London Borough of Waltham Forest

George Mason Lodge

Inspection report

George Mason Lodge
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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?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We inspected George Mason Lodge on 18 and 25 May 2016. This was an unannounced inspection. At the last inspection in July 2013 the service was found to be meeting the regulations we looked at.

George Mason Lodge is a residential home that provides care for up to 39 older people some of whom may be living with dementia. There were 35 people using the service when we visited.

There was a registered manager at the service at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

People had missed doses of their prescribed medicines, which may have affected their health and well-being. The arrangements for ordering medicines for people were not always robust. Medicines records were not always completed fully and accurately and we were not assured that appropriate arrangements were in place for the recording, using and safe administration of some medicines. Individual risk assessments were in place for people, to help protect them from harm. However, the assessments and care plans were not always comprehensive.

We found the provider had not sent us any statutory notifications for people authorised for Deprivation of Liberty Safeguards (DoLS) and people who had died. You can see what action we have asked the provider to take at the end of this report.

The service had appropriate systems in place for safeguarding people. Risk assessments were in place which provided guidance on how to support people safely. There were enough staff to meet people's needs.

Staff were well supported, received training and one to one supervision. People were able to make choices about most aspects of their daily lives. People were provided with a choice of food and drink and supported to eat healthily. People had access to health care professionals and were supported to lead healthy lifestyles.

People and their relatives told us they liked the staff. We saw staff interacting with people in a caring way and staff had a good understanding of how to promote people's dignity.

Care plans were in place and people were involved in planning the care and support they received. People had access to a wide variety of activities within the community. The provider had appropriate complaints procedures in place.

There was a clear management structure in the home. People who lived at the home, relatives and staff felt comfortable about sharing their views and talking to the registered manager if they had any concerns. Staff told us the registered manager was always supportive.

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. The service did not have effective systems in place for the management of medicines.

Individual risk assessments were in place for people, to help protect them from harm. However, the assessments were not always comprehensive.

The service had a safeguarding procedure in place and staff were aware of their responsibilities with regard to safeguarding adults.

There were enough staff at the service to help people to be safe.

Is the service effective?

Good

The service was effective. Staff undertook regular training and had one to one supervision meetings.

The service carried out assessments of people's mental capacity and best interest decisions were taken as required. The service was aware of its responsibility with regard to Deprivation of Liberty Safeguards (DoLS) and was applying for DoLS authorisations for people that were potentially at risk.

People had choice over what they ate and drank and the service sought support from relevant health care professionals.

Is the service caring?

Good

The service was caring. Care was provided with kindness and compassion. People could make choices about how they wanted to be supported and staff listened to what they had to say.

People were treated with respect and the staff understood how to provide care in a dignified manner and respected people's right to privacy.

The staff knew the care and support needs of people well and took an interest in people and their families to provide individual personal care.

Is the service responsive?

Good

The service was responsive. People's needs were assessed and care plans to meet their needs were developed and reviewed with their involvement. Staff demonstrated a good understanding of people's individual needs and preferences.

People had opportunities to engage in a range of social events and activities.

People knew how to make a complaint if they were unhappy about the home and felt confident their concerns would be dealt with appropriately.

Is the service well-led?

Requires Improvement

The service was not always well-led. We found the provider had not sent us any statutory notifications for people authorised for Deprivation of Liberty Safeguards (DoLS) and people who had died.

The service had a registered manager in place and a clear management structure. Staff told us they found the manager to be approachable and there was an open and inclusive atmosphere at the service.

The service had various quality assurance and monitoring systems in place. These included seeking the views of people that used the service.

George Mason Lodge

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.

Before we visited the home we checked the information that we held about the service and the service provider. This included any notifications and safeguarding alerts. We also contacted the local borough contracts and commissioning team that had placements at the home, the local Healthwatch and the local borough safeguarding team.

