Meridian Healthcare Limited

Fazakerley House Residential Care Home

Inspection report

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Date of inspection visit:
25 July 2016
28 July 2016

Date of publication:
12 September 2016

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection was carried out over two days on 25 and 28 July 2016. The first day of the inspection was unannounced.

Fazakerley House provides accommodation for up to 45 older people. The service is located in the Prescot area of Knowsley. Accommodation is provided over two floors. Bedrooms located on the first floor can be accessed via a stair case or passenger lift. There were 44 people using the service at the time of our inspection.

The service has a registered manager who was registered with the Care Quality Commission in January 2016. 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.

The last inspection of the service was carried out in June 2014 and we found that the service was meeting all the regulations that were assessed.

Improvements are required to ensure people receive all the care appropriate to their needs. People received the care and support they needed with their physical and healthcare needs from the right amount of staff, however there was not always enough staff to meet people's social needs. People and family members told us that staff were often too busy and did not have much time to sit and socialise with people Opportunities for people to take part in meaningful activities was limited. This was because the activities co-ordinator only worked for part of the week and care staff were required to carry out domestic tasks as part of their role leaving them little time to engage with people.

Some fire doors leading to people's bedrooms did not fit properly into the recess which posed a risk to people's safety in the event of a fire. The registered manager acted upon this immediately by arranging for the door closures to be adjusted. The door to a bathroom which was used to store items of equipment was wide open. This posed a trip, slip and fall hazard to people. The registered manager locked the door immediately and instructed staff to keep it locked at all times.

The registered provider had a safe and fair recruitment and selection policy. Applicant's suitability to work at the service was assessed based on information which they were required to provide. This included details about their previous employment history, skills and experience. In addition applicants underwent a series of pre-employment checks on their character before employment was confirmed.

There were safe systems in place for managing people's medicines. Medication was stored safety in dedicated rooms which were clean and tidy. Each person had a medication administration record (MAR) and a medication information sheet detailing their prescribed medication and any instructions for use.

People received their medication on time by staff who had received the appropriate training and competency checks. When required people had accessed healthcare professionals such as GPs and district nurses.

People told us they liked the food and had plenty to eat and drink. Peoples' nutritional and hydration needs were appropriately assessed and planned for. People received the support they needed to eat and drink and appropriate referrals were made on behalf of people to dieticians and speech and language therapists.

Care plans contained good information about people's needs and how they were to be met and they were reviewed regularly and updated with any changes to people's needs. Daily records which were maintained showed what care and support people had received and that staff had responded appropriately to any concerns about people's health and wellbeing.

People's privacy, dignity and independence was respected and promoted. People were approached in a kind and caring way and they were encouraged to do whatever they could for themselves. People's bedrooms were personalised, clean and tidy and they were offered a key to their rooms and a lockable facility for their personal possessions.

Staff received training and support that helped them meet people's needs. Training was made available to staff on an ongoing basis and their progress and knowledge was checked regularly to make sure they benefited from the training. Staff attended one to one meetings with their line manager and regular group meetings were held enabling staff to discuss their work, training and development.

Information about how to make a complaint was made available to people, their family members and visitors. People and family members said they would not be afraid to make a complaint if they needed to and they told us that they were confident they their complaint would be listened to and acted upon.

The service was managed by a person who people, family members and staff described as approachable and supportive. There was an open culture whereby all were encouraged to speak openly about any matters relating to people's care and support. There were effective communication systems across all departments which helped to ensure people received consistent care and support to meet their needs.

Checks on the quality of the service were regularly carried out to make sure people received safe and effective care. Improvements needed were highlighted during checks and clear action plans were put in place and acted upon promptly to improve the service people received. However checks on the environment failed to identify some safety concerns, the registered manager acted upon these immediately and put measures in place to minimise risks to people's safety.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe

Some parts of the service were unsafe, however steps were taken to address this.

Safe recruitment procedures for staff were followed.

People were protected from harm because staff knew how to recognise and report abuse. People's medication was safely managed.

