Chrissian Residential Home Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on the 9 January 2017 and was unannounced. The last inspection to this service was on the 22 February 2016 and was a responsive inspection as a result of information received from a whistle blower. During the responsive inspection in February 2016, we only looked at two lines of enquiry. Those being Safe and Well-led and found both areas required improvement. Prior to this the service had been rated as good overall in October 2015. At the time of our responsive inspection there was an acting manager in post. They have subsequently left before they could become registered with the CQC. At the time of our latest inspection there was an acting manager who has yet to be registered with the Care Quality Commission but they told us they have put in their application and were just waiting for it to be processed.

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 service can accommodate up to 22 people at any one time and provides residential care to older people. At the time of our inspection there were 21 people living at the service. .

At this inspection we found the new manager who was already familiar with the service was engaging well with people using the service and with staff. They had developed an action plan identifying what they needed to do in order to comply with the relevant standards. They told us that when they took over the management of the service, they had identified gaps and had not felt things were sufficiently robust. They were working towards bridging the gaps and ensuring records were up to date. Immediately following our inspection they sent us an action plan telling us how they would address the issues we raised which gave us some confidence in the ongoing management of the service.

We observed a caring, happy home in which staff appeared to get on well and were attentive to people's needs. The home was relaxed and people were sufficiently engaged. The home was comfortably furnished and we found the home to be clean and smelling fresh. Prior to the inspection, we had concerns raised with us about poor infection control practices of staff. In addition we had identified some poor infection control practices at the last inspection but did not have any concerns at this inspection.

Staffing levels were adequate and people's needs were reviewed to help establish if current staffing levels were adequate. However dependency assessment tools did not always identify changes in people's needs. During the day there were catering staff employed to assist with breakfast and main meal at lunch time but in the evening care staff were expected to serve tea some of which might have been prepared earlier. This meant there was a reduction of staff at certain times of the day and this was likely to have an impact on the care and supervision provided. .

Risks to people's safety were not always effectively managed. This is because we saw a number of incidents

had occurred at the service and actions taken were not sufficiently robust and did not help ensure that an incident did not reoccur. For example falls risks assessments did not clearly show what actions had been considered and put in place before and, or following a fall. Records were not collated effectively and we found information difficult to follow in terms of actions.

We also found poor recording in relation to allegations of poor care which had not been referred to the safeguarding team and had not been fully investigated to show the outcomes and impact on people.

Medicines were managed effectively and people received their medicines as intended.

Staff received training and support for their role. Supervisions were being updated to ensure all staff had the opportunity to discuss their role and any training and, or support they needed. Induction for new staff was sufficiently robust and staff were being given the opportunity for further study.

Recruitment of new staff has been a concern in the past and the home has not always followed robust recruitment processes. We found on this occasion procedures were being followed but improvements could be made to the interviewing process.
Staff promoted people's choice and had some understanding of the Mental Capacity Act 2005 and the Deprivation on Liberty safeguards. The MCA and DoLS ensure that, where people lack capacity to make decisions for themselves, decisions are made in their best interests according to a structured process.

People were supported to eat and drink in sufficient quantities for their needs. People's weights were monitored but fluctuations in weight were not always sufficiently recorded in terms of actions taken.

People had their health care needs monitored and staff acted upon changes in people's health but concerns were expressed about the responsiveness of one of the GP practices. This had an impact of the timeliness of medical intervention. We also found records did not always clearly reflect actions taken by staff.

People's needs were documented and care plans told staff what people's needs were and how these should be met. Staff knew people's needs well but we were concerned that records did not always reflect the changes in people's need or the impact of risk and how it could be reduced.

The home has undergone a number of changes in terms of its management but we were confident it is heading in the right direction but is not yet providing a safe and responsive service. However we consider the home is well managed and there are plans in place to improve upon the service delivery and the effectiveness of this.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what actions we told the provider to take at the back of the full version of this 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 knew how to raise concern and safeguard people in their care. However we identified concerns which had not been properly investigated and reported to appropriate agencies so were not confident in the systems in place.

