Silverleaf Care Homes Limited

Highfield Private Rest Home

Inspection report

77 Seabrook Road
Hythe
Kent
CT21 5QW

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13 June 2016

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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?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 10 and 13 June 2016 and was unannounced.

Highfield Private Rest Home is a care home providing care and support for up to 31 older people. There were 28 people living at the service at the time of our inspection. People cared for were all older people and were living with a range of care needs, including diabetes and epilepsy. Some people needed support with all of their personal care, and some with eating, drinking and their mobility needs. Other people were more independent and needed less support from staff.

Highfield Private Rest Home is a large proportioned detached house. Accommodation is provided over three floors, with a passenger lift and stair lifts allowing stair free access. There are communal sitting and dining rooms together with a sun lounge. Large enclosed gardens are accessed at the rear of the property.

The service had a registered manager in post. A registered manager is a person who is 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.

Highfield Private Rest Home was last inspected on 29 August 2014 and no concerns were identified. At this inspection we identified shortfalls where some regulations were not being met.

Medicines were not managed, administered or stored safely; the service could not account for some missing controlled medicine.

Service and safety certificates could not be located for some equipment used at the service.

No system was in place providing an oversight of incidents and accidents; not all incidents and accidents were recorded and reviews following an incident did not always link back to risk assessments and care planning.

Recruitment checks were incomplete because they did not ensure all staff employed were suitable to work at the service.

Deprivation of Liberty Safeguarding authorisations had not been applied for where people were unable to consent to restrictions in place; and mental capacity assessments had not been completed in line with the requirements of the Mental Capacity Act 2005.

Elements of some care plans were not tailored to individual preferences and clear links were not always made between some conditions and other associated care needs. This did not provide the service with the best and earliest opportunity to be responsive to changes in people's needs.

Auditing carried out for the purpose of identifying shortfalls in the quality and safety of the service provided had not been wholly effective.

People were supported by enthusiastic staff who received regular training and appropriate supervision. There were enough staff to meet people's needs.

Staff were caring, compassionate and responsive to people's needs and interactions between staff and people were warm, friendly and respectful. Staff spent time engaging people in communication and activities suitable for their current needs.

Referrals to outside healthcare professionals were made in a timely way.

People enjoyed their meals, they were supported to eat when needed and risks of choking, malnutrition and dehydration had been adequately addressed.

People commented positively about the openness of the management structure and were complimentary of the staff.

We found a number of 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 the report.

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.

Medicines were not stored, administered or recorded properly.

Risk assessments were not always reviewed when needed and management of incidents and incidents lacked oversight.

Recruitment processes did not ensure mandatory checks were completed for all staff.

People were supported by enough staff.

Is the service effective?

Requires Improvement

The service was not always effective.

Deprivation of Liberty Safeguarding authorisations had not been applied for when warranted.

Mental capacity assessments did not always taken place to the requirements of the Mental Capacity Act 2005.

People were supported to eat and drink when needed and they enjoyed the variety of food provided.

Training and supervision for staff had been carried out regularly and was effective in practice.

Is the service caring?

Good

The service was caring.

Staff were kind to people. They respected people's privacy and dignity, and maintained their independence.

Staff communicated well with people and their family members, giving them information about any changes.

People's families and friends were able to visit at any time and were made welcome.

Care records and information about people was treated confidentially.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Individual support preferences had not always been established and some information was not detailed enough to guide staff to support people consistently.

A complaints procedure was in place, people and visitors told us they had not needed to complain.

People enjoyed a range of activities and were supported to stay in touch with friends and family.

Is the service well-led?

Requires Improvement

The service was not always well led.

Audits and quality assessments were not wholly effective in identifying shortfalls within the service and records were not always complete.

Staff felt supported. They were aware of the service's values and behaviours and these were followed through into their practice.

People, their relatives and staff thought the service was well run and spoke positively about the leadership of the registered manager.

There was an open and transparent culture; people and staff felt encouraged to speak up with suggestions and concerns.

Highfield Private Rest 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 was a planned comprehensive inspection 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.

We undertook an unannounced inspection of this service on 10 and 13 June 2016. The inspection was undertaken by one inspector.

