Somerset Care Limited

Inver House

Inspection report

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Ratings

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

Overall summary

This inspection was unannounced and was carried out on the 5 and 11 December 2014.

Inver House is a care home owned by Somerset Care Limited. It provides care for up to 53 older adults. The home has two sections, the main home and the Petals unit. The main home provides care for up to 37 older people, some of whom have physical disabilities and varying levels of mental frailty. The Petals unit provides care in a secure environment for up to 16 people who are living with dementia. At the time of our inspection there were 42 people living in the home, 27 in the main home and 14 in Petals unit

The home provides care over two floors. Petals unit is located on the ground floor and the main residential rooms are spread over the ground and first floor. Two lifts are available to assist people to access the upper floors.

Summary of findings

The home has several dining areas and lounges. The grounds are well-maintained and accessible to people living in the home. A hair salon and communal IT facilities are available for people to use if they wished.

The home had a registered manager. 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 registered manager and staff did not fully understand their responsibilities under the Mental Capacity Act 2005. Staff gained consent from people who could give it before providing care, but where people did not have the capacity to communicate their consent, appropriate procedures had not been followed. CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). The registered manager understood procedures to deprive someone of their liberty and were complying with the requirements of DoLS.

Staff participated in a programme of training; however some areas of training had not been addressed with all relevant staff. For example, not all staff had been trained in caring for people living with dementia.

Some people could not verbally communicate whether they were in pain. The provider had not put in place pain assessment tools to assist staff to determine whether people were in pain or not. Therefore it could not be established whether people received pain relief when they needed it. Staff did not follow procedures for the safe disposal of medicines.

Some people's care and support plans had not been updated following a change in their needs, and lacked detail on how to provide individualised, person-centred care. Records were not always up to date or completed accurately. We have made a recommendation about the development of nutrition and hydration support plans for people whose healthcare needs affect their diet.

There were enough staff to support people effectively and staff were knowledgeable about how to spot the signs of abuse and report it appropriately. People said they felt safe in the home and were complimentary about the staff caring for them. The provider followed safe processes to check staff they employed were suitable to work with people.

Staff promoted a friendly atmosphere in the home and people said staff were caring. Staff spoke to people in a kind and caring manner and assisted people in an unhurried way. We observed staff supporting people with respect whilst assisting them to maintain their independence as much as possible.

People had opportunities to participate in a range of activities and trips to local places of interest and the registered manager arranged for local groups to come to the home to provide entertainment and activities. This helped people maintain contact with the local community.

People said they felt involved in their care and had access to information about their choices. Staff said they worked well as a team and that the registered manager provided support and guidance as they needed it. Improvements had been made to the home following feedback from people who use the service and staff. However, the current quality monitoring systems had failed to identify and address concerns that we found during our inspection.

We found several breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

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

Some aspects of the service were not safe.

Processes for pain management were not effective or safe. Medicines were stored securely; however, procedures for the safe disposal of medicines were not followed.

Risk assessments were not always up to date and relevant to the person's current needs. However, there were procedures in place to safeguard people in the event of a foreseeable emergency.

Staff knew how to recognise and report abuse. There were enough staff to care for people's needs. Checks on staff suitability to work in the care of older people were carried out before staff were employed in the home.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

Staff lacked an understanding of the Mental Capacity Act 2005 and how the principles should be applied to people who may lack the capacity to make decisions.

People were assisted by staff who provided the appropriate level of support for people's needs. However, care planning around people's dietary needs was not always person-centred for people with diabetes and dementia.

People's health needs were met in a timely manner and external health and social care professionals visited the home. Staff received effective supervision and training. However, the majority of staff had not received training in the care of people living with dementia.

Is the service caring?

Good

The service was caring.

Staff treated people with kindness and spoke to them in a respectful manner. They fostered a friendly and homely atmosphere in the home.

When people had communication difficulties staff were patient and kind, and established good relationships with people.

People were supported by staff who assisted them to maintain their independence as far as possible. When people became distressed staff intervened in a gentle and appropriate manner.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

Summary of findings

Some people's care plans were insufficiently detailed to ensure people received individualised care. Records of people's care and support were not always up to date or completed correctly.

People were offered a range of varied activities and had access to the local community.

