North Yorkshire County Council

Benkhill Lodge

Inspection report

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Ratings

Overall rating for this service	Good

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?	Good

Summary of findings

Overall summary

This inspection took place on 14 December 2015 and was unannounced.

Benkhill Lodge is registered to provide personal care and accommodation for up to 30 older people and is situated in the market town of Bedale, close to the centre of town and local amenities. The service is not registered to provide nursing care. At the time of our inspection 19 people lived at the service permanently and three were receiving short term respite care.

The registered provider is North Yorkshire County Council. The service had a registered manager, who had been registered with us since 5 October 2015. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Medicines were safely stored and there was evidence that people received the medicines they had been prescribed. However, we saw a staff member using unsafe administration practices.

Staff were recruited safely. People who used the service told us that care staff were very busy and that they sometimes had to wait for assistance. The registered manager was recruiting staff and covering shifts with the available staff team. However, we have recommended that the registered manager reviews the numbers and deployment of staff taking into account the feedback received from people using the service.

People using the service, and their relatives, told us they felt safe at Benkhill Lodge. Staff knew how to report any concerns about people's welfare and had confidence in the registered manager taking an action needed. People had individual risk assessments in place which ensured staff were aware of the risks relevant to each person's care.

The service's premises and equipment were well maintained and in safe working order.

Staff were supported to have the skills and knowledge they needed through relevant training. Staff felt well supported and received supervision, although the frequency of formal supervision varied because of recent staff [line manager] absences.

The service was following the principles of the Mental Capacity Act 2005. At the time of the inspection one person was subject to a Deprivation of Liberty Safeguards authorisation. The registered manager understood the DoLS and when they were needed.

People told us that the food was good. Snacks and drinks were available between meals if people wanted them. People's dietary needs were assessed and monitored and support was requested from relevant health care professionals if there were concerns about people's nutritional wellbeing.

We received positive feedback from a health care professional, who told us the service worked well with them and provided a good standard of care to people.

People told us that they were well cared for and treated with dignity and respect. We saw some very good examples of person centred care and a caring attitude by staff members.

Care staff knew people well and were able to describe people's individual needs. People had their needs assessed and had care plans in place. Care plans were not very individual or person centred, but the registered manager was in the process of improving this.

People had access to activities and were involved in their local community. Visitors were made welcome and could visit when they wanted.

A complaints procedure was in place and information about this was available in the reception area. The registered manager encouraged feedback from people who used the service and their relatives, through meetings, surveys and a suggestion box.

There was a strong staff team, with many staff who had worked at the service for a long time. The registered manager and staff were committed to providing good, individual care to people. Audits and checks were completed and a service improvement plan was in place, to help the service continually improve.

We identified a breach of Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014: Safe care and treatment, because the registered provider had not ensured the proper and safe management of medicines. We have required that the registered person make improvements. 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.

Staff had not always followed safe medicine administration guidelines.

People told us that they sometimes had to wait for staff to assist them and staff rotas showed that staffing levels had sometimes been lower than the registered provider assessed as necessary.

Staff were recruited safely and knew how to safeguard people from avoidable harm.

People who used the service and their families told us they felt safe. People had individual risk assessments in place so staff knew how to manage risks to people.

Is the service effective?

Good

The service was effective.

The service followed the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Staff were provided with training relevant to their roles and felt supported by the registered manager.

People's dietary needs were assessed and a varied menu of regular meals, snacks and drinks was provided.

The service sought advice and support when needed, and worked well with health care professionals.

Is the service caring?

Good

The service was caring.

Staff treated people with respect and maintained people's dignity. We saw people receiving kind and individual support from staff.

People were able to maintain relationships, with visitors made

welcome and relationships that developed within the home recognised by staff.

People were supported to make decisions and choices about their day to day lives, such as daily routines, where they spent their time and what they ate and drank.

Is the service responsive?

Good

The service was responsive.

People had their needs assessed and planned. Staff provided responsive care according to individual needs.