We found risks to people's safety had not always been managed effectively or demonstrated by robust record keeping.

Staff recruitment processes were adequate and helped ensure only staff suitable for employment in care were appointed.

There were systems in place to help ensure people received their medicines as required by staff trained to administer them.

Is the service effective?

Good

The service was effective.

Staff received training, support and induction appropriate to their role.

Staff promoted people's choices in the least restrictive way possible whilst ensuring sufficient safeguards were in place for people who lacked mental capacity.

People were supported to eat and drink in sufficient quantities but we could not always see how weight loss was effectively managed.

People's health care needs were monitored and recorded to show what actions were taken but it was less clear if needs were always met in a timely way due to the poor relationship with the GP practice.

Is the service caring?

Good

The service was caring.

Staff knew people well and provided care which was sensitive to

people's needs.

People's independence was encouraged as far as possible.

People were consulted on a daily basis about their care needs and asked for their views about the service in order to establish what the service was doing well and where the might need to improve.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Staff were responsive to people's needs because staff knew people well and were aware of their needs.

However records did not always reflect the care and support given to people or accurately reflect changes in people's needs.

People had various things planned to help keep them occupied and mentally stimulated but this could be expanded upon.

The service had a complaints procedure and took in to account people's wishes and feelings in how it planned and managed the service.

Is the service well-led?

Good

The service was well led.

The new manager was organised and had a clear oversight of the home.

They had developed action plans to help them systematically address and evidence the improvements they were making.

We have identified a number of things which require improvement but were confident that the manager had already started to address these.

Risks to people's safety were being managed but gaps in records made it difficult to establish if people always got the care they needed in a timely way or if risks to people could have been prevented.

Chrissian Residential Home Limited

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.

The inspection took place on the 9 January 2017 and was unannounced. The inspection was undertaken by two inspectors. As part of this inspection, we reviewed information we already held about the service including recent inspection reports, correspondence from the provider, notifications which are important events the provider is expected to tell us about. We also observed the care throughout the day which is particularly important particularly for people who can't tell us about their experiences. We spoke with the manager, deputy and four care staff. We also spoke with the domestic and catering staff. We spoke with a social worker and a relative. We spoke with eight people using the service. We carried out a medication audit and looked at record relating to the service including staff records and six care plans.

Requires Improvement

Is the service safe?

Our findings

People were not always fully protected from the risks associated with their care. Staff told us that they had the required training in place and understood their responsibilities in relation to protecting people from harm. One staff member told us, "Yes I have had the training very recently, this was a repeat as I ready knew this. I have never seen anything here that would cause me any concerns. "Another staff member told us. "People are kept safe. I check everything under my watch to make them as safe as they can be." Staff confirmed that they were aware of the different types of abuse and that this had been covered on their training. They said there was an adult protection policy and procedure in place and were confident that they would follow this if needed. One staff member said, "People here are vulnerable and we need to keep them safe." All staff said and felt they could raise concerns as required and were aware of external agencies and their responsibilities.

We were not confident that the manager had always taken appropriate actions to safe guard people. For example we saw a concern raised by a family about the role of the GP who the family felt had failed in their duty of care. The GP had provided a detailed response to the families concerns. The home were made aware of the families concerns but had not asked them it they could refer the matter to the safeguarding team to help ensure a proper investigation could commence to establish the facts and decide if actions taken were appropriate and adequately safeguarded the person. We saw another recorded incident in which a person had made an allegation against a staff member and then had later withdrawn it. Given the serious nature of the concerns raised this should have been further investigated to ensure adequate safeguards were in place for the person and to support staff. The manager told us at the time of the allegation they were not managing the home but it was brought to their attention for future learning.

Risks at this service were not always consistently and effectively managed. There were few people who regularly required hoisting. Staff were not aware of all the information they would need to manage this safely, for example what size sling people required. We looked at care plans and saw for one person who had three recorded falls and needed support to mobilise did not have a risk assessment or plan in place with regards to using the hoist or any information about using a sling for this person. We looked at other people's risk assessments for moving and handling and found that none in place stated the size of sling to be used based upon a person's weight and size. This lack of thorough assessment and guidance provided to staff was placing people at potential risk.