Is the service effective?

Good

The service was effective.

People's needs were met by staff who has received the right training and support.

People received a suitable diet which met their needs.

Staff had a good understanding of the principles of the Mental Capacity Act 2005 and the associated Deprivation of Liberty Safeguards (DoLS).

Is the service caring?

Good

The service was caring.

People were cared for and supported by staff that were polite, kind and caring.

People's privacy, dignity and independence was respected and promoted.

People were given information about the service and the standards they should expect from it.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always have their social needs met and they had limited opportunities to engage in meaningful activities.

Care plans detailed how people's needs were to be met and they were kept under review.

People had access to a complaints procedure and they were confident about complaining if they needed to.

Is the service well-led?

Good

The service was well led.

The registered manager was visible around the service and she was described as supportive and approachable.

People received a consistent service because there were good lines of communication.

Regular checks were carried out on the quality of the service and improvements were made promptly.

Fazakerley House Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the registered 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 over two days on 25 and 28 July 2016, the first day was unannounced. One adult social care inspector carried out the inspection.

During the inspection we observed the interaction between staff and people who used the service and we spoke with ten people who used the service and nine family members. We spoke with the registered manager, and staff who held various roles including, care staff, kitchen staff and domestic staff. We also spoke with two visiting healthcare professionals.

We looked at areas of the service including communal lounges, dining rooms, bathrooms, bedrooms, the kitchen and the laundry.

We reviewed a number of records, including care records for five people who used the service and four staff files. Other records we looked at which related to the management of the service included quality monitoring audits and safety certificates for equipment and systems in use at the service.

Before our inspection we reviewed the information we held about the service including notifications that the registered provider had sent us, information received from the local authority and Healthwatch and the Provider Information Return (PIR). The PIR is a form that asks the provider to give some key information about the service, including what the service does well and any improvements they plan to make.

Good

Is the service safe?

Our findings

People told us that the staff treated them well and that they felt safe living at the service. People's comments included, "Oh yes I feel safe ok" I've no worries about how they [staff] treat me they are all wonderful" "I've never felt safer" and "I've never come to any harm at all". Family members told us that they had no concerns about their relatives safety, their comments included, "I am confident that [relative] is in safe hands here" and "I think my [relative] is definitely safe here, I don't worry about her at all"

Some parts of the environment posed a risk to people's safety. A number of fire doors leading into people's bedrooms failed to close properly into the recess. This meant that the doors would not provide the occupants with full protection in the event of a fire. We immediately brought this to the attention of the registered manager who made arrangements to have the door closures adjusted so that they were safe to use. This was actioned on the same day. The door to a bathroom on the first floor was wide open and there were items of equipment including wheelchairs and bed mattresses stored in it. This posed a risk of slips, trips and falls to people. The registered manager confirmed that the bathroom was no longer in use and that there were plans in place to change its use to a storage room. The door was locked immediately and staff were given instructions to ensure it was kept locked at all times.

The environment was clean and hygienic and practices were followed to reduce the risk of the spread of infection. For example, colour coded bins and cleaning equipment were used to prevent cross infection. Staff used personal protective equipment (PPE) such as disposable gloves and aprons when providing people with personal care and when handling soiled laundry. Appropriate contacts were in place for the removal of clinical and non-clinical waste from the service. The service achieved a score of 96.2 % following an infection control audit which was carried out in May 2016.

Safe recruitment practices where followed to ensure that suitable staff were employed at the service. The registered provider had a safe recruitment procedure and recruitment records held for staff and discussions with them showed it had been correctly followed. Applicants had completed an application form, attended an interview and underwent a series of pre-employment checks prior to starting work at the service. For example, checks to confirm the applicant's identity, character and suitability to work with vulnerable people were carried out with their most recent employer and the Disclosure and Barring Scheme (DBS). A DBS check consists of a check on people's criminal record and a check to see if they have been placed on a list for people who are barred from working with vulnerable adults.