The manager had identified that the information in care plans could be more detailed and person centred and was working towards this.

A complaints procedure was in place. The service encouraged feedback from people who used the service and their relatives.

Is the service well-led?

Good

The service was well-led.

A registered manager was in place. They were well thought of by staff and committed to providing good quality care.

Effective systems to monitor, assess and improve the quality of the service were in place. These included opportunities for people using the service, relatives and staff to provide feedback.

There was a strong staff team, with many longstanding staff members, who enjoyed their jobs.

Benkhill 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.

This inspection took place on 14 December 2015 and was unannounced. This meant that the registered manager and staff did not know that we would be visiting on the day of the inspection. The inspection team consisted of one inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience for this inspection had experience of caring for a person who used care services and lived with a dementia.

Before the inspection we reviewed all of the information we held about the service. We looked at any notifications we had received from the service. Notifications are information about changes, events or incidents that the provider is legally obliged to send us within the required timescale. We asked the local authority (LA) commissioning team for feedback about the service. We also contacted Healthwatch, who had recently visited the service. Healthwatch represents the views of local people in how their health and social care services are provided, but unfortunately their visit report was not available at the time of our inspection.

The registered provider had not been formally asked to complete a provider information return (PIR) before our inspection. This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. However, the registered manager was aware of the need to submit a PIR and had completed one in readiness. They provided us with a copy of the completed PIR during our visit.

During the inspection we spoke with 17 people who used the service, a relative and visitor. We also spent time observing how people spent their time and the interactions between people and care staff. We looked around communal areas within the service, and we saw a selection of people's bedrooms, with their consent.

We spoke to the registered manager, a senior care worker, four care staff, the cook and maintenance staff. During the inspection we reviewed a range of records. This included four people's care records, including care planning documentation and medication records. We also looked at staff files, including staff recruitment and training records, records relating to the management of the home and a variety of policies and procedures developed and implemented by the provider.

During the inspection we spoke with a visiting healthcare professional, who regularly visits and works with the service.

Requires Improvement

Is the service safe?

Our findings

All of the people we spoke with who used the service told us that they felt safe at Benkhill Lodge. For example, one person said, "I definitely feel safe." Another said, "If things got bad, they [the staff] would do something."

We looked at the arrangements that were in place to ensure the safe management, storage and administration of medicines. We spoke with the registered manager and the senior care staff administering medicines. Both confirmed that staff who administered medicines had received training and had their competency checked. Written evidence confirmed this.

The senior staff member was able to answer queries about people's individual medication needs and we observed some excellent interactions between the staff member and people who used the service while they were administering medicines. For example, pleasantly asking if the person wanted to take their medicines, what drink they would like, and explaining when they could have their next dose of pain relief. However, we observed some secondary dispensing of medicines [multiple people's medicines being put into small pots and taken on a tray to be administered] and a delay of 10-15 minutes between the medicines being administered and the medicine administration records (MARs) being completed. No errors occurred during our observations, but both of these practices increased the risk of errors and omissions occurring [NICE Guidance: Managing medicines in care homes]. This was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014, because the registered person had not ensured the safe management of medicines. We spoke to the registered manager about this during our visit and they ensured that the staff member concerned was reminded about safe administration practices.

Medicines were stored safely, including arrangements for the storage of drugs that are liable for misuse [sometimes called controlled drugs]. We looked at a sample of four people's MARs and the controlled drugs register. Each person's MAR included a photograph and relevant personal information. Information was available to help staff administer medicines prescribed on an 'as required' basis. When we checked the stock of medicines available against administration records, the stock and records tallied correctly. The records we viewed were up to date and showed that medicines had been administered in accordance with people's prescriptions. However, the quantities of medicines carried over from one monthly cycle to the next were not always recorded on the MAR. Handwritten prescription entries on the MAR were not always checked and signed by a second member of staff. One person was prescribed a variable dose of medicine on an 'as required basis', but the guidelines available to staff did not provide any information on how they decided which dosage would be given.

