask for them."

There was an appropriate procedure for the recording and administration of medicines. We saw medicines were stored securely. Each person had a medication administration record (MAR) chart which stated what medicines they had been prescribed and when they should be taken. We observed staff ensuring people had taken their medicines before completing the MAR chart to confirm that medicines had been administered. We looked at MAR charts and saw they were completed fully and signed by trained staff. People who were prescribed 'as required' medicines had protocols in place to show staff when the medicines should be given.

We observed staff administering medicines safely, following the provider's medicines procedures, ensuring they explained to the person why they had a medicine. Medicines were stored securely at all times. The provider's policy was current and easily assembled for staff to reference. Staff told us only staff who were trained as competent to administer medicines did so and they had yearly competency assessments.

There were emergency and contingency plans in place should an event stop part or the entire service running. The

Requires improvement

Is the service safe?

registered manager had assessed the needs of each person should there be an emergency evacuation. Plans were person centred and gave clear instructions to how staff should manage a person's individual needs. Equipment was available on each of the bungalow's to enable people to be moved safely and quickly in case of an emergency. This meant people's safety was promoted in the case of any potential incident.

Good

Is the service effective?

Our findings

Relatives told us they thought staff were trained to meet their family member's needs. One person said, "All the staff are mostly very competent." A visiting healthcare professional said; "Confident staff make people comfortable from what I've seen, staff seem very nice."

The registered manager told us that all staff undertook an induction before working unsupervised to ensure they had the right skills and knowledge to support people they were caring for. The registered manager ensured that each staff completed their 'personal Induction booklet.'' We spoke to three staff who described their induction process. They explained how they had all spent time shadowing other more experienced staff and given time to understand the procedures within the home. One staff said; "I am on a two week induction, spending time getting to know what individual needs are, it's more observing at moment."

The registered manager had supported staff to learn other skills to meet people's individual needs, such as training for staff to become dignity champions. They said that this training had helped them understand and develop best practice when caring for people. One staff member said they undertake "All training refreshers" and "E- learning annually".

Staff said they had annual appraisalswhere the registered manager evaluates their work behaviour by comparing it with pre-set standards, documents the results of the comparison. This is used to provide feedback to the employee to show where improvements are needed and why. Staff also had regular supervisions which meant they had the opportunity to meet with their registered manager on a one to one basis to discuss their work or any concerns they had. One staff member said; "I had supervision last week, and was given a written record, had discussion about tasks, areas which are weaknesses and strengths."

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty safeguards (DoLS) which applies to care homes. DoLS are part of the Mental Capacity Act 2005 (MCA). They aim to make sure people in care homes are looked after in a way that does not inappropriately restrict their freedom.

Staff had received training in the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLs). Some people were restricted from leaving the home for their own safety. The appropriate capacity assessments and DoLS had been submitted to the local authority. The registered manager and staff demonstrated their understanding of DoLS. One staff member said they understood MCA and DoLS and told us, "It's about people's choices, preferences to make own decisions, those who can make own decisions." We observed on the day staff offering people choices, for example we saw one saftt member ask a person if the would like to attend the day centre.

People's nutritional needs were met. One relative said; "The staff are very good. They always offer me a hot drink and I can stay for lunch so it enables me to encourage my mother to eat. They do a very good job."

An external company provided meals to the home. A recent dining experience was held for relatives to come and sample the food and provide feedback as to the quality of the meals provided for residents. This was a success and relatives were happy with the food provided. People who ate lunch said it was "Tasty." The registered manager said they had taken on a new employee to provide a more personal catering service such as afternoon tea specials and cakes.

We saw a list in the kitchen of people's dietary requirements. The chef was able to identify those people who were on specialist diets. Staff were aware of the needs of people on specialist diets such as people who were diabetic or at risk of choking. One staff member explained to us that specialist sugar free food was provided to people who were diabetic and a choice was given daily.

The menu was displayed and included the main meal of the day, together with the alternatives on offer including a vegetarian option. During the day people had drinks in front of them and tea and coffee was offered throughout the day. We observed lunch in one bungalow and observed staff interacting with people, people eating at their own pace. We observed when one person indicated they needed assistance; staff positioned themselves at the person's eye level and verbally encouraged and helped them to finish their meal. Otherwise the person would have walked off and not eaten. Two people, who were able to communicate verbally, fed back to us that the food had been good.

Staff responded to changes in people's health needs quickly and supported people to attend healthcare appointments, such as to the dentist, doctor or optician.

Good

Is the service effective?