People were protected from abuse and the risk of abuse. Staff had received safeguarding training and they had access to the registered providers and the relevant local authorities safeguarding policy and procedure. In addition staff had access to other information about keeping people safe, such as guidance about how to recognise and report abuse. Staff demonstrated a good knowledge of the different types and indicators of abuse and they were confident about reporting any incidents of abuse which they witnessed, suspected or were told about. Staff comments included' "I know there are different types of abuse, it's not just about someone being physically harmed", "Any form of abuse is unacceptable and if I witnessed it I would report it straight away" and "If somebody told me they'd been hurt in any way I'd report it". A record of allegations of

abuse which had occurred at the service was kept. The records showed that the registered manager and other senior staff had taken appropriate action by promptly informing the relevant agencies such as the local authority safeguarding team and the Care Quality Commission (CQC). The records evidenced that action had been taken to reduce further risks to people.

Risks assessments were in place to help ensure that identified risks to people were minimised. For example, people's care plans considered risk relating to the environment, falls, nutrition and the use equipment to help people with their mobility. These assessments were reviewed on a regular basis and updated as and when required to ensure that any changes to people's needs in relation to risks were planned for.

There were sufficient numbers of suitably skilled and experienced staff to keep people safe. There were five care staff and a senior carer on shift throughout each day and three care staff at night. The registered manager generally worked Monday to Friday during office hours, however, she worked outside of those hours when required to ensure staffing numbers were at a safe level. Other staff including domestic and kitchen staff were also available at various times throughout the day. All staff had completed training and underwent a competency check in emergency procedures which meant they all had the necessary skills to keep people safe in the event of an emergency.

Medication was stored securely and administered to people safely. There was a dedicated room for storing people's medication and it was kept locked when unsupervised. The room was clean and well organised and there were safe systems in place for the receipt, storage and disposal of medication. A record was kept detailing medication received and removed from service. Lockable medication trolleys were used to transport medication around the service. Fridges were used to store medication which needed to be kept cool to ensure their effectiveness and items had been dated to show when they were opened. Daily temperatures of fridges were taken and recorded to ensure the fridges remained at a safe temperature. Controlled drugs (CDs) were stored securely in appropriate cabinets and records of the administration of CDs were properly maintained. Controlled drugs are medications prescribed for people that require stricter control to prevent them from being misused or causing harm. We checked a sample of medication and found the stock tallied with the records kept.

Each person had a medication administration record (MAR) detailing each item of prescribed medication and the times they should be given. The allergy section of MARs had been completed to show any known or unknown allergies. Staff completed MARs appropriately, for example after people had taken their medication staff initialled the record to show this. Specified codes were used to identify other circumstances such as when a person had refused their medication. Some people were prescribed 'as required' medication (PRN) medication. Information obtained from people's GPs confirming the use of PRN medication was in place along with instructions for staff about how and when it should be administered.

Good

Is the service effective?

Our findings

People told us that they thought the staff were well trained and did a good job. They said they liked the food and got plenty to eat and drink. People's comments included, "They [staff] are so good. They know what they are doing", "All of them [staff] look after me very well indeed" "We get more than enough to eat and it's lovely home cooked food" and "They [staff] serve us lots of cups of tea and we can help ourselves at any time to cold drinks".

People had their needs met by staff who had received appropriate training for their roles. On commencing work at the service new staff entered onto a twelve week induction programme. The induction which incorporated The Care Certificate Standards consisted of training and competency checks available on line via the registered providers learning and development programme. The Care Certificate which was introduced in April 2015 is a set of standards that social care and health workers stick to in their daily working life. Staff were provided with a unique password which enabled them to access on line training at any time at home or in the workplace. New staff also completed workbooks, attended workshops and shadowed more experienced staff as part of their induction. Staff were assigned a mentor, and they had contact numbers of designated trainers within the company who they could contact for guidance and support throughout their induction. A member of staff who was in the process of working through their induction described it to us. They showed us examples of workbooks they had completed and explained how their competency was checked following the completion of training modules. The member of staff described the induction programme as 'really good' and they said they were thoroughly enjoying it. They said the on line training enabled them to complete it flexibly.