We looked at the arrangements that were in place to ensure safe staffing levels. Feedback from people who used the service and relatives was that staff were very good and worked hard, but that they were short staffed. This was a consistent theme voiced by the majority of people we spoke with. Comments made to us included: "They're understaffed." "There is not enough staff." "They work flat out." "The staff are too busy sometimes." "You have to wait and wait and wait [for assistance]." During our visit there appeared to be enough staff on duty to meet people's needs. However, there were times when people in the lounges were

on their own and staff were not immediately available to assist people, although we observed that staff were usually close by. Also due to the layout of the building and the fact that some bedrooms on the top and bottom floor were unoccupied, some people who spent time in their bedrooms appeared isolated.

The registered manager confirmed that there had been some difficulties recently, due to a high level of unforeseeable absence within the staff team. They said the staff team had covered shifts effectively and recruitment was taking place to help provide a bigger staff team. Staff told us that there were usually enough staff to meet people's care needs and that people were not at risk because of inadequate staffing levels, although it could be very busy at times. For example, one staff member told us, "Sometimes it's difficult and sometimes been a bit low [staffing levels], but we have coped. I've never felt it's been at dangerous levels where we can't care for people."

We spoke with the registered manager about staffing levels and looked at rotas. At the time of our visit 19 people lived at the service permanently and three were receiving respite care. The staffing levels described as necessary by the registered manager were a member of senior care staff, plus four care staff in the morning, three in the afternoon, and two or three in the evening. Management and ancillary support was provided in addition to these staff numbers. One senior and one care worker were on in light of the feedback received from people who used the service we recommend that the registered manager reviews the numbers and deployment of staff, taking into account the feedback received from people who used the service.

We found that staff were recruited safely and people were protected from unsuitable staff. We spoke with the registered manager about staff recruitment processes and checked the recruitment records for three recently employed staff members. The records showed that a thorough recruitment process had been followed, including interviewing prospective staff, obtaining written references and a Disclosure and Barring Service (DBS) check. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, helping employers make safer recruiting decisions. Proof of identification had also been obtained. Induction records showed that staff had completed induction training and probationary reviews, to ensure they were able to carry out their role.

We looked at the arrangements that were in place for managing allegations or suspicions of abuse and managing concerns. Staff told us that they had been trained on how to identify and respond to abuse. The training records we saw confirmed this. Staff we spoke with were able to describe the different types of abuse and how they would report any concerns. Staff also told us they would feel comfortable raising concerns with the registered manager [whistle blowing] and felt confident that concerns would be handled appropriately. One staff member told us, "I actually honestly think they'd listen. They [the management] are really caring." Another staff member said, "If I saw anything I wouldn't hesitate to report it." We found that people were protected from abuse by staff who knew how to recognise and report any concerns, and would feel confident doing so.

The care records we looked at included risk assessments, which had been completed to identify any risks associated with delivering each individual person's care. For example, risk assessment and risk management plans were in place to help identify individual risk factors, such as safe manual handling, falls, nutrition, and maintaining skin integrity. These had been reviewed regularly to identify any changes or new risks.

Records were available to show that premises and equipment were regularly checked and maintained in safe working order. This included regular servicing and inspection of fire equipment and manual handling equipment. The registered manager had completed a general risk assessment of the service in October

2015, which identified any hazards and the control measures in place. A 'grab bag' and fire evacuation folder, containing emergency information and equipment, was available in reception, where staff could easily access it in emergencies. This included personal evacuation information regarding the people who used the service.

Accidents and incidents were recorded. These were reviewed and audited by the registered manager, to ensure that appropriate actions had been taken and to identify any trends or further actions that were needed. The registered manager was aware of notification requirements [events that the service is legally required to notify us of and we had received the required notifications from the service.

Good

Is the service effective?

