Anchor Trust

Sandstones

Inspection report

9 Penkett Road
Wallasey
Wirral
CH45 7QF
Tel: 0151 691 1449
Website: www.anchor.org.uk

Date of inspection visit: 4 and 7 December 2015
Date of publication: 03/03/2016

Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires improvement**

Overall summary

We undertook this comprehensive inspection on the 4 and 7 December 2015. The first day of this inspection was unannounced.

Sandstones is registered to provide personal care and accommodation for up to 35 people. The home is situated in Wallasey, Wirral, close to Liscard town centre. The home is a purpose built with a small car park and garden available within the grounds. The home is. A passenger lift enables access to bedrooms located on the first floor for people with mobility issues. Communal bathrooms with specialised bathing facilities are available on each floor. On the ground floor, there is a communal lounge and dining room for people to use and the home is decorated to a good standard throughout.

On the day of our visit, there was a registered manager in post. 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.

Summary of findings

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulated Activities 2014. These breaches related to medicine management and the implementation of with the Mental Capacity Act 2005. We also found a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 as the provider had not always reported notifiable incidents to the Care Quality Commission.

We looked at the arrangements for the safe administration of medication to people who lived at the home. We saw that medication records matched what had been administered and that staff had received training on how to administer medication safely. We observed two medications rounds however and saw that the way some staff administered medication was not consistently safe.

We reviewed the care records belonging to three people who lived at the home. Where people had mental health conditions that may have impacted on their capacity to make specific decisions, their capacity had not been assessed appropriately. This meant that the Mental Capacity Act 2005 legislation had not been followed to ensure people's legal consent was obtained. Care records also lacked sufficient guidance on how to provide person centred support to people who became emotionally distressed or displayed behaviours that challenged.

Care files provided sufficient guidance to staff on people's health needs and risks. People's independence was promoted in the delivery of care and their care plans gave staff an understanding of the person they were caring for and their preferences in day to day living. People's care had been regularly reviewed and records showed that people had prompt access to other healthcare professionals when needed.

People who lived at the home said they were well looked after. We saw that people looked well dressed and content. We saw that staff supported people in a patient, unhurried manner. Support provided in such a way as to promote the person's ability to be independent and staff were observed to be warm and compassionate.

The home had been without an activities co-ordinator for several months despite attempts to recruit to this post. The manager told us staff had helped out with activities during this time and one the day of our visit staff and people were enjoying festive activities. The atmosphere at the home was social and homely. People sat in companionship in the communal lounge and interactions with staff were good humoured. It was obvious that staff new people well and genuinely cared for the people they looked after. People told us they felt safe and had no worries or concerns.

Records showed staff were recruited safely. There were sufficient staff on duty to meet people's needs and staff received the training and support they needed to do their jobs effectively.

Staff spoken with, were knowledgeable about types of abuse and what to do if they suspected abuse had occurred. We found however that some accident and incidents and allegations of abuse had not been appropriately reported to the Care Quality Commission in accordance with legal requirements.

People had access to sufficient quantities of nutritious food and drink throughout the day and were given suitable menu choices at each mealtime. People's special dietary requirements were catered for and people we spoke with told us the food was good.

People were provided with information about the service and life at the home. Information about how people could make a complaint required the contact details for who people should contact in the event of a complaint, to be clarified.

The premises were well maintained and the home's equipment was properly serviced to ensure it was safe and suitable for use.

We observed the culture of the home to be open and inclusive. The staff team had a 'can do' attitude, were confident in their roles and worked well as a team. The management team were 'hands on and people's feedback about the service, gained through residents meetings and the use of satisfaction questionnaires, was consistently positive. This demonstrated good staff management and leadership in the delivery of care.

There were a range of audits in place to assess and monitor the quality of the service provided. We found some of these audits were not consistently effective. For example, care plan audits in place had not picked up that people's mental capacity had not been assessed where appropriate. Medication audits had not picked up that

Summary of findings

the way in which some staff administered was not consistently safe and other incident audits had not picked up some notifiable incidents had not been reported to The Commission. This aspect of service management required improvement.