The inspection team consisted of two inspectors, one pharmacist specialist, nursing dementia specialist and an expert by experience, who had experience with older people with dementia. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

During our inspection we observed how staff interacted with people who used the service and also looked at people's bedrooms and bathrooms with their permission. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We spoke with twelve people who lived in the service and two relatives during the inspection. After the inspection we spoke with three relatives. We spoke with the registered manager, one senior care worker, five care workers, the maintenance person and the chef. We also spoke to two health and social care professionals during the inspection. We looked at 13 care files, staff duty rosters, seven staff files, a range of audits, minutes for various meetings, six medicines records, accidents and incidents, training information, safeguarding information, health and safety folder, and policies and procedures for the service.

Requires Improvement

Is the service safe?

Our findings

People were assessed as not being able to order, store or administer their medicines, therefore the service was responsible for this. We checked the service's arrangements for the management of people's medicines by checking a sample of medicines records and medicines supplies. Although we found some areas of safe medicines management, such as the storage of medicines, and medicines being given to people in a caring and respectful manner, we found that medicines management required improvements.

We found that people had missed doses of medicines. For example, one person had sustained a fracture and been prescribed pain relief medicines four times a day. The person's pain relief medicine had run out the day before our inspection which meant the person had missed at least three doses. The home had requested medicine which had been delivered however there had been a dispensing error and the staff were in the process of sorting this out. The person was observed being in pain. We asked a staff member why they had not asked for an emergency prescription however they seemed unclear on how to do this. Although the incident had been recognised there had been no incident report in line with the provider's own medicines policy. Another example, one person had been prescribed medicine for Parkinson's disease four times a day. The person often would get up late therefore missing their morning dosage. Staff had not reviewed this to discuss this with the GP. Parkinson's medication is very time specific and a single missed dose can cause an impact to the person. On day two of the inspection the registered manager told us a medicine review had been organised with the GP.

Medicine records were not always robust. People were supplied medicines in dossett boxes and bottles by the pharmacy. Staff wrote up the dossett box supply on the medicine record as one entry which meant multiple medicines were recorded as one entry. This meant if a person refused one of the medicines it could not be recorded clearly. We spoke to the registered manager about this and on day two of the inspection and we saw records that medicines were now being recorded for each individual prescription. We also found medicine records did not always tally with medicine stock. For example, one person had been delivered 56 tablets and records showed that 46 tablets had been recorded which meant there should be 10 left in stock. However when we checked 11 tablets were left in stock. This meant possible missed doses of medicines could have a serious impact on people.

On day one of the inspection we gave feedback to the registered manager about the concerns we found regarding medicines. The registered manager sent us an action plan on 20 May 2016 addressing the concerns raised and what immediate action had been taken. On the second day of the inspection we checked the action plan to see if the concerns had been actioned. We saw the majority of the concerns had been addressed. For example, medicine records had been updated to reflect clearer recording and health professionals had been arranged to review procedures so people would not go without medicines.

The above issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risk assessments were in place for people however these were not robust as they did not always include

detailed information on how to manage risks. For example, the risk assessment for one person stated they had been physically aggressive towards staff and on occasions they had attempted to leave the service. There was no information about how to support the person and reduce the risk of physical aggression or how to prevent them attempting to leave the service. However, staff had a good understanding of people's care needs and had a good knowledge of the risks associated with each person. Staff told us they did not use any form of physical restraint when working with people. One staff member said, "We are not allowed to restrain anyone." The same staff member explained how they sought to de-escalate situations where people exhibited behaviours that challenged the service. For example, they said depending on who the person was they might take them for a walk, played music for them or sing a song with them. Another staff member said, "You get to know the service users and the triggers that set them off. Sometimes you have to leave them to themselves to calm down." Another member of staff told us, "Patience is the best thing to have when working with dementia. We try to distract them, bring them a cup of tea, and ask them if they want to watch a movie."

People who used the service and relatives we spoke with told us that they felt the service was safe. A relative said, "[Relative] feels safe there". Another relative told us, "Absolutely safe. [Relative] used to fall over at (previous) home but don't have concerns now." A health professional told us, "A hint of a pressure sore and they will call us in."