Our findings

All of the staff we spoke with told us they had completed the training they needed to do their jobs and had access to a variety of training, including updates. The registered manager was aware of the new care certificate training for staff and able to explain how this was being implemented. The Care Certificate is a recognised qualification which aims to provide new workers with the introductory skills, knowledge and behaviours they need to provide compassionate, safe and high quality care. The registered manager showed us how training was monitored using an online system. This enabled managers to check what training staff had completed and what training was due easily. Staff records we looked at showed that staff had completed training that was relevant to their role and were up to date with required training and updates. Overall we found that staff had the skills and knowledge required to support people who used the service.

Staff told us that they felt supported by the registered manager and could seek support whenever needed. For example, one staff member said "X [the registered manager] is approachable and easy to talk to, you can ask her anything." Staff said that they could get help when they needed it and that the registered manager and other senior staff oversaw their work on a day to day basis. Staff had not always received regular formal supervision. For example, one staff member told us they received regular supervision, while another told us that they had not received a formal supervision for some time, due to the absence of their line manager. The supervision records we looked at showed that staff received a detailed and formal supervision session when these did take place. There was also evidence that staff responsible for handling medicines had their competency reviewed on an annual basis. Overall we found that staff were being supported and supervised on a day to day basis, although the frequency of more formal supervision sessions could be improved for some staff.

We saw staff consult people and seek their consent throughout the inspection. For example, we saw staff offer people choices and explanations. We saw that staff gave choices of meals and drinks and that people spent their time in different places, depending on personal preferences.

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The service had in place a policy outlining the principles of the MCA and how people should be supported with decision making. Training on the MCA was provided to staff. The registered manager had undertaken training on the MCA and was able to describe the main principles of the act and how they involved people as

much as possible in making decisions about their care. The majority of people using the service at the time of our inspection had the capacity to make their own decisions about their care and support and we saw examples of where people's decision making and independence was being supported with positive risk taking. For example, one person had recently started to self-medicate and prepare their own drinks and meals because regaining independence was important to them.

The registered manager was aware of the DoLS and how to apply for authorisations when someone was being deprived of their liberty. At the time of our visit only one person was being deprived of their liberty and the manager had applied for a DoLS authorisation. We saw the records relating to this application. The assessment had taken place, but the manager was awaiting the authorisation paperwork from the authorising body.

We looked at how people were supported to maintain their nutritional wellbeing. People said that they had a choice of meals and could ask for drinks and snacks at any time. A staff member gave an example of this, "Food is always available, like last night about 19:30 a lady fancied a bowl of rice crispies, so I went and got her one." People also told us that the food was good with comments including: "The food is very good". "The food is marvellous, it's all homemade and fresh." A visitor told us that their relative's weight had been maintained since they came to live at the home over a year ago.

We spoke with the kitchen staff, who were able to describe people's dietary needs and how these were met. They confirmed that they had enough food supplies to provide people with a varied diet and focused on providing fresh home cooked food. The food we saw being served looked appetising and appealing. The menu was displayed on the wall and people were also shown the two dishes on offer. One person had an alternative meal because they did not like either of the choices on offer. The meal was served efficiently, but in a relaxed manner with staff supporting people and encouraging them to eat if they were sleepy or reluctant. Throughout our visit we saw people being offered and provided with drinks. For example, people had drinks within reach and we saw people being offered hot and cold drinks throughout the day. During our visit a health care professional told us that staff were very good at getting people to drink and as a result the service had a low incidence of urinary tract infections.

The care records we looked at included nutritional risk assessments. These assessments included regular weight monitoring and helped to identify anyone who was at risk due to poor nutrition or weight loss. We also saw evidence of the involvement of the doctor, dietitian and speech and language therapy team where there was concern about a person's nutritional wellbeing. In August 2015 the home had received a visit from an environmental health officer and was awarded a 5 star rating (the best available) for food hygiene.