Summary of findings

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 consistently safe. The way medication was administered required improvement to ensure it was always safe.

People who lived at the home felt safe. Staff knew how to recognise and report signs of potential abuse.

Care files showed that people's risks were assessed and safely managed.

Staff were recruited safely and there were sufficient staff on duty to meet people's needs.

The environment was safe, clean and well maintained.

Is the service effective?

Requires improvement

The service was not always effective. This related specifically to the implementation of the Mental Capacity Act (2005) at the home.

People said they were well looked after. It was clear from our observations that staff knew people well and had the skills/knowledge to care for them.

People were given enough to eat and drink and were given a choice of suitable nutritious foods to meet their dietary needs.

Staff were trained, supported in their job role and worked well as a team.

Is the service caring?

Good

The service was caring.

People and relatives we spoke with held staff in high regard. Staff were observed to be kind, caring and respectful when people required support.

Interactions between people and staff were warm and pleasant and it was obvious that staff genuinely cared for the people they looked after.

People were given information about the home and were able to express their views about the service provided.

Is the service responsive?

Good

The service was responsive

People's needs were individually assessed, care planned and regularly reviewed. Care plans contained person centred information.

The service was responsive when people became unwell and people received ongoing care from a range of health and social care professionals.

Summary of findings

People who lived at the home and the relative we spoke with had no complaints. The provider's complaints policy was displayed. The contact details for who people should contact in the event of a complaint needed to be included.

Is the service well-led?

Requires improvement 

The service was not always well led. Some improvements were required in relation to the implementation of the mental capacity act, medication administration and incident reporting to The Commission.

People who lived at the home and staff told us the home was well led and managed. A positive and inclusive culture was observed at the home. The manager was 'hands on' and well respected by the staff team.

A range of quality assurance checks were undertaken but some of these were not consistently effective.

Sandstones

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 4 and 7 December 2015. The first day of the inspection was unannounced. The inspection was carried out by two Adult Social Care Inspectors.

Prior to our visit we looked at any information we had received about the home. On the day of the inspection we spoke with six people who lived at the home, two relatives, four care staff, the cook, the care manager and the registered manager. We also spoke with a visitor to the home.

We looked around the home and reviewed a range of records. This included three care records, medication records, staff files and training records, policies and procedures and records relating to the management of the service.

Requires improvement

Is the service safe?

Our findings

People we spoke with told us they were well looked after and felt safe at the home. One person told us "Yes I feel very safe here" and another said "I feel safe here and well looked after". A relative we spoke with told us "We don't have any worries about them being here. We know she is safe and well looked after".

We saw that the majority of people's prescribed medication was stored securely in a locked medication room but some medicines, for example prescribed creams and inhaler medication was found in people's bedrooms. These medicines were not stored securely in people's rooms and were at risk of unauthorised use by other people who lived at the home, staff and visitors.

We reviewed the home's medication policies and saw that people's capacity and capability to self-administer their medication was to be assessed prior to authorisation for medication to be stored in their own bedrooms. We asked the manager if any of the people who had medication or creams in their rooms self–administered their own medication. We were told that some people did and we were shown appropriate documentation in relation to this. Those people who were not self-administering but who had medication or creams in their rooms had not had the risks of this assessed to ensure they were safe to have their medication or creams stored in this way.

We saw that some people had more than one pot of the same cream or medication in their bedroom. We asked the manager and care manager how they were monitoring the use of these prescribed creams and medicines. We found there was no safe system in place to monitor the usage of this medication and no proper checks in place to ensure that people were administering these medications safely for example, through a discussion of their medication at each care plan review.

We observed two medication rounds. On both medication rounds, the staff members administering the medication did so in a discreet and sensitive manner. We saw that one staff members however did not administer medication in a safe way.