Following induction all staff entered onto an on going programme of training specific to their job role. Training completed included updates in mandatory topics such as infection control, safer people handling and health and safety. In addition, staff completed training specific to people's needs such as diabetes and dementia care. Training was provided to staff in a number of different ways, including on line training and face to face training delivered by accredited trainers. Staff were required to complete a competency check following the completion of each training course. Competency checks helped to assess staff understanding of the training completed and to determine if additional training was required to further develop their knowledge, skills and understanding. Staff told us they were given plenty of opportunities to complete the training which they needed for their job. Up to date information detailing training completed and progress made by staff was readily available to the registered manager which enabled them to monitor staff performance and their training and development needs.

Staff received an appropriate level of support within their roles. Staff told us they felt well supported by the registered manager and other senior staff. Regular one to one supervision sessions were conducted between staff and their manager. These provided staff with an opportunity to discuss in private their work and performance. In addition staff were given the opportunity to meet as a group through team meetings which enabled them to speak openly together with the registered manager and other senior staff. Minutes of staff meetings were made available to all staff so that those staff that were unable to attend were updated with discussions that had taken place.

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 people lack mental capacity to make particular decisions, any decisions 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 2005. The application procedures for this are called Deprivation of Liberty Safeguards (DoLS). We checked that the service was working within the principles of the MCA 2005 and found that they were. Staff were aware of the principles of the MCA and they knew that everyone was assumed to have capacity unless they had been assessed otherwise.

Throughout the inspection we heard staff asking people for their consent before providing care and support. People's liberty was only restricted when there was no other means of keeping them safe. Staff were aware that any such restrictions should be properly authorised and always be the least restrictive option. The registered manager had made applications to the local authority to deprive some people of their liberty in order to keep them safe. At the time of the inspection a DoLS authorisation had been granted for two people and applications were being processed by the local authority for other people. A copy of the DoLS application and the authorisation for those granted were held in people's care files along with an appropriate care plan.

People had their nutritional and hydration needs met. Care plans were in place for people who had been assessed as needing support with eating and drinking. The level of risk people faced and the support they needed to manage this had been determined by the use of a recognised tool. Once completed the tool helped to identify if a person was malnourished, at risk of malnutrition (under nutrition), or obese. The level of support people needed to eat and drink was detailed in their care plan along with the details of any specialist equipment people needed to promote their independence at meal times, for example, adapted crockery and cutlery. People's food and fluid intake was encouraged and monitored as required. People had access to a constant supply of cold drinks from dispensers which were located in communal areas of the service. Staff replenished these on a number of occasions throughout the inspection, people and family members told us that cold drinks were always in good supply. Staff regularly offered drinks to people who had difficulty accessing them independently.

Food stores were well stocked with items of fresh tinned and frozen foods. People were complementary about the food and told us that they never felt hungry. One person said, "We seem to be getting food all the time, it's lovely". A new menu had recently been introduced at the service which people said was an improvement on the previous menu. One person said, "The food is much better lately, there seems to be more home cooked meals". People were given a choice of two hot meals or an alternative if they preferred. With their prior consent we joined a group of people for a meal at lunchtime on both days of the inspection. Meals were nicely presented and served hot. Most people were able to manage their meals as they were presented however staff cut up food for people who had difficulty with this. Care staff and kitchen staff had access to information about people's dietary requirements such as required food textures, known allergies, dietary preferences and favourites and food likes and dislikes.

Good

Is the service caring?

Our findings

People told us that the staff were polite and kind and that their privacy was respected. People said felt comfortable with staff and were never made to feel embarrassed when receiving personal care. People's comments included, "They [staff] are all lovely and they are so kind. I'm not afraid to ask for help from any of them", "They are careful and gentle" and "Nothing is too much trouble"

People and their families were provided with information about the service. A brochure about the service had been given to people and additional copies were available near to the main entrance for people and visitors to help themselves. A Service User Guide was also made available to all and detailed the services and facilities available for people to access within Fazakerley House. The registered provider's core values were detailed in the Service User Guide so that people were aware of the standards they should expect from the service. People and their family members confirmed that they had been provided with this information.