There were systems in place to mitigate risks relating to skin integrity, weight loss and falls. Staff understood that these were important risks to assess and be aware of in older people. Whilst we saw that systems were in place for individuals these were not always systematically updated or correct. An example being that one person's falls risk assessment had not been updated for two months despite them falling and sustaining an injury. Their dependency assessment and care plan also did not reflect a change in their needs.

Another person had a series of falls which eventually resulted in a significant injury. However after the first fall and subsequent falls we could not see what actions had been considered and discounted or what had actually been put in place to reduce the level of risk. Following injury the person continued to fall. We

discussed with the manager the use of bedrails which they had not considered. However their care plan did state to consider safety rails but because records were not updated regularly this suggestion had not been followed through. The falls assessment did not take into account the persons diagnosis of dementia, (cognitive impairment) or neurological factors which would have a bearing on the level of risk to the person.

Another person's waterlow had been incorrectly calculated as it did not take into account that they were a known diabetic. A waterlow score gives an estimated risk for the development of a pressure sore.

Although staff monitored people to ensure their health needs were met the relationship with the local GP practice was fragmented and we could not be certain that this was not impacting on people's care.

The above demonstrates a breach of Regulation 12 of the Health and social care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment.

Staff told us and showed us a system whereby each day they checked the environment to ensure it was safe. They gave an example of ensuring windows that had been open to air a room were then closed to ensure people were safe and warm.

We checked some visible equipment such as fire extinguishers and hoists and saw these were regularly serviced. This gave an indication that regular servicing contracts were in place to ensure equipment was fit to use if needed. People were at potential risk when using the stair lifts. There were two stair lifts in operation. However no instructions on their use were available for staff or people at the service to follow to ensure they were safely operating the equipment. The maximum weight limit of the equipment was not known.

We observed good standards of hygiene and staff wearing the correct personal protective clothing and following infection control procedures. Concerns about infection control were raised with us before the inspection. The manager told us that there were 22 commodes in use for people at night. We asked about how they were cleansed and kept clean for people. The manager said there was a rigorous checking of commodes to ensure they were safe and had not rusted. We were told that each morning commodes are emptied in the nearest toilet and then if required washed and cleansed in the laundry room that had one sink that was also used for hand washing. This process was placing staff and people at the service at risk of infection ad cross infection. The laundry was a place of potential risk and requires a separate wash hand basin. The laundry was clean and ordered. Equipment such as protective gloves and aprons were in use. The use of red bags was in place for managing soiled linen.

Staffing levels appeared appropriate to people's needs. One person told us. "I do like all the staff here. They help me when I need it". Staff spoken with said there was sufficient staff on duty to meet people's needs. One staff member told us, "I like the fact that you do not have to hurry people. There is time for the resident."

Our observations were that staff were always visible and at hand if people needed support. Staff spoken with confirmed that no agency staff were used and therefore people were supported by staff who knew them well. There was always a senior on call and available to staff should they need advice. The manager told us staff recruitment was on-going and the senior staff, (deputy staff.) had been given more supernumerary hours so they could effectively support the manager and staff.

We looked at rotas and saw sufficient cover was provided but time set aside for activities was restricted to a few hours a day. Some staff chose to give up their free time to support activities at times. There were sufficient day and night staff with no gaps from the rotas we looked at.

We looked at staff recruitment files. These contained adequate checks to ensure staff employed had not committed a criminal offence which might make them unsuitable to work in the care sector. Applications forms were completed showing staffs former employment history and references sought for the last employee and a second reference. Records also showed proof of identification and address and evidence of induction. We found the interview itself was not sufficiently robust from the records seen. Interview questions were basic and notes from the interview did not demonstrate that the interviewers had really explored the person attributes, experiences and suitability for the role.

People received their medicines as intended. We observed staff administering medicines and saw that they did this with a compassionate and caring attitude. They individually dispensed people's medicine by referring to the medicine chart. We observed a staff member telling a person about their medicine.