The registered manager said that they promoted collaborative care. We saw, in individual care plans, that staff made referrals to other health professionals such as the speech and language therapist (SALT), the falls team, district nurse or the dementia nurse when required. One person said; “If I need to see the doctor or the chiropodist, I only need to ask”. We spoke to a visiting professional during our inspection who told us that staff made appropriate referrals and in a timely manner and said “Staff tend to inform the District Nurse of key areas of concern”. They confirmed that equipment needed to support peoples health needs was provided in a timely manner; such as profiling beds and air mattresses.

Requires improvement

Is the service caring?

Our findings

Staff understood the importance of respecting people's privacy and dignity . We saw good examples of staff knocking on people's doors, and addressing people with preferred names they had chosen. However we observed people's individual needs around privacy and dignity were compromised on occasions. For example, where toilet doors did not shut securely. People who may be able to attend to their own toilet needs were at risk of being seen by others walking past. Another person was seen walking in the corridors with wet clothing. We asked staff to support the person to change their clothes as they had not noticed. They did this immediately.

We observed occasions when staff did not respond to the needs of people appropriately. One person was searching out of the window looking for a visitor. They were becoming more and more distressed, wanting to be taken home. The staff member said abruptly to them; "This is your home, you can't go home, this is your home now.' The staff member did not show any emotional support; There was a display of anger and tears from the person and the staff member did not provide any reassurance and just left the person alone.

On another occasion one we observed several people waiting by the an exit becoming increasingly anxious and banging on the doors. Staff did not intervene or try to distract people with positive behaviour management.

In another bungalow we saw that a person had spilt their drink, the staff mopped the floor providing no support to the person, whilst a relative of another person settled the person that was distressed.

We recommend that best practice guidance in managing people's anxieties is provided to the staff.

People and relatives told us that the staff were very caring. One relative said; "They (staff) are kind and considerate." A visiting health professional told us, "Staff are lovely, really good with people living with dementia, such as when the District Nurse does dressings, staff have a calm approach and settle people."

Some staff showed that they knew people well and they spoke to each other in a relaxed, jovial manner. One person had their dog living with them who was known to other people in the home. Staff told us they had conducted a risk assessment prior to the dog coming in. Staff said that the person had a high level of cognitive impairement which is characterised by a set of problems with short term memory, planning, language, and/or attentionspans. Howvere this person knew it was their dog. This showed staff demonstrated compassion and respect in terms of understanding what was important for an individual in delivering person centred care.

Staff understood the needs of people in their care and we were able to confirm this through discussions with them. Staff answered our questions in detail without having to refer to people's care records; for example one staff described the care they provided to someone with a pressure wound. This showed us that staff were aware of the up to date needs of people within their care.

Staff explained they offered information to people and their relatives in connection with any support they provided or that could be provided by other organisations e.g. Parkinson's Society and Age Concern. We saw the reception area had various leaflets which provided advice on advocacy, bereavement and safeguarding. Each person had a comprehensive residents guide in their room which told them about how to find further information, the structure of the home and how to make a complaint if necessary. People knew about the information available and felt comfortable asking for information about their specific illnesses.

People and those who matter to them and appropriate professionals contributed to their plan of care. We asked people and family members if they had been involved in their care planning or the care of their relative. They all felt that they were included and kept up to date. One person said "I know there is a care plan and they do talk to me about things in it."

Requires improvement

Is the service responsive?

Our findings

Staff did not always respond to peoples needs appropriately. One person said "It's boring here." Another person said "Sometimes there's nothing to do if you don't go to the day place."

People were supported to attend the day centre where there were regular activities going on throughout the week. An activities coordinator was employed who had specific responsibility for planning social activities. One person who attended the day care centre said; "It's wonderful. She's (staff) the best part of coming here. If they're (staff) happy and I watch them being happy, that makes me happy." The activities person checked throughout the day that people were happy to participate in the activity and asked for suggestions from people of how they would like the activity to run. They told us that they had spoken to each person and had tried to provide a mixture of group and individual activities to meet peoples' likes and preferences.

People who chose to stay in the individual bungalows had a different experience of social activities. In the majority we did not see staff interact positively or encourage people to undertake meaningful activities except for one example where a person told the staff member they liked quizzes. The staff member straight away found a quiz book for the person. The person was delighted and went straight to their room to start the quiz book.

We recommend that best practice guidance is sought to provide meaningful individual activities for people..

Before people moved into the home they had an assessment of their needs, completed with relatives and health professionals supporting the process where possible. This meant staff had sufficient information to determine whether they were able to meet people's needs before they moved into thehome. Once the person had moved in, a full care plan was put in place to meet the needs which had earlier been identified. We sawthese were monitored for any changes. Full family and life histories were drawn up so that staff knew about a person's background and were then able to talk to them about their family or life stories.