We focused on speaking with people who lived in the service, speaking with staff and observing how people were cared for and interacted with staff; including the lunchtime meal, administration of some medicines and the activities taking place. To help us capture the experiences of people who may not be able to express this for themselves, we used short observational framework for inspection (SOFI). SOFI is a tool developed with the University of Bradford's School of Dementia Studies and focusses on people's levels of engagement and mood as well as the quality and purpose of interaction between people and staff. We looked in detail at care plans and examined records which related to the running of the service. We looked at six care plans and four staff files as well as staff training records and quality assurance documentation to support our findings. We looked at records that related to how the service was managed such as audits, policies and risk assessments. We also pathway tracked some people; this is when we look at care documentation in depth and obtain people's views on their day to day lives at the service. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

We looked around most areas of the service including some bedrooms, bathrooms, lounges and the dining area as well as the kitchen and laundry area. During our inspection we met and spoke with 10 people who live at the service, four visitors, three care staff, the chef, and the registered and deputy managers.

We reviewed the information we held about the service. We considered information which had been shared with us by the local authority. We reviewed notifications of incidents and safeguarding documentation that the provider had sent us since our last inspection. A notification is information about important events which the provider is required to tell us about by law.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe and were happy living at the service. Their comments included, "I feel happy and settled here", "I am well looked after" and "This is the only home I've ever come back to; that should tell you a lot". A visitor we spoke with felt they were kept up to date with the care and support their relative received and told us, "I don't have any doubts or concerns about, the dedication of the staff, the safety of my relative and the care they receive". During our inspection the relatives of a person who had moved to another home came back to Highfield Private Rest Home to thank staff for the care and support their relative had received.

Although people and visitors gave positive feedback about the service, we identified areas of concern which meant that the service was not safe.

Medicine management was not safe. We assessed the procedures for ordering, receipt, storage, administration, recording and disposal of medicines. A central medication room contained some medicines and also acted as a storage area for any medicines due to be returned to the pharmacy. Non refrigerated medicines need to be stored at temperatures not exceeding 25°C, this is because storage above this temperature risks medicines becoming desensitised, not working as intended or potentially ineffective. An independent audit identified temperatures were not monitored in the medication room, despite a thermometer hanging on the wall. During our inspection temperatures in the medication room reached 29°C. Additionally, for the same reasons, refrigerated medication should be stored at temperatures between 2°C and 8°C. Records of fridge temperatures showed this range was once exceeded, albeit marginally. No action had been taken to address either of these shortfalls.

Procedures for the return of medicine no longer required were ineffective; our checks showed a controlled drug was unaccounted for and could not be located within the service. When discussed with the registered and deputy managers, they were unable account for this discrepancy. When not in use, portable trolleys used to store and administer medicines from must be secured to prevent unauthorised removal. The service used two trolleys, checks found one trolley was unsecured because the securing point had been removed from the wall.

Medicine administration records (MAR) were not always completed by staff when prescribed medicines were administered. The MAR is a part of a person's care records, staff are required to sign the record at the time that the medicine is administered or code the MAR correspondingly if medicines are not given or are refused. The failure to do so presents a risk that medicine has not been administered and that medicine may be incorrectly re-administered by another staff member. Similarly, records intended to show prescribed creams were applied to people were not always completed.

People were at risk of unsafe care and treatment because reviews of incidents and accidents did not always link back to risk assessments or always record sufficient measures required to keep people safe. For example, a person had suffered a fall onto concrete while smoking in the garden; they were unsupervised at that time and required emergency treatment as the result of the fall. Their risk assessment was not reviewed

following the fall and no measures introduced to reduce the risk of them falling again. People were at risk of continuing injury and poor care because investigation of accidents and incidents did not reflect learning to minimise the risk to people of incidents happening again. Management of accidents and incidents did not always feedback into risk assessment reviews. There was no system of oversight for incidents and accidents which may have identified trends and allowed for timely interventions. Additionally, a sample check of incidents and accidents held in people's care plans did not tally with records held by the registered manager. Therefore accidents reported to the registered manager were understated and would not be subject to proper review.

Providers are required to ensure the premises and any equipment used there are safe. Although a gas certificate certified the boilers as fit for purpose and safe to use, checks did not extend to other gas appliances used at the service such as the tumble driers and cooker range. Additionally, the service was not able to provide certification for the service and safe operation for the two stair lifts.