We wanted to look closely at how medicines for people were being managed. We audited some medicines and found that the amounts prescribed, administered and recorded all correctly tallied. An audit of the medicines had been completed the evening before and had found some anomalies. This was due to be addressed by the manager on the day of our visit. Therefore the medicines were safely monitored and accounted for through quality assurance processes in place.

Medicine was appropriately stored. The medicine trolleys were kept secure at all times and temperatures of storage were regularly taken. We observed staff giving medicines to people and they did so after explaining and gaining people's consent. The only concern, we had was the noise and interruptions staff were faced with which did not help them concentrate and might of increased the risk of medication errors.

Whilst there were instructions in place of what to do if an error occurred there was not an up to date policy and procedure in place to guide staff that was based upon up to date best guidance from appropriate bodies. The manager agreed to address this matter.

Good

Is the service effective?

Our findings

People were supported by staff who were able to demonstrate that they had the skills and competencies to deliver the care that people needed. People we spoke with told us that they were looked after well by staff. The staff we spoke with said that they had the training to do their job and confirmed that this made them confident and competent to perform the tasks asked of them. One staff member said, "I have completed my first aid training, dementia training and moving and handling. This has helped me do my job. I am now doing my NVQ II." One new staff member told us that they had completed shadow shifts to give them the knowledge of how the home ran and how best to support individual's needs. They confirmed that they had completed the Care Certificate and had obtained NVQ II and III. As part of their induction to this home they had been required to update their knowledge on safeguarding adults from abuse and The Mental Capacity Act that included information on Deprivation of Liberty Safeguards. This new member of staff said that they had been supported well by both the management and staff and made to feel welcome within the team.

A high percentage of staff had either already completed or were working towards additional qualifications and these were appropriate to the roles staff held within the home. Roles and responsibilities were defined within the home.

Additional training had been sought for staff to help them meet people's individual needs. This including how to recognise infections, preventing falls, ulcer prevention, dementia care, and managing diabetes. The manager had worked hard to access further training for staff and this was planned and included: stroke awareness, and health awareness. Senior staff were training to be care assessors so they could effectively support staff with the care certificate.

A staff member told us that they had regular team meetings approximately three or four times a year. This along with a yearly appraisal and on the job supervision made them feel well supported by management. We saw from the recently designed planner that staff supervisions had been established for the year to help ensure staff received regular supervisions.

We saw evidence of induction and new staff working alongside a more experienced member of staff until they had developed the necessary skills and competencies to work more independently. New staff new to care were enrolled on the care certificate which covered common induction standards for staff working across the care staff and is nationally recognised.

People were supported to make their own decisions and consent was sought as appropriate. We found good examples of staff seeking consent and acting within the relevant legislation and guidance. Staff were observed routinely asking people about their preferred choices in relation to food and drink and medicine such as pain killers. Staff were observed routinely seeking peoples consent to assist them with personal care and support. Decisions and consent in matters such as resuscitation if a person's heart stopped was appropriately decided and known about by staff. In the care plans we saw that people had been asked and had signed to agree to the use of the photographs and use on social media. An example of a care plan statement was, 'I'm able to make my own small decisions, but want my family to help me make bigger

decisions'. Where people had family members acting on their behalf and holding enduring power of attorney this was recorded.

In three care plans we saw DoLS applications had been appropriately completed and submitted. The home were aware of when to apply for a Dols and had done so accordingly. Deprivation of liberty safeguards applications are sought from the Local Authority when it is felt necessary that a person is detained against their will. The Local Authority might grant a DoLS when it felt necessary to ensure the safety and welfare of the person. The home did not impose unnecessary restrictions on people who freely accessed the service. People were observed going into the garden. The cook told us people could access the kitchen if staff were in the vicinity.

People were supported to have an adequate diet and have enough to eat and drink according to their needs. People told us staff always asked them if they wanted a drink. We observed staff promoting fluids throughout the day. People told us that they liked the food on offer. One person was later getting up and was able to come to the dining room and be served their breakfast later than others. This showed the flexibility the staff had in serving meals when people wanted them. We were told that people had a cooked breakfast at a weekend. Tea and coffee along with fruit snacks and milk shakes were frequently available through the day.