The registered manager told us staff were supposed to have safeguarding adults training on an annual basis however records showed that only 10 out of 29 staff had in date safeguarding training. The registered manager told us they were aware of this issue and that they had raised it with the local authority who was also the care provider. Safeguarding issues were discussed with staff during their one to one supervision meetings and at staff meetings. Records confirmed this. Staff had a good understanding of their responsibilities for reporting any safeguarding allegations. One staff member said, "I would report it [allegation of abuse] to my manager or my senior who is on duty." The same staff member was aware of whistle blowing procedures and told us they could report any concerns to the Care Quality Commission if appropriate. Another staff member said, "I wouldn't have none of that [abuse]. I would report it to [registered manager]." Staff were confident in how to raise concerns with their manager and other health and social care professionals if required. Safeguarding policies were available at the service and were in different formats so that they were accessible to people, staff and their relatives.

The registered manager was able to describe the actions they would take when reporting an incident which included reporting to the Care Quality Commission (CQC) and the local safeguarding team. This meant that the service reported safeguarding concerns appropriately so that CQC was able to monitor safeguarding issues effectively.

Accidents and incidents, including falls, were recorded by staff and reviewed by the manager. Staff discussed incidents during handover to identify if any immediate action needed to be taken to prevent future incidents. In addition, a monthly analysis was maintained and the registered manager reviewed this to identify if there were any trends or repeated incidents. Staff took appropriate action and gave consideration to the events that led up to the incident to reduce the risk of a repeated incident. Staff understood what could be potential triggers and there was a plan in place to reduce the possibility of a similar incident.

Sufficient staff were available to support people. Relatives told us there were enough staff available to provide support for people when they needed it. One relative told us, "Always enough staff on and someone there to help people. No one is left alone." Another relative said, "Always one member of staff to four people. You can always get help to assist people." Most staff we spoke with said that staffing levels were sufficient

and that they had enough time to carry out their duties. One staff member said occasionally they were short staffed if someone cancelled a shift at short notice and they were not able to arrange cover. However, they said when this happened, "We work together, we rally round and help each other. The senior [staff member who did not usually provide care directly] will come and help with the situation if we are struggling."

The service had a robust staff recruitment system. Records confirmed that appropriate checks were carried out before staff began work, references were obtained and criminal records checks were carried out to check that staff did not have any criminal convictions. This assured the provider that employees were of good character and had the qualifications, skills and experience to support people who used the service.

The premises were well maintained and the service had completed a range of safety checks and audits. The service had completed all relevant health and safety checks including hoist checks, first aid, fire system and equipment tests, gas safety, portable appliance testing, electrical checks, water regulations and emergency lighting. The systems were robust, thorough and effective.

The premises, décor and furnishings were maintained to a good standard. The home was free of any unpleasant odours. They provided people with a clean, tidy and comfortable home. Repairs were carried out in a timely way and a programme of regular maintenance was in place. There was a secure accessible garden for people's use. One person said about the garden, "It's very well used and safe." Another person told us, "I have to watch the floor as they mop it twice a day but they [staff] do warn us." A relative said about the home, "Always clean and lovely smelling."

Good

Is the service effective?

Our findings

People and their relatives told us the staff were very good and supported them well. One person said, "The carers here are very attentive." Another person said, "They [staff] really help us if you ask." The same person told us, "They [staff] pretend they are not watching us but they do really and see if we have problems and help us." A relative said, "They [staff] do a fantastic job. They help [relative] and look after her."

Staff told us they had training to support them to carry out their role effectively. One staff member said, "I'm up to date with my training. I've done dementia, medicines, moving and handling and first aid." Records showed staff had undertaken training in core topics which included fire safety, first aid, food hygiene, medicines management, falls management and moving and handling. We found that senior care staff and care assistants had undertaken training in dementia care. However other staff such as domestics and kitchen staff had not undertaken training about dementia, even though they routinely interacted with people living with dementia. We discussed this with the registered manager who agreed it would be good practice for all staff working at the service to undertake training about dementia.