People were involved in the planning of their care and knew how to raise concerns or complaints if they needed to.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led.

Staff felt they were well-led and supported by the management. An open culture was evident throughout the home.

Improvements had been made to the service following feedback from people and from staff.

However, the current quality monitoring systems had failed to identify and address concerns that we have identified to be breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

Inver House

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 5 and 11 December 2014 and was unannounced. The inspection team consisted of two inspectors and a specialist advisor in the care of frail older people and in particular those living with dementia.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information we held about the service including notifications. A notification is information about important events which the service is required to send us by law. We contacted health professionals who were regularly involved in the care of people living in the home, including a GP, three nurses, a psychiatrist and a representative of the advocacy service.

We spoke with seven people living in the home and two relatives. We also spoke with the registered manager, deputy manager, nine care staff, a cook and a kitchen assistant. We observed staff providing care and support to people in the lounges, and during the lunchtime meal. We looked at care plans and associated records for ten people, staff duty records, three recruitment files, records of complaints and accidents and incidents, medicine administration records, staff meeting minutes and the provider's policies, procedures and quality assurance records.

At the previous inspection in July 2013, we found that there were no areas of concern.

Requires Improvement

Is the service safe?

Our findings

Medicines management practices in the home were not safe. The home's medication policy was more than five years' old and did not include recent relevant information, for example, an up to date list of medicines controlled by law (CDs).

Nine people had been prescribed pain relief medicine, some of whom were not able to communicate verbally that they were in pain. The provider did not use a standardised pain assessment tool to help staff determine if the person was in pain and required pain relief. Medicine administration records (MAR) showed some people's need for pain relief had increased over the course of a month which should have triggered the need for a pain assessment to be made. Other people were prescribed one or two tablets of pain relief but there was no indication on their records about when they should receive one or two tablets. People could therefore be receiving a dose that was not effective, or more than they required. Records showed that three people became agitated whilst personal care was being provided by staff. It was not known whether pain was a potential cause of this as an assessment had not been carried out.

Two people had been prescribed medicine for anxiety to be given "if distressed". No guidance was available to staff about what this meant in terms of the person's behaviour. A further two people had been prescribed a similar medicine, with instructions to administer "as necessary". No clear guidance was available to staff about what this meant. As a consequence, the provider could not be certain people received their medicines when they required it.

Arrangements to safely dispose of unwanted or refused medicines were not followed. In the medicines room there was a box which contained medicines to be returned to the pharmacist. On top of the box was an unsealed envelope in which there were more than ten different types of tablets. It was not possible to identify what the tablets were. The book for recording medicines for disposal was not always completed. There was no audit trail to allow the provider to account for these medicines and their safe disposal.

The registered manager told us that two days before our inspection, an error concerning one person's medicine had been discovered. The person had not received their medicine for two months prior to our visit, and this had happened because of a breakdown in the process for ordering medicines from the pharmacy. The guidance regarding the medicine said that it should not be stopped suddenly because of the effects on the person such as the symptoms of their condition increasing. The person's GP had been contacted for advice. The registered manager told us there had been no discernible impact on the person. However, the person's mood and behaviour had not been monitored since the error had been known. Therefore the provider could not be sure how this affected the person's health and behaviours.

Appropriate arrangements were not in place so that all people were protected from the risk of not receiving medicines when they were required. Procedures for the safe disposal of medicines were not followed.

The above issues were a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People's care plans contained individual risk assessments. Risks to their safety were identified, such as allergies, falls and skin integrity. Some people's risk assessments and support plans were not up to date and did not reflect people's current needs. One person's risk assessment identified they had an allergic reaction to a particular food group and the person had access to emergency medicine in the event of a severe allergic reaction. However, no information was available about the signs and symptoms that may indicate the person was having a reaction, or how to use the emergency medicine to treat them. A member of staff, who cared regularly for the person, said they had recently become aware of the allergy but they did not know the symptoms or how to treat it. The registered manager and deputy manager were not clear about the nature of the person's allergy which placed the person at risk of not receiving safe or immediate treatment.