At lunchtime we saw a variety of meals served to people as well as those set out on the menu. Lunch was well organised and a pleasurable experience for people based in two small dining rooms or people ate in the rooms. Some people had to wait considerably longer than others to be served. The meal was hot when served. However, one person reported the food not to be hot enough and staff immediately heated it up. People in their rooms were encouraged and given the support to eat if required. We noted that one person was unwell and was given a main meal which they found difficult to eat.

We spoke with the cook who was knowledgeable about people's needs and showed through their knowledge how they mitigated risks for people. For example they told us how they fortified meals to help ensure people who were at risk of weight loss had additional calories to promote weight gain. This included things like adding cream to porridge and using full fat milk, giving people jelly and snacks in between meals. They were aware of any one with allergies or special dietary requirements and were able to fulfil these. There was lots of guidance for staff about how to meet people's nutritional needs.

People were supported with their health care needs but relationships with other health care professionals were fragmented which could compromise the level of service provided. Staff raised concern about accessing health care and felt their knowledge of the person was sometimes thrown in to question and they did not always get the response they would expect from the GP practice. The home was using three/ four different practices but felt one in particular was under pressure and used a lot of locum doctors. The manager is trying to address this with the GP practice with the involvement of the Clinical Commissioning Group.

People told us their health care needs were met. "One person said, "I had the flu jab recently but then ended up in hospital. " They then told us about the weight they had lost but told us the reason for this but said they are now maintaining their weight. They told us they had not had any falls and saw the chiropodist regularly. Another person told us they were diabetic. They said, "it's managed through a controlled diet, staff keep a check on this and I have a low sugar diet. I am seen by the District nurse regularly and happy my health care needs are met. I see the chiropodist regularly. "

Whilst we were at the service a person became unwell. The GP had been called and later they were

appropriately transferred to hospital. Staff were well prepared and ensured that information about the persons care needs along with medicines prescribed were sent with the person.

We saw from care plans that people had regular access to the GP, optician and chiropody. However we found it difficult to follow and track through care plans and daily notes to find out what had actually happened. One person had broken a bone and we could not trace through records their journey of treatment and follow up from health professionals. Another person's needs had changed but information was sometimes contradictory and it was not always possible to see what advice staff had been given following a visit from another health care professional.

Good

Is the service caring?

Our findings

People were positive about the staff that supported them. One person said, "The staff are lovely, you won't hear any complaints from me." Staff demonstrated positive, caring relationships with people. One staff member said, "I like it here. It is homely and lived in." Another staff member said, "We are all a happy family. We all get on." The term 'like a family' was one we heard several times throughout the day. A new member of staff told us, "I absolutely love it here." There was a relaxed atmosphere and people looked content and happy to be at the home. We spoke with a visiting social care professional. They told us that the person they had placed at the home was happy to be there and very satisfied with the care and support they received. We met a person who had been given some upsetting news. They told us how staff had been supporting them and communicating effectively with their family. They said staff made them a cup of tea, sit with them and gave them support. We did observe caring interactions from staff that knew people well and genuinely cared for people. We saw caring practice and staff ensured people were well and kept warm and hydrated

Although the staff were caring we identified some practice which was not consistent with a good understanding of people with dementia. One person became distressed and asking when they could go home to which staff replied 'you are home, you have lived here for a long time.' When the person said this was not the case staff insisted it was which just added to the persons distress and felt this could have been reduced if staff had used diversion tactics to bring the conversation around to something else. Care plans did not have guidance about supporting people when distressed or how to minimise people's distress. Several staff were dementia champions and had received specific training. This needs to be cascaded down to staff in order to be effective. We also noted staff carrying round a cordless phone and talking as they walked which we found intrusive.