Personalised care plans had been developed with regard to the way that people chose to be supported and if risks had been identified, a risk assessment had been put in place to minimise them as much as possible. For example: some people liked to have a cigarette, risk assessments were in place to support people maintain their lifestyle choice. The registered manager showed us that the care plans were in the process of being changed to an electronic format. Staff members showed us the electronic care plan and notes system. They explained that they typed all daily notes in and logged if people's need changed and the action that had been taken.

We read that reviews were undertaken and staff discussed with people their goals. A staff member said they got to know what people wanted, including what time they wanted to get up and how they liked to spend their day. Staff said they had handovers when they first came on duty. This was an opportunity for staff to share any information about people.

Individual care plans contained information which related to people's preferred name, allergies, family history, personality, the social activities they liked doing and their care needs. There were also details about how they wished to be looked after if they became unwell. Staff showed us a file which recorded people's weights. People were weighed regularly and staff calculated people's body mass index (BMI), so they could check people remained at a healthy weight. We saw that one person had lost weight and staff had referred this person to the GP for a dietician referral and to the SALT team for further guidance on managing the weight loss and nutritional needs. The computerised system gave full details and analysis of people's changing needs which showed easy to read graphs etc. of weight, and risk increase or improvements.

People were supported to raise concerns and complaints without fear of reprisal. Relatives told us they knew how to make a complaint if they needed to.One relative told us "I've no major complaints." We saw how the registered manager had dealt with previous complaints and had identified improvements or actions that needed to be taken. The complaints policy was displayed in the foyer and each person had a copy of it in their service user guide.

People felt they had a say in how the home was run. People told us that they remembered filling out a survey. We saw minutes from the last residents meeting which detailed how staff were making a 'Hollywood' corner. They asked people what should go in the corner and one person

Requires improvement

Is the service responsive?

suggested posters of Marilyn Monroe and Bing Crosby. People and relatives said “There is a resident’s meeting every month” and “They do try to resolve issues brought up at the meeting.”

Good

Is the service well-led?

Our findings

One member of staff told us, “It’s a nice place to work, good support from senior management.” They also told us, “I enjoy working with peer group and colleagues… (it’s a) homely friendly atmosphere.” Another staff member said; “The manager’s really good, really listens.”

The home had a registered manager. The registered manager was in day to day charge and supported the staff within the home. People and relatives we spoke with all knew who the registered manager was and felt that they could approach them with any problems they had. One person said “He’s always around to talk to.”

We observed the registered manager interact well with the people. An external healthcare professional said “The registered manager is approachable.” We observed on numerous occasions them sitting and chatting to people and asking if there was anything that people needed.

Staff were positive about the management and the support. One staff said “Staff meetings are held in which we could speak openly and make suggestions.” Staff meetings were regularly held and minutes of the meetings were recorded and made available to all staff. We saw a record of staff meeting minutes. Best practice guidance was discussed during these meetings and any concerns that staff had. For example discussions around the handover forms, CQC inspections and the duty of candour. The duty of canour is a regulation to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. One member of staff said when new staff started they received training on the aims and objectives of the service. It was then up to senior staff to monitor them to ensure that new staff promoted the aims and objectives of the home into practice. This was done through observation of practise and supervision. This helps develop consistent best practice and drive improvement.

The registered manager told us about the homes missions and values, they said “the aim of the home is to help older people to live happier, healthier and more fulfilling lives.” Staff we spoke to understood the values to ensure people received kind and compassionate care. This was implemented from the staff induction process and reviewed regularly. We saw that the values were promoted in the ‘Residents Guide’, which anyone wanting to find out about the home or who lived there could read.

The registered manager told us about the systems they used to ensure the delivery of high quality care. We saw the quality assurance systems in place were robust. We saw evidence of audits for health and safety, care planning, medication and infection control. This enabled the registered manager to identify deficits in best practice and rectify these. The registered manager explained that regular health and safety meetings and staff meetings were held. The minutes of the meetings were recorded and made available to all staff. Care UK also undertook a regulatory governance audit which follows the Health and Social care Act five domains and questions of ‘Is the home Safe, Effecticve, Caring responsive and Well Led. This internal audit showed ‘on the whole the home was well managed.’ The registered manager had undertaken regular audits. Such audits monitored as care plans and activities, the registered manager identified there was a need for another part tine activities staff to support peoples social needs and as such had advertised for staff for the role.This showed us that both the registered manager and provider was continually assessing the quality of the home and driving improvements.

The registered manager had ensured that appropriate and timely notifications had been submitted to CQC when required and that all care records were kept securely within the home.

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 18 HSCA (RA) Regulations 2014 Staffing **The provider did not ensure enough suitably qualified, competent, skilled and experienced staff was deployed to meet the needs of people.18(1)**