For example, two people's tablet medication was poured out of the medication pot straight onto the dining room table where both people were sat. This meant there was a period of time when there was a selection of loose tablets on the table that could have been mislaid, fallen from the table or mixed up with the other person's medication. For a short period of time, both people were unsupervised with this medication. The staff member was also observed to sign one person's medication administration record (MAR) as having observed the person taking the medication prior to the person actually taking it. This meant an inaccurate entry was made in the person's MAR as the staff member had not observed the consumption of the medication prior to signing the record.

Staff administering medications should always supervise the taking of medication and observe the person taking the medication before they sign the person's medication records.

These incidences were a breach of Regulation 12 as the provider did not have suitable systems in place to ensure the proper and safe storage and administration of all medicines in the home.

Records showed that staff received training to administer medication safely and that their competency to do so was assessed by the manager. We checked a sample of people's medication administration charts (MAR). We found that stock levels balanced with what medicines had been administered.

We saw that the provider had a policy in place for identifying and reporting potential safeguarding incidents. Staff spoken with told us they had completed safeguarding training and knew the action to take should an allegation or incident of abuse occur. We looked at a selection of safeguarding incident records and saw that safeguarding incidents had been investigated and responded to appropriately by the manager. Accident and incident records showed that staff had responded appropriately and people had received any medical support they required. Incidents however had not always been reported to The Care Quality Commission in accordance with requirements.

We looked at the care files belonging to three people who lived at the home. People's risks in the delivery of care had been assessed and suitable management plans put into place. For example, risks in relation to malnutrition, falls, moving and handling, pressure sores and cognition were all assessed. Care plans were easy to read and gave a good overview of the care people required to keep them safe.

Requires improvement

Is the service safe?

Personal emergency evacuation details were in place to provide staff and emergency services with immediately accessible information about people's needs in order to assist them in an evacuation.

People we spoke with thought the premises were well maintained. On the day of our visit, we found the home to be clean, warm and of a good standard. We saw that the provider had been awarded a five star rating by Environmental Health in June 2014 for its standards of food hygiene. A five star rating is very good. We found the kitchen to be well organised and managed.

We looked at a variety of safety certificates for the home's utilities and services, including gas, electrics, heating, fire alarm, fire extinguishers and portable appliance testing. We saw that they all conformed with the recognised safety standards and were regularly inspected and serviced by external contractors.

We looked at four staff files. All files included evidence of a satisfactory recruitment process. Each file contained an application form, previous employer references, proof of identification checks and a criminal convictions check.

We looked at staff rotas. Records showed sufficient staff were on duty each day and during our visit, we observed that people's needs were responded to promptly by staff.

We saw that staff had the time to sit and chat to people as well as support them with their personal care needs and a staff member was always visible in communal areas Staff had access to appropriate managerial or supervisory support and people's needs and dependency levels were reviewed regularly to ensure staff levels remained adequate.

We saw that antibacterial soap and alcohol hand gels were available throughout the home to assist with infection control. The home was adequately clean and there was ample protective personal equipment for staff to use in the delivery of personal care.

The provider's system for monitoring and controlling the risk of Legionella required further development. We noted that the provider's water hygiene had been tested and disinfected in April 2015 but there were no regular checks of the water temperature at the home to ensure that water temperatures were at a safe range to control the risk of Legionella. Legionella bacteria naturally occur in soil or water environments and can cause a pneumonia type infection. It can only survive at certain temperatures. Under the Health and Safety Act 1974 a provider has a legal responsibility to ensure that the risk of legionella is assessed and managed.

Requires improvement

Is the service effective?

Our findings

We looked at four care files. We found that some people's legal right to choose how they lived their life at the home had been respected whereas others had not.

For example, we saw one person had refused health related advice in respect of a health condition that placed them at risk of harm. We saw that staff at the home had contacted the person's GP and other healthcare professionals to discuss the person's wishes and had advised them that the person understood the risks associated with this decision. The person's plan of care was adjusted to reflect the person's wishes.