We saw evidence that the service liaised with relevant health and social care professionals based on people's needs. For example, visits by doctors, nurses and other professionals were recorded in people's care records. People who used the service also told us that they had access to doctors and other health and social care professionals when needed. For example, one person told us, "They were very quick with the doctor yesterday." Another person told us they were waiting to see a specialist. During our inspection a community nurse was visiting people who used the service and told us that the community nursing service visited on a daily basis to provide support. They felt the service worked well with them, listening and implementing advice, and seeking nursing input appropriately. They told us, "They [the service] are very sensible, they know what they can and can't handle themselves."

Good

Is the service caring?

Our findings

We looked at the arrangements in place to ensure that the approach of staff was caring and appropriate to the needs of the people using the service. All of the people we spoke with were full of praise for the staff and how they treated people. For example, one person told us, "The girls [care staff] are marvellous. I think it's great. They look after you so well." Other comments made to us included: "They're very good, very friendly. They're dedicated." "They're very nice here, very kind." "You're made to feel welcome and at home."

We observed the care and support people received during our visit. We saw that staff had good relationships with people who used the service. For example, staff interacted with people in pleasant, friendly ways and knew individual likes and dislikes. When a new member of staff came on duty they acknowledged people individually in the lounge. One person was gently encouraged to eat their lunch. Several staff bent down and talked with the person, some putting their arm around them. Throughout our visit there was a friendly and homely atmosphere evident.

Staff ensured people's dignity and privacy was respected. During our inspection we observed staff knocking on doors before entering and ensuring that care was carried out in private. Staff we spoke with were able to describe to us how they helped to maintain people's privacy and dignity. For example, by giving people as much privacy as possible during care tasks and ensuring doors and curtains were closed. One staff member described how some people didn't like bright lights on when staff assisted them with personal care, so they would put smaller lights or lamps on to make people feel more comfortable. There was a display on the reception area wall promoting dignity in care and identifying who the service's dignity champions were.

We looked at the arrangements in place to support people in maintaining relationships. We observed people coming and going throughout the day. Visitors told us that they were always made to feel welcome and visiting was not restricted. Several people told us how they could go out with their family and friends if they wished to. Records showed that staff training had included equality and diversity, to help staff understand and support different relationships.

We looked at the arrangements in place to ensure that people were involved in decisions about their day to day lives. We saw that people had their own routines and preferences respected. For example, we saw one person brought into the dining room in a wheelchair and asked if they wanted to transfer to a chair or stay in their wheelchair for their meal. Some people spent time in the communal areas while others spent time in their own rooms, according to their preference. We also saw people being offered choices regarding their meals and drinks. Staff we spoke with knew people well and were able to describe people's preferences and how they involved people in decisions about their day to day lives.

The registered manager told us that each person living at the service had a named key worker. This meant that each person had a named person responsible for overseeing their care. People we spoke with felt that they were involved in making decisions about their care and support and that any issues they raised with staff were sorted out. However, the care plans we looked at did not contain a lot of evidence of people being involved in care planning. For example, people had not signed the care plans we looked at, to show their

agreement and involvement. The registered manager had already recognised this and was working on making care plans more person centred.

We saw that the last residents meeting had included saying good bye to two people who had lived at the home and sadly passed away recently. This recognised that people living in the home had developed friendships and relationships with each other, and gave people chance to reflect and grieve if they needed to. Staff we spoke with told us about recent training provided on palliative [end of life] care. A health professional we spoke with told us that the service was very good at looking after people at the end of their lives. They described how the service helped people to stay in their home for as long as possible and in accordance with their wishes, while accessing support from other professionals to help meet people's needs; "They [the service] are very good at looking after palliative [end of life] care, they keep people and look after them very well."

Good

Is the service responsive?

Our findings

We looked at the arrangements in place to ensure that people received person-centred care that had been appropriately assessed, planned and reviewed. Person-centred planning is a way of helping someone to plan their life and support, focusing on what's important to the individual person.