Information in the form of leaflets and posters was made available to people in relation to local advocacy services. This helped to ensure that people had access to independent support when required. The registered manager said no one at the time of our inspection required the support of an advocacy service; however they knew the circumstances of when advocacy services would be required.

Each person had their own bedroom which they were encouraged to personalise as they wished. People's bedrooms displayed items which held special memories to them such as pictures, photographs and ornaments. Although bed linen and towels were provided as part of the service, people who chose to, used their own which either they or family members had purchased. Bedrooms were kept clean and tidy and people who were able were encouraged to help with this. Locks were fitted to bedroom doors and were appropriate people given the choice of having a key to their rooms. People were also provided with a lockable facility in their rooms so that they could lock away any valuables or other personal items. One person showed us their lockable cabinet which was secured to their bedroom wall and they told us how important this was to them.

There was a laundry service operated on each day of the week. People and most family members told us that the laundry service was efficient and that clothes were nicely laundered and returned in good time. However one person's family member said they had for some time been unable to locate an item of clothing which they bought for their relative. We raised this with staff and they invited the family member to have a look around the laundry for the lost item. The item could not be located and the family member was assured that every effort would be made to find it. We raised this with the registered manager who said if it could not be found they would arrange to reimburse the family member for the item of clothing so that they could replace it.

People's privacy and dignity was respected. Care plans included information about people's wishes, choices and preferences including which gender of carer people preferred to provide their personal care. Staff knocked on people's bedroom doors and waited to be invited in and they closed doors when supporting people with their personal care. People told us that this was usual. One person said, "They [staff] always

knock before coming in my room". Another person who chose to spend time in their room during the day said, "They [staff] know where I am and pop in to ask if I'm ok or need anything". Staff had completed dignity training and they understood the importance of maintaining people's privacy and dignity. They gave examples of how they practiced this which included, speaking to people in private about intimate matters and sharing information about people on a need to know basis only. Personal records about people were locked away when not in use and staff were discreet when completing records so that they could not be seen by others.

When speaking exclusively with people who were sat in chairs, staff bent down to ensure they made eye contact with the person and they listened carefully to what was being said.

Family members and other visitors were made to feel welcome. Staff greeted family members, provided them with information relevant to their relative's progress and offered them with refreshments. Family members said they were always made to feel welcome and that there were no restrictions placed upon them when visiting their relative. Visiting professionals said they had always been made to feel welcome and they described the staff as polite and caring.

Staff knew people well they took an interest in things which were important to people. People or where appropriate family members were invited to complete a booklet titled 'Remembering together' as a way of sharing information about the person's life history, for example, where the person was born, special family memories, friendships previous working life, skills, interests and personal attributes. The information gave staff a good insight into people's lives prior to them living at the service. This helped staff to understand people's backgrounds and what was important to them. Discussions with staff showed they knew people well including their preferred routines, things of importance, likes and dislikes.

Some people had a 'do not attempt resuscitation' (DNACPR) order in place which had had been authorised by their GP. These were put in place where people had chosen not to be resuscitated in the event of their death or in cases where they cannot make this decision themselves, where the GP and other individuals with legal authority have made this decision in a person's best interests. DNACPR certificates were placed at the front of people's care file so it was clearly visible. This information was also highlighted to staff during handovers so that staff knew what action to take in the event of a person's death.

Requires Improvement

Is the service responsive?

Our findings

People told us, "They [staff] do talk to me but not for long because they are so busy" and "They haven't got a lot of time to sit with me but I know they are busy", Family members commented, "Staff always seem to be too busy to be able to sit and talk to the residents" and "They [staff] do their best but I don't think they have enough time to talk with [relative] or any others". "They [staff] come as quick as they can", "It's not very often I have to wait too long" and "I can do most things for myself but they [staff] are there like a shot if I need them".