Another person's file however indicated that their legal right to consent had not been respected in the same way for a period of approximately six months. Records showed that this person had regular episodes of challenging behaviour when care was provided at a particular time of the day. The person had expressed that they did not want their care provided at this time. We saw that despite this, staff had been instructed to continue to deliver care to the person in this way.

We asked the manager about this. They told us that due to health risks, it was in the person's best interests. We asked the manager if the person had capacity to understand and accept these risks. The manager told us the person had the capacity to decide this for themselves. This meant that the legal rights of the person to choose how to live their life at the home and to consent to the care they were given had not been respected.

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 saw that one person had a 'do not resuscitate' record (DNAR) in their care file. Records showed that this DNAR had been requested by a relative in conjunction with the person's GP. There was no evidence that the person's relative had the legal right to make this decision on their behalf under a Lasting Power of Attorney. We asked the manager and care manager at the home if the person had been involved in this decision. They did not know. We asked if the person knew that they had a DNAR. They told us the person was unaware that this decision was in place.

After our inspection we referred this person to the safeguarding team at the Local Authority.

These examples demonstrate a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider did not have suitable arrangements in place to ensure the principles of the Mental Capacity Act 2005 were followed to gain legal consent, where a person's capacity may be in question.

We spoke to the manager about the implementation of the MCA and DoLS legislation at the home. They acknowledged that this was an area for development and demonstrated a positive commitment to ensure improvements were made. They had already started work on this before our visit had finished.

People we spoke with said the care was good and they were well looked after. One person told us "I could not be in a better place. The staff are brilliant and take really good care of us all". Another said "The staff are marvellous and the food is great. I feel so fortunate to be here". A relative we spoke with said "The carers all seem to be well trained and I always hear them asking before they help anyone".

Staff we spoke with demonstrated a good understanding and knowledge of people's needs. We observed staff supporting people throughout the day and from our observations it was clear that staff knew people well and had the skills and knowledge to care for them.

Staff training records showed that staff had access to regular training opportunities. For example, training was provided in safeguarding, moving and handling, the safe administration of medication, infection control, mental capacity, deprivation of liberty safeguards and dementia

Is the service effective?

awareness. Staff files showed that staff had received appropriate appraisal and supervision in their job role and we saw that staff had access to managerial or supervisory support on each shift.

People we spoke with were pleased with the choice and standard of the food at the home and said they got enough to eat and drink. One person told us "The food is absolutely lovely and if you want some more you just ask".

We spoke to the cook. They told us that the menu was changed every six months and that a choice of main meals was always available. We asked the cook about people's special dietary requirements. We were shown a copy of the information provided to the cook and saw that clear guidance on what foods some people could and couldn't eat was provided.

We observed the serving of the lunchtime meal. The meal was served promptly and pleasantly by staff. The dining room was light, airy and the lunchtime meal was served in a relaxed, social atmosphere. The tables were set pleasantly with cotton tablecloths, napkins and a floral centrepiece. Each table had a copy of the daily menu for people to choose from.

The lunchtime meal was fish, potatoes and vegetables or bacon and eggs. The food provided was of sufficient quantity, looked and smelt appetising and people were offered additional portions. Where people required prompting or assistance to eat, staff supported people's needs sensitively, promoting people's independence where possible.

At the end of the meal, the cook visited the dining room and asked each table of people whether they had enjoyed the meal. There was a comments book in the dining area for people to leave suggestions or comments about the food provided. We did a random check of people's comments and saw that they were consistently positive.

Care files showed that people's nutritional needs were assessed and managed. Dietary supplements were available for people at risk of malnutrition and drinks and snacks were provided throughout the day. People's bedrooms were supplied with a small fridge and we saw that people had a jug of water in their fridge and a selection of snacks. People were weighed regularly and medical advice sought if people's dietary intake significantly reduced.