Staff said they helped to promote people's independence by supporting people to do what they were able to do for themselves. This was reflected in people's care plans. We observed one person helping to lay the tables and bringing in the post in but did not observe anyone else engaged in house hold tasks. We noted that people mostly ate independently and staff facilitated this whenever possible. Where people needed assistance this was provided respectfully. Where people were independent they had built up cutlery, plates with a lip and slip mats where required.

People's privacy was not always upheld. Upon arrival we noted a person door ajar which potentially compromised the persons dignity. We discussed this with the manager who told us it was the persons choice to have their door open. We asked them to review this. We found throughout the day staff did uphold people's privacy by knocking on doors and asking people's consent before providing care.

People were not always supported at the end of their lives in terms of their wishes because there was not always documentation in place about people's wishes. We were told this was being addressed. The manager told us that people and their relatives did not always want to discuss this and we asked that this be recorded.

People confirmed that resident meetings sometimes took place and they were consulted about their needs

and wishes. Staff consulted with people on a daily basis and people knew staff and felt able to raise concerns or ask questions of them.

Requires Improvement

Is the service responsive?

Our findings

We spoke with people about their care needs. One person told us they managed their own care needs but staff assisted them with a bath on a Thursday. Another person said, "Staff are kind, they help me with my personal care." One person told us about how much they enjoyed their bath but said this was only once a week and they didn't think they could have one more often. Staff said people could have a bath where there was time.

Staff responded appropriately to people's needs and care plans documented people's needs but these were not always accurately recorded and updated when changes had occurred.

We looked at six peoples care plans and associated records. We looked at one person's records who had recently been admitted to the home. The home had recorded good back ground information leading up to the circumstances of the person's admission and current needs. This included an in-depth assessment from the social worker. However despite the person being there for a month staff had yet to complete a care plan which reflected their needs and informed staff how they should be meeting them.

Care plans did not always record people's current needs or show how risks associated with the persons care were mitigated as far as possible. For example, we spoke with a person who had recently fallen and had sustained an injury which we observed as having an impact on them. They told us they were less independent as a result of their injury. Their care plan however showed no recorded change in their dependency level or level of support they required from staff to help them with day to day tasks such as: mobilising and eating. We saw that they had lost a significant amount of weight since sustaining an injury which would suggest there was an impact of their injury and we observed their mobility had declined.

We noted for another person despite a history of falls their care plan was not updated to show an increased risk or actions taken to try and mitigate the risk. Their records did not reflect a change in their dependency level even after a significant injury which meant their needs no longer reflected what was recorded in the care plan. Their daily notes did not always enable us to see how the person needs were being met. Care plan evaluations did not always report on the changes in need we observed or those reflected elsewhere in the persons records. This potentially could mean a decline in someone's health not being identified quickly and acted upon to prevent further decline. The manager had information about people's falls including individual falls trackers, some of which were not up to date and did not show all the falls which had occurred.

We saw in one record under the care plan relating to capacity there was information about the person having 'outbursts' but there was no written information about what actually happened or what helped the person to manage the situation. By going through the records we found this person slept in their chair. The associated risks from this were not documented.

The above demonstrates a breach of Regulation 9 of the Health and social care Act 2008 (Regulated Activities) Regulations 2014: Person centred care.

We noted that some people had, 'This is me' which gave an introduction into the person's life and included information about their occupation and family life. It was divided into sections showing, this was me when I was young, middle age, old which was really helpful and reflected on significant events and achievements.

Activities were planned throughout the day. We asked people how they were occupied through the day and saw some people had activities they were engaged in: including watching the television, magazines, newspaper and word search. One person told us they chose not to join in activities. They said, "Staff try and involve me but I don't want any of that nonsense. " Another person said, "I do bingo on a Wednesday, we win prices. They told us what they liked to do in terms of interests and hobbies but said they had no opportunity to do them now. Another person said they liked to play dominoes but unfortunately said the person they liked to play with was in hospital. They were unable to see the television due to sight impairment so were restricted in what they could do but told us they liked word searches and had different things to occupy them. The scope of activities was rather limited and not personalised according to individual needs.

We noted that through the day staff did encourage people to join in different things. We also noted that space was compromised and one person was sat next to someone they told us they did not like. We asked why they didn't sit in a different chair and they said because they wouldn't be able to see the television.