Two risk assessments we looked at related to one person's abilities and risks when being assisted to bathe, and their skin integrity. Their support plan stated they would 'like to be left alone' for a while in the bath, and that their skin condition was 'healthy'. The person's care notes showed the person had a recently diagnosed pressure injury to their sacrum The person's risk assessments and care plans did not reflect the person's most up-to-date needs as the person's health had deteriorated significantly and they

Requires Improvement

Is the service safe?

were no longer able to support themselves whilst bathing. Leaving the person alone whilst bathing would present a risk to the person's safety. Daily records of care were not clear about the level of support care staff were providing.

People were not protected against the risks of inappropriate care because care and support plans, and risk assessments, were not always up to date and relevant to the people's individual needs.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People said they felt safe living in the home. They said staff knew how to support them when they required equipment to help them mobilise. One person commented that the staff had used a hoist to lift them after they had fallen and they felt confident that staff knew what to do in that situation. We observed staff assisting people to mobilise with equipment using safe moving and handling practices. Records showed equipment used in the home was appropriately maintained and serviced.

Staff were trained in the safeguarding of adults. They were able to describe signs of abuse and how they would report their concerns according to the provider's and local authority procedures. They were confident the management would take appropriate action in response to their concerns, and that they would report the matter to the local authority, or to the Care Quality Commission, if necessary. Staff were aware of the whistle blowing policy and the procedure to follow.

Potential environmental risks to people's health and welfare had been assessed and managed. People said they could access all parts of the home safely. Staff had discussed with one person the risks involved with their chosen mode of transport when going out. They had agreed an outcome and a risk assessment was in place. When people's movement around the home was restricted, such as when the home had an outbreak of diarrhoea and vomiting, people said they had been informed of the risks involved and had received a full explanation of the home's policy. They understood the reason for the restrictions put in place.

Staff knew what to do in the event of a fire. All shift supervisors were trained fire marshals. An emergency plan was in place which covered fire, flood, and electricity and gas failure. Emergency supplies of water and lighting were kept in the home and an arrangement was in place with a nearby care home which people could be evacuated to if the need arose.

The recruitment and selection process was safe. Candidates completed an online application form and if suitable, were invited to interview with the registered manager and deputy manager. Successful candidates did not commence working in the home until two satisfactory references had been received, as well as a criminal record check with the Disclosure and Barring Service (DBS). Staff suitability to work in the care of older adults was established by these necessary checks.

There were enough staff to meet the support needs of people living in the home. Each member of staff knew in which area of the home they would be working on each shift. Staff were not rushed when providing care and call bells were answered promptly. People said staff were on hand to assist them when they needed it. One person said, "you can count on them [the staff]". Staff absences were always covered which enabled staff to have more time when providing care to people.

Requires Improvement

Is the service effective?

Our findings

Staff were not familiar with the principles of the Mental Capacity Act (MCA) 2005. The MCA aims to protect people who lack capacity, and maximise their ability to make decisions or participate in decisions that affect them. Five care records for people living with dementia did not contain an assessment of capacity specific to decisions the person may need to make. The MCA was part of the training for all new staff. However, four staff we spoke with about the MCA, including a senior member of staff, were not able to describe how the MCA applied to their work. Both the registered manager and staff were not aware of resources available that would assist them to complete mental capacity assessments. A lack of understanding and application of the MCA Code of Practice meant it could not be ascertained whether decisions were made in people's best interests.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Where people were able to consent to care, staff asked for this before providing care to them. For example, we observed staff asking people whether they required assistance to reposition themselves, before providing this support.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. The manager understood their responsibilities in regard to DoLs. An appropriate application for a DoLS had been made for one person and others were in the process of being made.

People spoke positively about the meals served in the home. They were happy with the quality and the quantity. One person said, "The food is good here – no complaints". Another person said, "The food is beautiful; if I don't like what I get, they take it away and bring me something I do like". A relative told us, "mum loves the food; it always looks tasty".

People were assisted to be as independent as they could be at mealtimes. Staff were on hand to give people the assistance they required. People could eat their meal when it suited them and serve themselves with vegetables if they wanted to. Menus were available and people were able to make a choice the day before. However, they could change their minds on the day if they preferred a different meal. Hot and cold drinks were offered throughout the day and fresh fruit was available. People said they could get something to eat at any time of day if they wanted.