The provider had not ensured medicines were stored, administered or disposed of safely or that some equipment used within the service was safe and remained fit for purpose. This was a breach of Regulation 12 (1)(2)(a)(b)(d)(e)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not protected as far as practicably possible by a safe recruitment system. Disclosure and Barring Service (DBS) checks had not been undertaken for two people working at the service. DBS checks are required for unsupervised volunteers and staff aged 16 and above who have direct access to, or work directly with adults at risk. This is to establish if any cautions or convictions mean that an applicant is not suitable to work at a service. Staff should not work unsupervised before DBS check results are known.

Processes were incomplete; this did not promote the principles of a robust recruitment process to protect the safety of people living at the service. This is a breach Regulation 19 (1)(a)(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were sufficient staff to meet people's needs. People and relatives told us they were satisfied with staffing levels. We spoke with people about how long it took staff to come to their bedroom if they pressed the call bell or if they needed help around the service. People were confident staff would come when called, no one told us they felt they had to wait for too long. Staffing numbers were established based upon people's dependency needs. The registered and deputy managers provided support and oversight for the service as well as 'hands on' assistance with some delivery of care and support. Care staffing comprised of five carers per morning shift and four carers in the afternoons, always including a senior carer. Three waking staff provided night support. Other staff undertook other duties such as housekeeping and maintenance duties. A chef provided meals supported by kitchen and supper assistants. Agency staff covered any shortfalls that could not be met through use of existing staff. The service ensured they used the same agency and staff where possible, this helped to ensure consistency of care. The two agency staff on duty during our inspection and knew each person by name and were knowledgeable about individual support needs. The registered manager confirmed an open dialogue with the provider about staffing numbers who had recently agreed to the recruitment of an additional member of care staff.

Any concerns about people's safety or wellbeing were taken seriously; records confirmed staff had received safeguarding training. Discussion with staff showed they understood about keeping people safe from harm and protecting them from abuse. Staff described different types of abuse and what action they would take if they suspected abuse had taken place. There was a policy and procedure that informed them what to do. The service were familiar with locally agreed safeguarding protocols. Staff said in the first instance they would alert any concerns they might have to the registered manager, but understood about and could

name the relevant agencies that could be contacted if their concerns were not acted upon.

Environmental safety audits highlighted any hazards or repairs needed throughout the service and records confirmed these had been signed off as completed promptly. We walked around the service and looked at most areas of it. Many areas were recently decorated, the service benefited from an onsite hair salon, most bathrooms were refurbished and a new sluice room provided. People, visitors and staff commented positively about the upkeep of the service and the improvements made. One visitor told us "I have noticed an appreciable investment in the décor of the home". A maintenance planner scheduled any remaining work for completion.

Records showed other equipment was checked regularly to help keep people safe. Checks included the electrical installation, boiler gas safety, portable electrical appliances, fire alarm and fire fighting equipment. Tests and checks of the alarm and emergency lighting were carried out on a weekly and monthly basis, to ensure equipment was in working order. Service contracts ensured equipment to support people with their mobility such as the service's shaft lift was safe and fit for purpose.

People were protected from fire and other urgent risks. Personal emergency evacuation plans were in place for each person and included information about individual support needs. Numbers of staff needed to assist people and any equipment required, such as a wheelchair or walking frame. Collapsible emergency evacuation chairs were positioned around the service, ensuring they were ready if needed. There was an emergency plan in place for major incidents which had been recently reviewed. Fire alarm drills were recorded.

Requires Improvement

Is the service effective?

Our findings

People and their relatives spoke positively about the quality of care provided. People told us they had confidence in the staff who supported them, they felt staff understood their needs and knew how to meet them. Comments included, "All of the staff are very good", "Staff are hardworking and efficient" and "The staff are all very considerate and friendly". People and their relatives said staff communicated well with them. A visitor commented, "Staff are always welcoming, they all know my name and are good at keeping me up to date about how my relative is". Other visitor's comments included, "I feel reassured by the staff, I come here any time on different days and I am always welcome, it makes me feel there is nothing to hide". We looked at records from visiting health care professionals and spoke with staff; staff were knowledgeable about the people they supported, they had taken on board comments and instructions from visiting health care professionals and were proactive in ensuring people received the care and support they needed. However, we identified some concerns which meant that the service was not always effective.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS form part of the Mental Capacity Act (MCA) 2005. It aims to make sure that people in care settings are looked after in a way that does not inappropriately restrict their freedom, in terms of where they live and any restrictive practices in place intended to keep them safe. The MCA requires providers to submit DoLS applications to a 'Supervisory Body' for authority to impose restrictions. We discussed with the registered manager whether referrals had been made where people lacked capacity and were subject to continuous staff supervision. Although the registered manager acknowledged there were people who would be unable to leave the service without constant supervision, mental capacity assessments or best interest meetings had not been completed and applications had not been made to the local authority for DoLS authorisations.