Newly recruited staff undertook an induction programme on commencing work at the service. This included shadowing experienced members of staff for a week to learn how to support individuals. New staff also completed the Care Certificate. The Care Certificate is a training programme designed specifically for staff that are new to working in a care setting. One staff member said of their induction, "We went through the clients, my job, what I am supposed to do."

Staff told us and records confirmed that they had regular one to one supervision with a senior member of staff. One staff member said, "I had one [supervision meeting] yesterday. We talked about any health and safety issues, anything to do with the clients, seeing if they are eating and drinking or if their health had deteriorated. We discuss about working together with each other and if we are happy with our work." The same staff member told us they found supervision helpful and added, "In supervision we can open up and discuss things we want to talk about." Another staff member said of their supervision, "You can tell her [supervisor] anything. She wants to know am I treated fairly, if there are any concerns with the residents." Records of staff supervision showed they included discussions about safeguarding adults, care issues and staffing issues. In addition to monthly supervision we saw that staff had an annual review of their performance and development needs.

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

The registered manager had a good understanding of the MCA and DoLS and made sure that people were

supported to maintain their freedom. The registered manager knew how to make an application for consideration to deprive a person of their liberty, however staff we spoke with did not have a clear understanding of DoLS and how it could apply to people living at the service. Staff told us they had not undertaken any training about MCA and DoLS and demonstrated only a limited understanding of issues involved. Staff did not know if anyone on the units they worked on were subject to a DoLS authorisation and were not aware that they did not have the legal right to prevent people from leaving the service without a DoLS authorisation in place. Further, staff did not understand the principles of the Mental Capacity Act or how to assess if a person had capacity to make a decision. One staff member said, "I would be guessing if said that" when asked if they knew what a mental capacity assessment was. We spoke to the registered manager about this and we were told this would be addressed. On day two of the inspection the registered manager advised us that all staff had been scheduled for training and this would be completed by the end of June 2016. Records confirmed training had been booked for all staff at the home.

Records showed that people's mental capacity had been considered as part of their initial and on-going assessment. We observed that people's consent was sought by staff before assisting or supporting them. Staff told us they supported people to make choices, for example about what to eat or what to wear. One staff member said they used visual aids to help people make choices with their clothing. They told us they asked the person, "Do you want this red dress or the blue one, and hold them up for them to see."

People's nutritional needs were assessed and regularly monitored. For example, people's weights were monitored to ensure that people remained within a healthy range, and when concerns were identified further action was taken to monitor and improve this. People were supported with their nutrition with referrals to dieticians or speech and language therapists when necessary. One relative told us, "The speech therapist put [relative] on a food thickener."

There were menus on display on tables setting out the choice of meals for the day. Staff told us that they showed people the different types of meals available if that helped them to make a choice and we observed this during the inspection. The cook told us that the service had a three week rolling menu which was designed with input from people that used the service. They told us if a person did not want either of the two meal choices on any given day they were able to request something else. One person told us, "Sometimes the staff will cook me [culturally specific] food and they are very good at it but the regular meals are better than okay." Another person said, "Lovely food." A relative told us, "The food is a good choice." Another relative told us, "[Relative] likes the food they are eating."

The cook told us that one person required a pureed diet. They said they ate the same meals as other people but the food was pureed all together. This meant the person was not able to identify the different component parts of the meal and different flavours. We discussed this with the cook and registered manager who both agreed to puree the different parts of the meal separately in future.

We saw that people were able to choose to eat their meals either in their bedrooms or communal areas. We observed one person being supported by staff to eat their lunch and the support was provided in a sensitive manner, going at the pace that suited the person. Food served looked appetizing and nutritious.