One person had recently been prescribed a liquid diet as they had developed difficulties swallowing. The chef was aware of the need to provide their food to a specific consistency and we observed they received the support they required. Kitchen staff provided low sugar desserts for people with diabetes and a gluten free diet for one person. People with a health condition that might affect their dietary needs, such as diabetes or dementia, did not have a specific nutrition and hydration care plan describing how the condition affected them individually.

We recommend the provider seeks advice and guidance about the development of individual nutrition and hydration care plans for people whose health could affect their dietary needs.

The provider had procedures in place so that people's health needs were attended to. A doctor visited the home each week. If someone was unwell outside of this time then a doctor was called to the home promptly. A relative told us, "all mum's needs are met". People had access to routine health checks such as chiropody, dentistry and optical care. One person's needs had changed rapidly over the course of a few days. Their care had been reviewed involving the person's doctor, a speech therapist and a social care manager from the local authority. The person's needs had been reassessed and updated and staff were following the latest guidance from the health professionals involved in the person's care. For example, changes to their dietary needs had been posted in the kitchen, and the heightened supervision they required whilst eating had been posted in their room. These new instructions were followed by staff assisting the person to eat and drink.

New staff received a formal induction in line with the Skills for Care common induction standards and completed a workbook as part of this. Completion of training in health and safety, fire, and moving and handling formed part of the induction process. The registered manager held review meetings with new staff at six weeks and 22 weeks to check their capability and progress. New staff manual handling

Requires Improvement

Is the service effective?

assessments were repeated after two weeks by a manual handling assessor. Review meetings were documented and actions recorded so that new staff continued to progress in their knowledge and good practice. Staff suitable for career progression completed further training before taking on more senior responsibilities. Staff told us they received, “loads of training” and a range of further training opportunities had been organised each month. The registered manager aimed for 75% of the staff achieving a care qualification. The current level was 70% with seven additional staff currently undertaking a qualification in the provision of care.

Staff competency was assessed following training and a number of staff had been assessed following training in medicines administration. Whilst the home had a dedicated unit for people living with dementia, not all staff had completed training in the care of people living with this condition. We observed care in this part of the home and whilst the majority of staff demonstrated an understanding of people’s needs, some staff did not. We alerted the registered manager to this. They told us training in dementia awareness and best practice for care staff had been arranged for January 2015.The lack of appropriate training could result in people’s needs not being met in the most effective way for them.

Staff received regular supervision which provided them with one to one opportunities to discuss anything they required support with. One member of staff told us that supervision opportunities meant they were able to address issues, and with the registered manager had achieved a positive outcome. One member of staff had requested further training in care planning and this had been arranged for them.

Good

Is the service caring?

Our findings

Staff treated people with kindness and spoke to them in a respectful manner. One person, who had recently moved into the home, said of the staff, “they are very caring; it’s beginning to feel like home”. Another person said, “they are very respectful”. One person said they had “no problems” getting the help they needed, adding, “I can’t fault the staff”.

People were involved in daily tasks around the home, where they were able. For example, one person assisted a member of staff to carry tea and coffee. The staff member said, “[the service user] is my helper today”. We observed staff administering medicines to people in a sensitive and caring way and people had a good rapport with staff. A pleasant atmosphere with banter and laughter was created with staff conversing with people in the dining room.

Staff showed an understanding of people’s needs and how to meet them. For example, two staff were talking with a person who did not want to go to the dining room for their meal. The staff knelt down to listen to the person and find out if something was wrong. They explained the different options the person had, and when the person decided they would go to the dining room, the staff member made sure they were comfortable there. Staff provided support in a caring manner when assisting people to eat independently. At mealtimes staff gently checked people’s preferences were respected, showing interest in people and engaging them in conversation. One member of staff provided support to a person walking along a corridor saying, “Just tell me if your hip is painful; I can get the wheelchair if you’d like”. The person responded appreciatively but declined the offer. The staff member patiently assisted them, at the person’s pace, to get to where they wanted to go.

Where communication with some people was difficult, staff were patient, smiled and held people’s hands appropriately. As a consequence even when communication was complicated between people and staff there appeared to be a mutual understanding and good relationships. Some people became distressed and staff intervened in a gentle manner and diverted their attention. In two instances this approach helped to avoid further escalation between people and avoided potentially distressing situations.