People did not receive all the care and support to meet their needs. People's personal care routines and requests for assistance were met in a timely way, for example, people were assisted out of bed, to bath/shower and to use the toilet when needed. However care staff had little opportunity to spend time socialising with people, because when they were not responding to people's care need requirements they were required to focus on domestic tasks, for example, preparing the dining rooms prior to meals and setting tables. Following meals staff spent a considerable amount of time washing dishes and clearing up tables, floors and kitchen areas. Whilst staff carried out these tasks people sat in lounge areas adjacent to the dining rooms either asleep or watching TV and staff had little direct contact with them. The majority of contact staff had with people was passive, for example, staff checked on people, greeted them enquired about their wellbeing and offered them drinks. Staff said they tried to spend as much time as they could socialising with people but found it difficult due to their workload. When we fed this back to the registered manager, they confirmed that they had recognised this and had raised it with senior managers. The registered manager said the staffing arrangements were being reviewed with a view of introducing a new post dedicated to managing meal times such as preparing dining rooms before meals and clearing up after.

People had some opportunity to engage in activities which were organised and facilitated by an activities coordinator employed at the service. However the activities co- ordinator only worked 16 hours per week during the afternoon between Mondays to Friday each week. This meant that opportunities for people to take part activities were limited to those times. As a result of the limitations most activities which were provided involved group activities such as bingo and arts and crafts. This meant people who preferred and would benefit from one to one activity lacked opportunities for stimulation. This arrangement coupled with the lack of opportunities for care staff to engage with people as described above meant there was a risk of people becoming socially isolated.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people did not receive all the care appropriate to their needs.

Each person underwent an initial assessment of their needs prior to moving into the service or within 48 hours following an emergency admission. The registered provider's pre admission assessment documentation took account of people's health, physical and social care needs and any risks associated with them. Need assessments carried out by other health and social care professionals were also obtained in respect of people and care plans were developed on the basis of all the assessments. Care plans covered things such as mobility, personal hygiene, communication and eating and drinking and any risks associated

with and how they were to be managed. Each care plan identified the area of need, the preferred outcome and instructions for staff about how they were to meet the person's needs. Care plans were reviewed routinely each month or sooner if a person experienced a change in their needs. People who were able to, contributed to their assessment and the development and reviewing of their care plans. Records which were completed following each review detailing how it took place and who was involved. Staff were notified during handovers of any changes made to care plans so that they were up to date with people's needs. Staff were aware of people's needs and how they wished their needs to be met. This meant people received individualised personal care and support delivered in the way they wished.

People's needs were communicated effectively amongst the staff. Handovers which took place during each shift change enabled staff to share important information about people's care and support needs. Daily records were maintained for each person of what care and support they had been offered and had received. In addition records were maintained for people who required aspects of their care and support monitoring such as weight, mobility, skin integrity, behaviour and food and fluid intake. The records were used as a way of tracking people's care and they helped to identify people's progress or any additional care and support they required. Appropriate action had been taken in response to any concerns noted for example, referrals had been made to other professionals such as the falls team and district nurses. Records were kept for each person detailing visits they received from other professionals.

The registered provider had a complaints procedure which was made available to people and their family members. The procedure described the process for making a complaint and the response people could expect if they made a complaint. A copy of the procedure was displayed in the main entrance and it was summarised in a brochure about the service. People and their family members told us they were confident about complaining if they needed to. A complaints log was kept with a record of complaints made, how and when complaints were investigated and the outcome.

Good

Is the service well-led?

Our findings

People and family members told us they thought the service was well managed by a person who was visible around the service, supportive and approachable. Comments made by people and family members included, "Anne is very nice, you can talk to her quite openly" "She [registered manager] is around if you need her" and "I have had no problem with contacting her [registered manager] and she has always listened and been very helpful".