Care records showed that referrals for specialist advice had been sought in respect of people's care. Referrals to dietary services, memory clinic, physiotherapy, mental health, falls prevention team, tissue viability services and district nurses had been made as and when required. People's daily notes showed that staff monitored people's health and wellbeing on a daily basis and responded appropriately when people became unwell.

The premises was tastefully decorated and adapted to meet people's needs with hand rails in communal corridors to assist people's mobility. A passenger lift enabled people with mobility problems to access the upper floors. The manager told us that the provider was currently looking at how the environment in the home could be improved to support people living with dementia. For example, personalising people's bedrooms doors, the use of different colour schemes to aid orientation and reminiscence areas for people to enjoy. We saw that there were already some provisions in place in people's rooms such as raised and coloured toilet seats, appropriate signage on bathroom and toilet doors and people's photographs on their bedroom doors so they were able to recognise their bedroom easily.

Good

Is the service caring?

Our findings

People who lived at the home and the relatives we spoke with, told us that staff were kind, caring and respectful. People's comments included "From the manager down, all the staff are brilliant" and "The carers are kept busy yes, but they often sit down for a chat with us if they can. They're lovely". A relative we spoke with also told us "The staff are so patient and caring and are really respectful towards everyone". It was clear from our discussions with people who lived at the home and their relatives that staff and the management team were highly thought of.

We observed staff throughout the day supporting people who lived at the home. We saw that all interactions were positive. Staff maintained people's dignity at all times and people looked well cared for and content.

Staff we spoke with had a good understanding of people's needs and preferences and spoke warmly about the people they cared for. From our observations it was clear that staff genuinely cared for the people they looked after and people were treated in a warm and compassionate manner. This was confirmed by the healthcare professional we spoke with, who said that staff at the home "Genuinely cared" about the people who lived there.

We saw that there were periods throughout that the day when staff took the time to sit with people and have a general chat. The mood was jovial and homely and festive music played softly in the background during the afternoon with staff and people who lived at the home joining in to sing together. The communal lounge was a popular area with people who lived at the home. People sat in companionship with others either in day to day conversations or undertaking an activity together. For example, on the day of our visit, a group watched a Christmas programme together and decorated their mobility aids with Christmas decorations. The atmosphere was warm, festive and conducive to promoting people's emotional wellbeing.

We observed that staff were respectful of people's needs and wishes at all times and supported them at their own pace. People with mobility needs were supported patiently and kindly. We saw that staff gently promoted their ability to be independent with the use of mobility aids. Staff encouraged people to go at their own pace and used positive touch to reassure them that they were there for support if needed.

People who required assistance with their meals were supported in a dignified manner. Staff ensured people who had physical difficulties had the adaptive aids they needed to be independent. For example, plate guards to stop the food falling off the plate and no spill drinking cups that enabled people to drink independently. Staff discreetly observed those people who had not eaten very much or who required prompting to eat. They quietly reminded people of the meal in front of them and checked if they liked it or wanted something else. We saw that staff did not rush in to support people who needed encouragement to eat instead they allowed the person, the time and opportunity to eat independently before providing support.

Care plans contained evidence that people and their families had been involved in discussions about the care they required. There was evidence that people's ability to self-care and maintain their independence had been discussed and considered in the planning and delivery of care with care plans clearly outlining what people needed help with.

We saw some evidence that end of life discussions had taken place with people and their relatives with people's preferences and wishes recorded. This showed us that the home understood and respected the advance decisions made by people in respect of their end of life care. The manager and staff at the home had completed and achieved accreditation in the NHS Six Steps Programme for end of life care. Some improvements were needed in the way the home worked with medical staff to assist the person to make decisions about 'do not resuscitate' directives.

We looked at the daily written records that corresponded to the care records we had reviewed. Daily records detailed the support people had received and gave information about the person's general well-being. Daily records showed that people had received care and support in accordance with their needs and wishes.

The home's statement of purpose was in everyone's bedroom for people to refer to. We looked at the information provided and saw that it provided easy to understand information about the home.

Good

Is the service caring?