A person must not be deprived of their liberty for the purpose of receiving care or treatment without lawful authority. This is a breach of Regulation 11(1-5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Otherwise, particularly in relation to day to day decisions, staff understood the basis of the MCA and how to support people who did not have the capacity to make a specific decision. We heard staff encourage people to take their time to make decisions and staff supported people patiently whilst they decided. Staff gained people's consent to give them care and support and carried this out in line with their wishes. People were involved in their day to day choices about the food they ate, the clothes they wore and the activities they preferred. Policies reflected that where more complex or major decisions needed to be made, involvement of relevant professionals such as GP's and an Independent Mental Capacity Advocate was required. Advocates are people who are independent of the service and who support people to make and communicate their wishes. Information about these processes was available to people and visitors within the service. We saw examples where the advocacy service had been used.

New staff members told us and training records confirmed they were required to complete an employer specific induction programme. This concentrated upon the expectations of the provider in terms of their policies and safety aspects around the service. Induction progress was monitored and signed off once

complete by senior staff. Staff who had not completed the induction programme were not permitted to work unsupervised.

The service did not subscribe to the Care Certificate, which is an identified set of standards that social care workers should keep to in their daily working life. The Care Certificate is not a mandatory requirement; however, the expectation is that appropriate staff who are new to services will achieve the competences required by the Care Certificate as part of their induction. The induction programme in place, in combination with mandatory and vocational training provided, broadly addressed each standard set out in the Care Certificate and met the needs of staff employed and people supported.

There was an established programme of on-going training for staff. Training records and certificates confirmed the training undertaken. The training plan identified when essential training, such as fire safety, health and safety, manual handling and safeguarding required updating. Staff training identified other courses relevant to the needs of people supported by the service such as dementia, epilepsy and diabetes awareness as well as catheter care. Care staff were encouraged to carry out formal training in health and social care, such as vocational qualification training or diplomas to levels 2 or 3. These are work based awards that are achieved through assessment and training, and show staff have the ability to carry out their job to the required standard. Most care staff had undertaken this. Staff rotas confirmed the service gave appropriate consideration to the skill mix of staff when planning the various shifts. This helped to ensure people's needs could be effectively met.

Staff spoke positively about training received and were able to tell us how they used it in their day to day role, for example, in relation to skin care to reduce the risk of pressure areas. People told us they trusted the staff, thought they were well trained and knew how support them. One person commented, "They all know their job and are good at it". Discussion with staff confirmed they understood their roles and responsibilities. Staff told us they felt valued and proud of where they worked. They described the service as clean, friendly and a homely place for people to live.

Staff supervision and appraisal took place in line with the service's policy in addition to informal discussions to keep up to date with any changes. Supervisions included discussions about previous action plans, the job role, working relationships, reviews of training and personal development plans. Staff said this gave an opportunity to talk about any concerns, think about their development and receive support to achieve their goals. The supervision process enabled the registered manager to maintain oversight and understanding of the performance of all staff to ensure competence was maintained. This helped to ensure clear communication and expectations between managers and staff. Supervision processes linked to disciplinary procedures where needed to address any areas of poor practice, performance or attendance.

We observed staff handover during the change of shift. This was structured and informative, giving a detailed and individual summary of people in terms of their wellbeing and any needs as yet unmet. The service used a diary system to keep track of medical appointments, blood tests and follow up of blood test results.

Each person had a health care plan. This set out their initial assessment when they arrived at the home and regular, subsequent reviews charted changes in their health needs and ongoing support needed. Care staff were knowledgeable about the people they supported, their specific health needs and how the needs should be met. Where needed, the service sought input from social and health care professionals such as the community psychiatric team, speech and language therapists and occupational therapists. This helped to ensure people received the right help to support any emerging needs. People told us they saw their GP when they needed to and felt their health care needs were being met.