People who used the service told us that they received the individual help and support they needed with personal care, although there was feedback that people sometimes had to wait for this support if staff were busy. People also told us that staff tried their best to accommodate individual requests and preferences. For example, one person told us, "They do the best they can. They're very helpful." The people we spoke with were complimentary about the individuality of care and support they saw provided. For example, a regular visitor told us, "I am very heartened by what I see here".

We observed a lot of examples of person-centred care being provided. One person who liked to be left alone told us, "They leave me alone – I'm happy." Another person could no longer hear [staff explained that hearing aids no longer helped]. We saw staff using a whiteboard to communicate with the person and using it to joke with them about their favourite choice of biscuit for afternoon tea. Staff told us that they used the whiteboard even when they're bathing the person, because it was one to one time when communication was especially important. We also saw staff helping a person who was blind to move from room to room. At lunchtime they gave the person a plate with high sides and cut up their food, using the clock face method [describing the position and type of food as if the plate was a clock face] to describe what was on their plate. These were all examples of good person centred care and attention by staff.

During our visits we looked at the care plans and assessment records for three people in detail. The care records we looked at all contained initial assessments and risk assessments covering key areas of care, such as nutrition, manual handling and skin integrity. The risk assessments had been reviewed and updated regularly to ensure that risks to people's wellbeing were monitored. Two of the care plans we looked at had been completed and providing basic details about people's individual needs. However, the care plans we looked at lacked person centred information that was individual and detailed. For example, one person was receiving specific individualised support with their medicines, but this detail was not included in their care plan. One person's care plans had not been completed. The care plans we looked at did not contain a lot of evidence of people being involved in care planning. For example, people had not signed the care plans we looked at [to show their agreement and involvement] and there was not a lot of information in people's care plans about decision making, capacity or consent, other than 'summary of capacity' forms and information relating to specific DoLS assessments and authorisations. We discussed these limitations with the registered manager. They had showed us that they had already highlighted the need to improve care plans in their service improvement plan and showed us a care plan that had been updated and improved as part of these improvements. This care plan was much more individual and detailed than the others we had seen and better reflected the person centred care we observed being delivered.

All of the staff we spoke with knew people well and could answer any questions or queries we had about people's individual care needs. For example, one staff member told us about one person's bereavement,

and how it was important to recognise and support people's psychological needs as well as their physical care needs. They told us, "Not everything is about physical support, sometimes it's emotional."

Health and social care professionals we spoke with were complimentary about the approach of the service's staff and that staff knew people well and were responsive to their needs. One healthcare professional said, "Staff are very knowledgeable about people's likes and dislikes and how to get people to comply."

We looked at the arrangements in place to help people take part in activities, maintain their interests, encourage participation in the local community and prevent social isolation. We received mixed feedback from people who used the service about the activities and social stimulation provided. One person told us, "I get bored to tears." Another person told us there used to be more activities and that people in the lounge now just sleep most of the time. However, other people told us about the activities that took place and how they enjoyed these. There was evidence of regular activities and social events taking place. For example, one person told us they had decorated the Christmas tree and regularly helped to set the tables and feed the birds. Another person told us that they got a newspaper delivered regularly and we saw a local newspaper was available for people to read. One person told us about a recent visit from local school children who sang carols and then talked with the residents, which they had greatly enjoyed. Another person told us that they sometimes did exercises in the afternoons. There was an activities schedule on display and notices about forthcoming events. For example, the Christmas raffle, secret Santa, church services, pantomime and coffee morning. There were also photographs on the walls showing past activities and trips that had taken place. During our visit we saw a quiz take place in the lounge. People in the lounge took part and one person told us that they really enjoyed the quizzes because, "You learn such a lot." In the lounge, there was a display cabinet containing items from the past and book cases, containing books and jigsaw puzzles for people to use. We also saw that people had been asked for feedback about the activities and events on offer during the most recent resident and relatives meeting.