Regular resident's meetings were undertaken where people were able to express their views and suggestions about the running of the home. The minutes were displayed on a communal noticeboard in the entrance area for everyone to see. Where people had made suggestions, there was evidence that these had been acted on.

Good

Is the service responsive?

Our findings

People we spoke with told us that staff were responsive to their needs and that they received the medical support they needed when required.

During our visit, we observed the culture of the home and the planning and delivery of care to be person centred and holistic. Care records contained sufficient information about people's needs and risks including their preferences and wishes in the delivery of care. We saw that people's personal life histories has been discussed with the person and shared with the staff team to enable person centred care to be delivered. Personal life histories enable the person to talk about their past and give staff, visitor and/or and other professionals an improved understanding of the person they are caring for. Staff however required more detailed personalised information and guidance on how to support people's emotional needs for example when they became distressed or displayed behaviours that challenged.

People's care plans had been regularly reviewed with the person to ensure that the plan and delivery of care still met their needs. It also enabled the person to be involved in choices about their care. We saw that people's care plans were changed as and when required.

Throughout the day we saw that people's needs were responded to on an individual basis by staff. Staff were observed to support people when required and respect their right to be independent whenever possible. People were spoken to by name and treated as 'people first' rather than 'patients' to be cared for by the staff that supported them. People were happy and relaxed with staff and visitors were welcomed throughout the day.

We saw that people's social and activity interests had been discussed and documented in people's care plans. The manager told us that they had not had an activities co-ordinator for a while but that staff had volunteered to ensure people had appropriate activities to engage with during this time. During our visit, we saw that people were given the opportunity to join in festive group activities with staff. The manager had also ensured that the home had a stock of Christmas items to so that people could 'shop' for small gifts for their loved ones.

A staff member we spoke with said "If a resident told us they wanted to do something, maybe go shopping or just for a walk, we would take them out and support them". A person we spoke with confirmed this. They told us "If I wanted to go out I could but at the moment, in this weather I would rather stay in". A relative we spoke with also said "Staff have asked them (the person) to go out on several trips but they choose not to go, but they have been asked". A new activities co-ordinator was due to start in January 2016.

People who lived at the home and the relatives we spoke with during our visit had no complaints. Everyone was happy with the care they received and thought highly of the staff. We reviewed the provider's complaints procedure and related information.

We saw that the provider's complaints procedure was displayed in the entrance area to the home. We saw that it provided information on the timescales for the acknowledgement, investigation and response to any complaints made. Contact details for who people could contact in the event of a complaint were however not provided.

For example, no contact details were provided for the manager of the home, the Customer Relations Team to whom the policy referred, the Local Authority Complaints Department or the Local Government Ombudsman. This meant people may not know who to direct to their complaint to in the first instance, or which external bodies to escalate their complaint with, should they be dissatisfied with the manager or provider's response to their complaint in the first instance.

We looked at the provider's complaints records. We saw that the manager had investigated and appropriately responded to the majority complaints in a timely manner.

Requires improvement

Is the service well-led?

Our findings

We found the service was not always well-led. We found that some managerial improvements were needed with regards to the implementation of the mental capacity act 2005 and the practical administration of medication at the home. We spoke to the manager about both of these issues. They demonstrated a positive, proactive approach to addressing these issues and told us they would be looked into and addressed without delay. They had already started this work before we had completed our visit.

During our visit we looked at a range of safeguarding and accident and incident records. From these records we could see that the manager had fully investigated and responded to these issues appropriately. Safeguarding incidents had been reported to the Local Authority Safeguarding Team in accordance with local safeguarding procedures but only some of these incidents had been reported to The Care Quality Commission in accordance with legal requirements. Some accidents and incidents had also not been reported.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) 2009 regulations as provider had not notified The Commission of all notifiable incidents as detailed in the legislation.

We spoke to the manager about this, who told us that this was an oversight and that they had not realised they had not reported these incidents to The Commission. The day after out visit, we received all outstanding safeguarding notifications.