Relatives were satisfied with the health care people received at the home. Chiropodists, dentists and opticians visited the home when people needed them. The registered manager recognised the importance of seeking expertise from community health and social care professionals so people's health and wellbeing was promoted and protected. Where people needed specialised support, for example, pressure relieving mattresses and cushions to help reduce the risk of skin damage, suitable equipment was in place.

People received a wide variety of homemade meals, fresh fruit and vegetables were available every day. People told us they enjoyed the food and appreciated the efforts of the chef and kitchen staff. A menu planner showed lunch and supper time meals and choices of desserts. There was a selection of breakfast choices, including a cooked breakfast. The food served was well presented, looked appetising and was plentiful. People were encouraged to eat independently and supported to eat when needed. Drinks were provided during meals together with choices of refreshments and snacks at other times of the day. Where people required soften or low sugar meals, these were provided. Staff encouraged people to drink where needed. The chef was familiar with people's different diets, and kitchen staff regularly discussed menus and the food with people. This helped to ensure they were aware of people's preferences and received direct feedback about the food they provided. Kitchen standards had been assessed by the Environmental Health Authority and had achieved a five star rating, this being the highest standard.

Good

Is the service caring?

Our findings

People were cared for in a kind and compassionate way and said they were happy and content in the service. One person said, "The girls (staff) are really very good." Another person told us "I'm very happy with all the staff, there's not a bad one among them". A relative commented about their mother, saying, "They took great care of her, she improved tremendously coming to live her. The staff, the manager, honestly I couldn't have wished for better".

People told us staff listened to them and acted on what they said; they felt valued and respected as individuals. This was evident from our observations during the inspection together with their enthusiastic and engaged delivery of support.

Staff were clear about how to treat people with dignity, kindness and respect. All of our observations were positive, staff used effective communication skills which demonstrated knowledge of people and showed them they were thought of as individual. For example, if people were seated staff crouched down, often touched the person's hand or arm and spoke with people at the same level. They made eye contact and listened to what people were saying and responded according to people's wishes and choices. This approach helped people not to feel intimidated, it gave people the sense that staff were being sincere with them and helped to orientate people to the responses staff gave. Staff were courteous and polite when speaking to people behind closed doors. For example, we heard a staff member supporting a person in their room. They gave the person time to respond and spoke in a way that was friendly and encouraged conversation.

Staff showed attention to the details of care, people's hair was brushed; they were helped with nail care, jewellery or make-up, or assisted with shaving. Clothes were clean and ironed. This level of care helped to demonstrate that staff valued and respected the people they supported. Visitors confirmed they found staff knowledgeable about the support their relative needed. They commented that whenever they visited, people seemed well cared for and happy. People were supported to maintain important relationships outside of the service. Relatives told us there were no restrictions on the times they could visit the service, they were always made welcome and invited to events. Staff recognised people's visiting relatives and greeted them in a friendly manner and offered them drinks. Visitors told us they could speak to people in private if they wished and gave positive comments about how well staff usually communicated with them, for example, about changes in people's health.

Staff knew people well and demonstrated a high regard for each person as an individual. Staff spoke with affection about the people they cared for. They were able to tell us about specific individual needs and provide a good background about people's lives prior to living at the service; including what was important to people. We saw people were addressed by their preferred name and staff took the time to recognise how people were feeling when they spoke with them. For example, one person became agitated and confused about where they were. Staff spoke calmly and slowly with the person while stroking their hand which helped to calm them down.

People's privacy and dignity was protected. Staff knocked on people's doors and tended to people who required support with personal care in a discreet and dignified manner. When supporting people with their continence, if in a communal area, rather than asking people if they needed to use the toilet staff asked if people wanted to "powder their nose" or "have their hair brushed" or "come for a little walk". People knew what this meant and found it a less intrusive or obvious way of being prompted to use the toilet.

Throughout the day staff spent time with people, chatting often with appropriate and shared humour and laughter. Some people shared experiences with each other as they chatted with staff, reflecting on past times and encouraging each other to reminisce. Staff encouraged conversations and activities which they knew people enjoyed. Some people enjoyed games whilst other people received their daily newspaper and spent time quietly reading or listening to music. Staff actively encouraged people to remain independent and participate in activities of their choice.