We looked at the arrangements in place to manage complaints and concerns. Information about the complaints procedure was available in the service's reception area. There was also a suggestions box. A comments and commendations log was used to record and monitor comments and feedback about the service. We looked at this and saw that all recent entries were messages of thanks and commendations. The service kept a record of formal complaints and the actions taken to resolve them, but there had not been a recent formal complaint. The registered manager told us they were open to suggestions and complaints and encouraged people to raise any concerns with them. People who used the service told us that if they had any issues they raised these with staff and they were sorted out. One staff member told us, "I've never really had to raise concerns, but I feel that they [management] listen and if I did raise a concern they would deal with it."

Good

Is the service well-led?

Our findings

We looked at the arrangements in place for the management and leadership of the service. At the time of our inspection visit, the home had a registered manager in place who had worked at the service since June 2015. A registered manager is a person who has registered with CQC to manage the service. During the inspection we received feedback from people who used the service, visitors and staff that the registered manager was approachable and that people felt able to go to them to discuss issues or concerns.

Throughout our visit the registered manager was open and honest. They were able to show us the service improvement plan they had put in place since they started work at the service. This showed that they were already aware of areas for improvement and able to show us what they were doing to improve. The staff team told us that the service was well managed, and focused on the needs of the people they were looking after. One staff member said "X [the registered manager] is quite enthusiastic about the residents and what we [the staff] are doing and moving forwards." Another staff member told us, "I've been in a few care homes and I like it here and I think they [the people using the service] are very well looked after." Discussions with staff and observations made during our visits showed that the staff team worked well together and there were many long standing members of staff.

The registered manager had received support and supervision from senior management. Records of this supervision were detailed and showed that the work of the registered manager was being monitored and supported. This helped to ensure that effective management systems were in place. Arrangements for the supervision of staff were also in place. Staff meetings had been held monthly. The records showed that staff meetings had included feeding back results from recent audits, discussing practice points such as fire safety, mental capacity, safeguarding and infection control, and discussion of recent training.

Arrangements were in place to gather feedback from people who used the service and their relatives. For example, a suggestions box was available in reception and monitored regularly by the registered manager. Two meetings for people living at the service and relatives had been held since the registered manager started work. These had been well attended. A record of the most recent meeting was displayed on a notice board, so that people could read it. The record showed that people had been asked for feedback on activities, menus, plans for Christmas festivities and other aspects of life at the home.

Surveys had also recently been sent to people who used the service and their relatives. The manager explained how people had been given support to complete the surveys from relatives or visitors [from the local church], rather than staff. People had also been able to return the surveys anonymously if they wanted. This helped ensure people felt able to give their views more freely. The registered manager had not yet analysed and produced a report on the survey results, although this was planned. We looked through the surveys that had been returned and saw positive responses and feedback about the service.

We looked at the arrangements in place for quality assurance and governance. Quality assurance and governance processes are systems that help providers to assess the safety and quality of their services, ensuring they provide people with a good service and meet appropriate quality standards and legal

obligations. A service improvement plan had been developed, and set out the key areas for development and improvement for the year. The registered manager showed us the records of regular checks that were completed on the premises and equipment, to ensure the service was safe and maintained in good order. Medication audits and checks had been completed, with action plans put in place and discussions with staff to help improve practice. A visit from the council's contracting department had taken place and resulted in an action plan. Accidents and incidents were recorded and monitored. These records showed that incidents and accidents were reported and actions taken to help minimise the risk of reoccurrence. An audit had also been completed to look for trends and ensure all appropriate actions had been taken. An audit had also been completed by a visiting dietician in March 2015, to help ensure that staff were implementing the malnutrition universal screening tool [MUST] appropriately.

We looked at the standard of records kept by the service. Overall the majority of records we viewed at the service were up to date, accurate and fit for purpose. However, in some areas the registered manager had identified that improvements could be made and was working towards these. For example, in relation to care planning records.

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 12 HSCA RA Regulations 2014 Safe care and treatment The registered person had not ensured the proper and safe management of medicines. Regulation 12 (g).