People's healthcare needs were monitored by knowledgeable and consistent staff, and staff understood how care should be delivered effectively. One person said, "The GP comes regularly or when we ask especially." Staff were aware of people's health needs and could recognise when people were unwell. One relative said, "If [relative] not well they [staff] will call the doctor." One health professional told us, "Any problems they [staff] will liaise straight away." People who lived at the home had regular healthcare checks and care records showed that people had access to specialist nurses and their local doctors when they

needed extra support. Records showed people were supported to access a range of visits from healthcare professionals including chiropodists, dentists and opticians as necessary.

Good

Is the service caring?

Our findings

People who used the service, relatives and health professionals told us the care and support provided was of a high standard. We saw that people received care and support from staff who were caring and understood their needs. One person told us, "The carers are lovely." Another person said, "It's a very happy place and the staff try so hard to make us content." A relative told us, "I think it's brilliant. [Relative] is well cared for and her needs are met." The same relative told us, "I thank them [staff] from the bottom of my heart for saving [relative] life." Another relative said, "[Relative] loves it there and loves the staff. The staff are like friends." A third relative told us, "If I have to go into a care home I want to go to George Mason Lodge."

The registered manager and the staff were clear that their role was to support people to live the lives they wanted to. For example, the home had arranged an office space to be made available to a person who lived in the home. This was to enable the person to reminisce about their previous working life. The registered manager told us she was "passionate" about the care being provided to people. Staff felt empowered by the registered manager to deliver a service that focused on the individual. The maintenance person told us, "It's their home at the end of the day." One staff member said, "You have to remember that each individual is different." Another staff member told us, "You have to have a passion for this kind of work. You either love these people or you should go. No exceptions." A third staff member told us, "We are all encouraged by the management to think of ourselves as a family. We are asked and wish to spend more time with those who are not so able, we make sure that nobody gets left out. It doesn't matter if life is nearly over, all the more reason to have as happy a time as possible."

We spent time in the lounge and dining areas at the home and observed staff approach people in a sensitive way and engaged people in conversation which was meaningful and relevant to them. There was a positive atmosphere throughout our visit and people's requests were responded to promptly. Throughout the visit, the interactions we observed between staff and people who used the service were friendly, respectful, supportive and encouraging. We heard staff call people by their preferred names. For example, we heard a staff member ask a person if they would like to go for a walk. The person responded, "Can you help me?" and the staff member said, "Yes I can." We also heard a staff member ask someone if they would like a cup of tea and the person responded, "I would love one." A relative told us, "It's very caring. Some occasions people will get frustrated and the staff handle the situation calmly and effectively."

Staff told us how they made sure people's privacy and dignity was respected. They said they knocked on people's doors before entering their rooms. We observed staff knocking on doors and ask if it was okay to come in before entering people's rooms. One staff member told us, "If you're washing people make sure the doors and curtains are closed so they have their dignity and privacy." Staff told us they tried to maintain people's independence as much as possible by supporting them to manage as many aspects of their care that they could. One staff member told us, "Because we work with the same individuals we get to know people and we learn what they can do." Another staff member said, "You have to give people respect. You have to ask them if it is OK to give them personal care. We know what they can do for themselves." A person told us, "I can get up whenever I want." A relative said, "They [staff] respect him [relative]. They make sure he is appropriately dressed."

People's needs relating to equality and diversity were recorded and acted upon. Staff members told us how care was tailored to each person individually and that care was delivered according to people's wishes and needs. This included providing cultural and religious activities and access to their specific communities. Also arrangements had been made to provide food that reflected people's culture.

Relatives told us there were no restrictions on when they could visit their family member. This was confirmed as we saw people's relatives and friends visiting without prior notice or appointment. We saw and heard visitors welcomed into the home. Relatives told us the staff were kind and caring and they always felt welcome to visit. A relative told us, "We are always made to feel welcome at any time." Another relative said, "We are invited to pop in at anytime. I live just up the road. Some other relatives live practically on the doorstep. They are often here."

Staff had decorated the hallways and communal rooms to help people find their way around and to promote memories and conversations. Outside each person's bedroom was a "memory box" which had objects relevant to that person's life. For example, the memory boxes had photos of the person and their family, objects associated with the person's working life, and music memorabilia. There were vintage artefacts available for people to handle and reminiscence with. Also each floor had "dementia bags" with objects in that people could take it out and this would facilitate memory association. This also meant people were at a reduced risk of becoming restless with their surroundings.