The registered manager's office was located centrally within the service, it was near to the entrance of the service and close to areas people occupied making it easily assessable to all. The office door was open other than when private discussions took place. The registered manager was visible around the service at intervals throughout the inspection and people, family members and staff told us this was usual.

There was a clear management structure operated within the service which everybody understood. The registered manager and staff understood their roles and responsibilities and they were made aware of the visions and values of the registered provider through training, meetings and news updates. The registered manager had day to day responsibility for the running of the service and they had the support of a deputy manager and a team of senior care staff. There were clear lines of accountability in the absence of the registered manager. There was a rota made available to staff which clearly showed the designated person in charge of each shift during the day and night. The registered manager had the support of a senior management team, including an assistant operations manager who they reported directly to and they received support and supervision from them.

There were processes in place to ensure clear lines of communication. The registered manager facilitated residents and relatives meeting and staff meetings for staff from all departments. The meetings were recorded and those that were unable to attend had the opportunity to read the minutes. Senior staff from different departments held daily meetings to share information about people's care and other items which affected them. A record of the meetings which was kept showed who was in attendance and items discussed which included, people's care, housekeeping, catering and staffing. Following the meetings information was shared with other relevant staff on duty at the time. Staff were invited by the registered provider to complete a survey giving them the opportunity to rate and comment on aspects of the service from an employer's perspective. 29 staff completed the most recent survey which was carried out in June 2016 and the results were mostly positive. They showed staff either agreed or strongly agreed that there was good communication and support from management.

The registered provider had a range of policies and procedures for the service which were made available to staff. Policies and procedures support effective decision making and delegation because they provide guidelines on what people can and cannot do what decisions they can make and what activities are appropriate. Policies and procedures were regularly reviewed by the registered provider to ensure that they were in line with current legislation and best practice. Staff knew where to find policies and procedures and they said they were informed of any changes made to them. Staff demonstrated they were aware of whistleblowing procedure and they said they would not hesitate to use it if they needed to. Whistle-blowing

occurs when an employee raises a concern about dangerous or poor practice that they become aware of. Staff said they had access to the numbers they needed to use to raise any of these types of concerns, including the contact details for the relevant local authority safeguarding teams and the Care Quality Commission.

There were systems in place for assessing and monitoring the quality of the service and making improvements. The system consisted of a combination of practical tools and documentation with guidance for checking and improving the service people received. The frequency of checks and audits varied depending on the activity required, for example walk arounds were required twice daily to check on things such as the direct care and support people received and that the environment was safe. Monthly and three monthly audits were required on infection control, care plans and medication. Records of audits showed they were carried out at the required intervals and areas identified as requiring improvement were acted upon. As part of the services quality assurance framework the assistant operations director for the service conducted monthly 'Home visits' to the service to ensure the processes for assessing and monitoring the service had been followed in line with the registered providers requirements. Following their visit the operations director produced a report of their findings and shared it with the registered manager who was responsible for following up on any actions identified during the visit. We viewed the last three months 'Home visit' reports. They showed how the visit was carried out and who was involved. For example, checks were carried out on the environment and records and feedback from people who used the service, visitors and staff was obtained. Areas for improvement which were identified during the visit where included in the 'Home visit report' along with who was responsible for actioning them and when. The actions were followed up during the next visit. We saw examples where actions had been noted to improve the service and evidence that they had been completed. Checks on the environment did however fail to identify faulty fire doors and a trip, slip and fall hazard. The registered manger addressed the concerns immediately and said they would ensure that these checks were carried out as part of the daily walk arounds conducted by the person in charge.

Accidents or incidents which occurred at the service were recorded and reported in line with the registered provider's procedure. This included the completion of accident/incident forms and copies were held in the person's care records. The occurrences were also reported through Datix, a web based system, which was reviewed by the registered provider each month. Information held on Datix helped the registered provider to identify any patterns or trends and plan for any additional measures which needed to be put in place to reduce the risk of further occurrences.

The service had notified the Care Quality Commission (CQC) of significant events which had occurred in line with their legal obligations.

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 People did not receive all the care appropriate to their needs.