We asked the manager for evidence of the systems in place for monitoring the quality and safety of the service. We saw that there was a range of suitable systems in place to protect people from risk and ensure the service was of good quality but that some of these were not consistently effective.

There were cleaning checklists in place to ensure the home was clean and audits in place to monitor infection control standards. A health and safety audit was completed monthly which covered all areas of the home and its equipment and weekly fire safety checks were undertaken. On the day of our visit, the home was clean, well maintained, homely and free from environmental hazards.

A monthly check of call bell systems including bed and chair alarms was also undertaken but we saw that a number of the bed sensor and door alarm faults showed on consecutive audits. This indicated they had not been fixed. We asked the manager about this who told us that despite repeated contact with the supplier, they had had limited response so they had changed suppliers who were due out within the week.

There was a system in place for ensuring medication stock was appropriately checked and accounted for and medication audits were in place to check the management of people's medication. We saw that any issues identified had been addressed and on the day of our inspection all stock levels were correct. The systems in place however failed to pick up that the way in which some staff were administering medication was not always safe.

An audit of people's pressure area care was undertaken regularly to ensure that people's skin integrity was properly managed. There was some evidence that the quality and accuracy of care plan information was checked periodically to ensure care plans gave clear and up to date information on people's needs and risks. These were somewhat effective but the system in place failed to pick up that people's mental capacity and emotional needs required further assessment and care planning.

We looked at the manager's accident and incident audits and saw that the manager used this information to identify trends in the type of accidents or incidents occurring so that preventative measures could be put in place, where possible. This information prompted appropriate action to be taken in relation to people's falls. For example, prompt referrals to the falls prevention team were made where people were identified as having persistent falls and requests for assistive technology.

We saw that some accidents and incidents were not recorded on this audit although an accident record had been completed. The manager told us that this was because they were not sure the person had fallen. It is important that all accident and incident information is monitored to ensure a true picture of the types of trends in accident and incidents are analysed.

We asked people who lived at the home and the relative we spoke with if they thought the service was managed well.

Requires improvement

Is the service well-led?

People told us it was. One person told us "The manager is really great and easy to talk to. She's around all the time so you can talk to her anytime you like", another person said "You could not get better".

On the day of our visit, we observed the culture of the home to be open and inclusive. During our visit we found both the manager and care manager responsive with a compassionate approach to people's care.

Staff we spoke with had a good understanding of their roles and responsibilities towards people who lived at the home. They worked well together as a team and were observed to have warm, supportive relations with both the manager and the care manager in their day to day interactions.

Staff we spoke with felt supported in the workplace and said the home was well run. One staff member told us "I think we have a good management structure here and we can all ask each other for advice if we need to. We do get well supported from head office". This demonstrated good staff leadership and management in the delivery of care.

Everyone we spoke with was positive about the care they received and said they were happy living at the home.

The provider commissioned an independent survey of people's views once a year. The survey was called 'Your Care Rating' and was conducted by an external company called Ipsos Mori. We were provided with a copy of the results from the survey undertaken in 2014. The survey assessed people's satisfaction across a range of categories such as the staff team; the care provided; home comforts; choice and having a say and quality. We saw that the home scored well in all categories and 100% of those surveyed (34 people who lived at the home) said "Overall, I am happy living here".

Overall, we found the home to have a person centred, flexible approach to people's care but that some improvements in the way the management team ensured the service was safe and effective were required.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 11 HSCA (RA) Regulations 2014 Need for consent There were no suitable arrangements in place to ensure that the service always obtained the consent of, and acted in accordance with the consent of people who lived at the home. Regulation 11(1),(2),(3) and (4).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way for service users as the management and administration of medicines to people who lived at the home was not always safe. Regulation 12(1),(2)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The provider had failed to notify the Commission of notifiable incidents and injuries in accordance with legal requirements. Regulation 18(2) (b)(ii) of the Care Quality Commission (Registration) Regulations 2009.