Good

Is the service responsive?

Our findings

People told us they felt staff supported them and responded to their needs, they said they were asked about their interests and preferences and were offered choices. One person told us, "The staff are kind and cheerful. They leave me be when I don't want to take part." A relative said, "They [staff] know them well such as their likes and dislikes." Throughout our inspection people were cared for and supported in line with their individual wishes.

People had their needs assessed by the registered manager before they moved into the service to establish if their individual needs could be met. Relatives told us they were also asked to contribute information when necessary so that an understanding of the people's needs was developed and recorded. One relative told us, "[Registered manager] did an assessment. My sister was there."

Care records contained detailed guidance for staff about how to meet people's needs. There was a wide variety of guidelines regarding how people wished to receive care and support including their likes and dislikes, personal care, washing and dressing, toileting, skin and oral care, eating and drinking, medicines, medical condition, communication, mental health and cognition, mobility, social and hobbies, and cultural and spiritual needs. The care plans were written in a person centred way that reflected people's individual preferences. For example, one support plan stated "[Person] talks about projects or work ventures which he was involved. Although it might not make sense to us it is very real to [person]. Staff need to be understanding and show empathy." Care files also included a section which had details of the person's life history including previous jobs, memorable events and family history.

People were encouraged by staff to be involved in the planning of their care and support as much as possible. Staff told us they read people's care plans and they demonstrated a good knowledge of the contents of these plans. We were told that plans were written and reviewed with the input of the person, their relatives, their keyworker and records confirmed this. Care plans were reviewed regularly. One relative told us, "I am invited to meetings. We have had discussions about the care plan." Another relative said, "I went there for a meeting in April. We discussed if [relative] happy there and any concerns." Detailed care plans enabled staff to have a good understanding of each person's needs and how they wanted to receive their care.

The home had a unit which was "short stay" which meant people were there from hospital or transitioning between accommodation. People on average were in the "short stay" unit for around six weeks. People in this unit had care plans however, these did not always contain personalised information about how to support the individual. For example, the care plan for one person about their personal care needs stated, "[Person that used the service] needs a lot of prompting and supervision in order to have a wash. He is assisted with bath and shower as and when needed." There was no information about how to provide this support to the person, for example about what they could do for themselves or what staff needed to do.

People and their relatives told us they were able to spend their days as they pleased and care staff supported them in their choices. We saw some people doing individual activities, such as reading, jigsaw

puzzles, listening to music and watching television. People told us they could also spend time in shared activities. The home did not employ an activities co-ordinator however the registered manager told us the care staff mostly led on group activities. The home had done an analysis of the staff's interests and matched leading activities on those interests. For example, if a staff member had an interest in fitness then they would lead on this activity. On the first day of our inspection we saw one of the people who used the service leading on a Tai Chi activity. The registered manager told us this person did this once a week for people. That afternoon a group of people went to visit a local museum. On the second day of the inspection the home had arranged an entertainer to sing for people living at the home. Throughout the inspection we saw staff member's singing, dancing and engaging with people. People were involved with the garden and growing vegetables. The maintenance person told us, "We all eat the produce the garden provides." A relative told us, "They do cooking and play bingo. On Tuesday [relative] went to a museum and they thoroughly enjoyed it." Another relative said, "Things going on there everyday. People come in and play guitar, wine tasting and bingo."

People were encouraged to build and maintain links with their community by taking part in local and national events and by inviting people and organisations to visit. For example, the registered manager had invited the local school to take part in an art project which involved students and people painting an outside wall at the home. Also the home had the local football club attend to help people with exercise, and a local craft shop visit to lead on arts and crafts. The home were also doing activities as part of "Dementia Awareness Week" which included visiting local museums and paintings by people on display at a local art exhibition. Also last year the home had started a choir of staff members and people who used the service. The choir performed for people in the home and other events such as memorial services for people who had passed away.