Set activity hours were between 1.30 and 3.00 pm but we observed staff engaging people in activity throughout the day such as skittles, and music was on which staff were singing alone to and encouraging people to join in. Staff told us they had outside entertainers in and had taken people out on trips to local places. They had started a Facebook page so family and friends could view and see what people had been up to.

The service routinely took into account feedback it received about the service which helped to improve the service. A visiting social care professional told us that the manager was approachable and open to feedback about the service. There was an established complaints procedure and only one recent complaint which had been recorded. Mostly compliments were received thanking staff for the high standards of care being delivered. The manager told us if families or people using the service had any concerns or suggestions these were actioned straight away so not always recorded which we advised them to do.

Good

Is the service well-led?

Our findings

The service has been subject to a number of changes in manager which has meant some instability. The current manager. Was able to demonstrate a positive commitment to change in order to continuously improve the service. The manager knew people really well and advocated for them as required. Since the last inspection to the home in February 2016 the manager in post at the time has left. They had applied to be registered with the CQC but the planned interview was cancelled. The homes manager left without being registered and a new manager was appointed immediately to ensure the home remained appropriately supported. The new manager is related to the provider and knows the service well. They had appropriate qualifications in care and a good general knowledge. They have put an application in to become registered with the CQC and are just waiting for an interview.

People spoken with knew the manager and the owner and told us they were able to raise concerns.

During our inspection in January 2017, we highlighted some concerns and the manager sent us an action plan immediately following the inspection showing us how they were planning to address these concerns. This demonstrated their commitment to improving the service and providing high standards of care. They had explained that some of the home shortfalls had only been identified recently since them coming into post and there was already an action plan in place to address these.

Staff provided care according to people's wishes and needs. Staff were familiar with people's needs and responded appropriately to them. The size of the home contributed to a 'home to home' feel with people having sufficient space and opportunities for socialisation. However we have already noted that space was compromised in the annex and this in effect meant people were sitting in close proximity with others in order to see the television.

The manager had an oversight of the risks to people's well-being and safety and kept information which enabled them to see how people's needs were being managed. For example they had a falls and weight trackers so were able to identify anyone who had fallen and check what actions had been taken. They could use the data to identify people who had fallen more than once and to determine any themes or patterns such as the times people were falling and if this had any correlation with levels of staffing. This helped them to plan a service around the needs of people using it. They also tracked people's weights so knew when people needed to be weighed more often or referred to the GP and dietician to help support their nutritional needs. However we have identified that people's care plans and risk assessments were not always being updated as people's needs changed or there was a change in the person's level of risk. Falls trackers did not always have the most up to date information about falls. Accident logs were brief and gave little details of actions taken. The service would benefit from records being cross referenced so it is easier to case track through actions taken to assess, implement and manage changes in people's needs.

Audits were in place but need to be more robust to identify some of the areas we did and on the whole record keeping should demonstrate how staff are monitoring and reviewing people's needs to ensure they are safe, well cared for and their health and welfare promoted.

Improvements in the way the home support people's health care needs and access to the GP was being addressed through liaison and discussion with the GP practice to encourage a more proactive service which was responsive to people individual care needs.

The manager told us they were trying to establish more regular meetings with the involvement of people using the service and relatives by establishing the best time for relatives to meet. Some families regularly visited and there was an open door policy. We saw health care professionals and visitors were welcome to the home. The provider told us some people were accessing the community and different outings and trips had been organised and had taken place. The home had recently sent out feedback forms to ascertain people's views about the service provided. These also went to relatives. At the time of our inspection they were waiting for these to come back so they could use these to inform them of what they were doing well and what they could do better.

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 The care plans did not always reflect people's current needs or risks associated with their care. This meant there was an increased risk of people receiving the wrong care or staff not taking correct actions to ensure people's needs were met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service were not adequately protecting people from risk associated with their care because records did not show adequate assessment, planning and evaluation of risk or actions staff should take to keep people safe. Regulation 12 (1) (2) a, b