Care plans recorded details of end of life care arrangements. When needed, this was provided in conjunction with community nursing or hospice services. The service had adopted a system of 'Just in Case' boxes to support anticipatory prescribing and access to palliative care medications, for people who were approaching the end of their life. People often experience new or worsening symptoms outside of normal GP practice hours. The development of 'Just in Case' boxes seeks to avoid distress caused by poor access to medications in out of hours periods. This is done by anticipating symptom control needs and enabling availability of key medications in the service.

The registered manager told us a member of staff would always sit with a person in their final hours, ensuring they were comfortable and addressing any needs with dignity and compassion. Funeral arrangements were discreetly available and staff and people could be supported to attend if they wished.

Care records were stored securely and information was kept confidentially. Staff had a good understanding of privacy and confidentiality and there were policies and procedures to underpin this.

Requires Improvement

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 choice in all parts of their care. One person told us, "I like to stay in my room, so that's what I do. Staff look in on me and I have a call bell if I need help". Another person commented, "They know exactly how to look after me and that's what happens; they look after me exactly as I've asked them to". Throughout our inspection people were cared for and supported in line with their individual wishes. However, some elements of care planning were not tailored to individual symptoms or care needs. Without individual needs identified and supported, the service could not be wholly responsive to people's needs.

Pre-admission assessments were completed from the outset and intended to ensure the service could meet people's individual needs. These included all aspects of their care, and formed the basis for care planning after they moved to the service. Each person had a care plan. Their physical health, mental health and social care needs were assessed and care plans developed to meet those needs. Care plans included information such as people's next of kin, medication, dietary needs and health care needs. However, we found that some aspects of care planning were not sufficiently developed or adequately detailed to be individually meaningful. For example, diabetes and epilepsy support plans were not personalised specifically for the people they were intended to support. There was no guidance for staff about acceptable blood sugar ranges for people or any details of symptoms a person may display if blood sugar levels ranged outside of safe margins. Similarly, where a person experienced epilepsy, seizure records were not maintained; there was no information about the type of seizures the person had or symptoms staff should look out for which may indicate a seizure was imminent. This would have helped to identify the support needed as well as any changes in the frequency or type of seizures and provided information in anticipation of medicine reviews.

Information and care requirements were not always specific to individuals, making it difficult to know if their health care needs would be effectively managed. For example, there was no information provided to staff about how and when people's catheter bags should be emptied, how the catheter tube should be positioned to prevent risk of skin damage or compression of the tube, which may prevent adequate drainage.

Individual needs and preferences had not been fully established. The provider had not ensured care and treatment was person centred to meet with people's needs and reflect their preferences. This was in breach of Regulation 9 (1)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Changes in health or social needs were responded to. Short term care plans were in place for people with acute conditions for example chest and urinary infections. Other examples included assessments and care plans drafted with the support of mental health services where a person's behaviour had changed. Where weight loss was noted for another person, an action plan also ensured relevant external bodies had been consulted such as their GP and a dietician. Where advice and instruction was received from health care professionals, such as District Nurses, these directions were put into practice. This showed evidence of staff being responsive to the changing needs of people who lived at the home.

An activities timetable was displayed in a communal area. Some of the activities listed included quizzes, puzzles, armchair exercise, outings, visits to the local park and visiting musicians. There was much laughter during the activities observed and people told us they enjoyed spending time with one another and staff. People were supported to stay in touch with family and friends. The service organised outdoor seasonal events. People were encouraged to have visitors to stay for meals.

The service had a complaints procedure, which was available to people and visitors to see. It was also included in the information given to people and their relatives when they moved to the service. The procedure was clearly written; it contained details of different contacts and set out timescales in which complaints should be addressed. There was an 'open door' policy and the registered manager made themselves available to people and their relatives, this was evident during our inspection and commented upon positively by visitors we spoke with. There was a system for people to write down any concerns and staff told us how they would support people doing this. People were confident they could raise any concerns with the staff or the registered manager and said they would not hesitate to complain if they needed to. At the time of the inspection, the service was not dealing with any complaints; on the contrary, they had received cards and letters expressing thanks for the care and support they had provided.