Resident meetings were held monthly and we saw records of these meetings. The minutes of the meetings included topics on food, activities, laundry, complaints and cleanliness of the home.

There was a complaints process available and this was on display in the communal area so people using the service were aware of it. Staff we spoke with knew how to respond to complaints and understood the complaints procedure. We looked at the complaints policy and we saw there was a clear procedure for staff to follow should a concern be raised.

People knew how to make a complaint and knew that their concerns would be taken seriously and dealt with quickly. There were systems to record the details of complaints, the investigations completed, actions resulting and response to complainant. Records showed there had been one complaint since our last inspection. We found the complaint was investigated appropriately and the service aimed to provide resolution in a timely manner.

Requires Improvement

Is the service well-led?

Our findings

In preparing for this inspection we looked at the information we already held about the service. We found the provider had not sent us any statutory notifications for people authorised for Deprivation of Liberty Safeguards (DoLS). During the course of this inspection we found that 18 people had been authorised for DoLS and CQC had not been sent notifications of these. We discussed this with the registered manager who said they were not aware that such incidents needed to be notified to CQC.

The above issue was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We found the provider had not sent us any statutory notifications for four deaths since the last inspection. We discussed this with the registered manager who said they were not aware that the death of a person who used the service needed to be notified to CQC.

The above issue was a breach of Regulation 16 of the Care Quality Commission (Registration) Regulations 2009.

People and their relatives told us that they liked the home and they thought that it was well led. One person said about the registered manager, "Wonderfully good natured and imaginative." A relative said, "She is fair and very good." Another relative said, "She is excellent and very professional." A third relative told us, "I find her helpful and co-operative. If you have a concern you can approach her." A visiting health professional said, "She is very good. Any problems she will deal with them."

There was a registered manager in post and a clear management structure. Staff told us the registered manager was open and approachable. They said they felt comfortable raising concerns with them and found them to be responsive in dealing with any concerns raised. One staff member told us, "Management is very good. [Registered manager] is good. Anything you want for service users she is quick to help out. She is really open, you go to her and she helps. She is not a manager you are scared of going to." Another staff member said, "She is a good manager. She listens to you, she is very fair." A third staff member told us, "I am very happy with the way [registered manager] manages. She interacts with everybody in the house."

Staff told us the service had regular staff meetings. Staff said that team meetings were helpful and that all staff had input into discussions about the service. Records confirmed that staff meetings took place regularly. Agenda items at staff meetings included health and safety, safeguarding, updates on people who used the service, activities, and maintenance. One staff member told us, "We have regular monthly meetings. You bring in whatever issue, health and safety, the food, anything. We all bring in our opinions."

The provider's quality assurance system included asking people and their relatives about their experience of the service. The questionnaires asked what people thought of the quality of food, if people have a choice, staffing, care planning and what the home could do better. The provider took action to improve the quality of the service based on the results of the surveys. For example, in response to issues raised about the food

menu the home had arranged a meeting for people to discuss. Comments on the questionnaires included "Can't fault staff at all" and "Mix of different needs is difficult but the staff do it well."

The provider's service manager monitored the quality of the home through regular visits, during which they checked the environment, paperwork including care plans, medicines, speaking to people who used the service and staff interaction with people who used the service. The service manager also monitored night staff by doing unannounced night visits. Records confirmed this.

There were policies and procedures to ensure staff had the appropriate guidance, staff confirmed they could access the information if required. The policies and procedures were reviewed and up to date to ensure the information was current and appropriate.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 Registration Regulations 2009 Notification of death of a person who uses services The registered person did not notify the Care Quality Commission about statutory notifications for the death of a service user. Regulation 16(1)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered person did not notify the Care Quality Commission about statutory notifications for people authorised for Deprivation of Liberty Safeguards (DoLS). Regulation 18(4)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not protect service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the recording and safe administration of medicines. Regulation 12(f)(g)