Requires Improvement

Is the service well-led?

Our findings

A registered manager was in post. People and visitors were complementary about the manager and staff, commenting positively about how approachable they were. People told us they felt staff made time for them. Relatives and visitors to the service told us they were made to feel welcome. Staff and people were positive about the registered manager, describing them as "Knowledgeable", "compassionate" and "going an extra two miles, let alone a mile". However, we identified some shortfalls which meant the service was not always well led.

Auditing and checking procedures were in place within the service. The registered manager and key staff undertook regular checks of the service to make sure it was safe and people received the support they needed. These included areas such as infection control, medicine management, nutrition, mobility, care plan quality and building maintenance. The concerns identified during this inspection illustrated the quality assurance framework in at the service was not fully effective. This was because it had not recognised or put measures in place to resolve areas where regulations were breached. These include ensuring DoLS applications were made where needed, medicines were properly accounted for, safely administered and stored within required temperature ranges. Therefore, systems had not ensured a continuous oversight of all aspects of the service.

Some records were incomplete because they did not provide a complete assessment of people's needs or record the support people had received. For example, one person experienced four falls within two months, although the service had taken action to reduce the risk of falls, their care plan did not reflect the changes made or new measures in place. In addition, records of topical creams were generally incomplete. This made it difficult to determine if people had received creams when they were supposed to.

The failure to provide appropriate systems or processes to assess, monitor and improve the quality and safety of services and maintain complete and contemporaneous records was a breach of Regulation 17(1)(2)(a)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Established systems sought the views of people, relatives, staff and health and social care professionals. All responses were positive and included comments such as 'The carers are more than excellent and treat the residents with great respect and always have a smile and time for the residents, nothing is too much for them' and 'My mum has been her for a year and is very happy, she has been very ill lately and has been looked after with great care for which I am truly thankful to you all'.

Regular meetings and a suggestions system ensured people and their families felt involved in the service and listened to. Where people had made suggestions, these were well received and acted upon. Staff felt the provider and registered manager listened to their opinions and took their views into account. For example concerns about people receiving other people's laundry back had been addressed; a revised system ensured people were satisfied with this.

Staff told us and records confirmed the culture within the service was supportive and enabled staff to feel

able to raise issues and comment about the service or work practices. Staff generally commented about the open culture at the service and felt able to speak out about anything. Staff told us, if needed, they felt confident about raising any issues of concern around practices within the service and felt they would be supported by the registered manager.

The service has a charter of rights which is given to people when they came to live there. The registered manager told us the values and commitment of the service were embedded in the expected behaviours of staff; these were discussed with staff and linked to supervisions and appraisals. Staff told us the values and behaviours included treating people with dignity and as individuals, being respectful, teamwork and making the most of people's strengths to live a fulfilled and independent life. Staff understood the values of the service and could see how their behaviour and engagement with people affected their experiences living at the service. Staff displayed these values during our inspection.

People knew the different roles and responsibilities of staff and who was responsible for decision making. Observations of staff interaction with each other showed they felt comfortable with each other and there was a good supportive relationship between them. Staff felt they worked together to achieve positive outcomes for people, for example, discussing outings or the health of a person who was agitated and suggested actions.

Policy and procedure information was available within the service and, in discussion; staff knew where to access this information and told us they were kept informed of any changes made.

Issues identified during the inspection were immediately investigated and where possible rectified. This demonstrated receptive, responsive staff and management team, who were open to suggestions and observations made.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Individual needs and preferences had not been fully established. The provider had not ensured care and treatment was person centred to meet with people's needs and reflect their preferences. Regulation 9 (1)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent A person must not be deprived of their liberty for the purpose of receiving care or treatment without lawful authority. Regulation 11(1-5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured medicines were stored, administered or disposed of safely or that some equipment used within the service was checked to ensure it was safe and remained fit for purpose. Regulation 12 (1)(2)(a)(b)(d)(e)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured appropriate systems or processes were in place to assess, monitor and improve the quality and safety of services; or ensured accurate, complete and contemporaneous records in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. Regulation 17(1)(2)(a)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Mandatory recruitment processes were incomplete; this did not promote the principles of a robust recruitment process to protect the safety of people living at the service. Regulation 19 (1)(a)(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.