People felt informed about their care. They were told of changes to the service and how this would affect them, such as when one of the lifts was out of order for a period of time. Whilst people expressed this was, “a little inconvenient”, they appreciated being told of the alternative arrangements in place. Staff let people know when an activity was taking place and directed them to the right location if they wished to join in.

People said “the small things that matter” were respected by staff, such as how they would like to be addressed, and who they would like to sit with in the lounge. The chairs in the lounge areas had been arranged so people could interact with each other in groups if they wished. Staff demonstrated they understood people’s likes and dislikes. Daily records of care showed people’s preferences were respected by staff, for example, respecting a person’s wish to stay in bed.. Staff spoke fondly of the people they cared for. One member of staff said, “they are like my mums, dads, uncles and aunts; I want to take care of them”. Another member of care staff told us they were scheduled to work on Christmas Day. They said, “I want to be here on Christmas Day; I want to make it special for them”.

Two relatives said, “they let us know when mum’s not well, or if something needs to change”. They had observed their relative was encouraged by staff to join in activities and they “always enjoyed” these.

At the shift handover meeting staff respectfully passed on information about people and their day to day support needs to the next shift. The home had specific staff designated as Dignity Champions; information and displays around the home illustrated how a person’s dignity should be maintained whilst providing care with good and bad examples demonstrating the impact on people.

People felt their privacy and dignity was respected by staff. They said staff, “always knock on the door before entering”.

Requires Improvement

Is the service responsive?

Our findings

Care plans contained information about people's preferences, although some care plans had little detail about people's personal histories. Some care plans had not been updated when people's needs had changed. For example, one person's care plan contained conflicting information on how they should be assisted to move safely. Their risk assessment stated they needed the hoist with two staff assisting, whereas their support plan showed they required the assistance of one member of staff. The deputy manager said this was incorrect and that the person "required a stand-aid" to move safely. The daily records of care provided to this person showed the support of two staff was being provided, but the use of either the stand-aid or the hoist was not mentioned. Therefore it was not clear whether appropriate mobility equipment was being used. The same person's night-time care plan said the person should be assisted to turn every two hours due to an area of pressure injury. However, the person no longer had a pressure injury. The deputy manager was unsure whether the person was being unnecessarily woken in the night to be assisted to turn as the daily records of care did not reflect this. Care plans did not always reflect people's current needs and as such it could not be determined if they received the individualised support they required.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Records were not always up to date, complete or accurate. The daily records of care for one person showed care staff were applying cream to the person's foot. Their personal care plan did not detail this as a need. Another person's medication care plan stated they should not eat grapefruit or drink grapefruit juice as this could interfere with the effectiveness of their medicine. However, the person's eating and drinking plan did not reflect this or that the person had diet-controlled diabetes. Their moving and handling care plan stated the person's skin quality was dry and that staff should apply cream regularly. Staff told us they did apply creams appropriately. However, their personal care plan did not mention creams, no support plan was available for the application of creams and daily records of care did not say whether staff were applying cream or not. The same person required regular appointments with a chiropodist. There were no records to show the person had seen a chiropodist or not, and staff were not able to confirm whether the person had received appropriate foot care. People's care plans did not accurately reflect their most up to date needs.

Behavioural support care plans for people living in the secure Petals area were insufficiently detailed. No clear assessment or plan was available for people who became agitated whilst personal care was being provided. This would help enable staff to react appropriately so that distress to people could be minimised. A senior member of care staff told us two people were regularly involved in conflict situations. The registered manager told us staff completed a behaviour chart for one person. However, we found the charts had not been completed comprehensively. We found multiple gaps, particularly in the evenings and at night.

Staff had not always followed the provider's procedures when recording marks they had noticed on a person's body. Body maps were completed by staff if a person had sustained a fall or an unwitnessed incident. These lacked detail and the information was not always noted on the person's daily record of care. In one case we found the information had not been recorded as discussed at the staff shift handover. This meant the person may not have been monitored appropriately.

We observed three incidents where people became agitated and distressed. Staff responded well to these situations, but they were not recorded in people's care plans. A senior member of staff said, "these flare ups happen most days and we are all on the look-out for them, but we tend not to record them if they don't lead to anything". Risk assessments for people with behaviours causing concern stated that "any incidents must be recorded" in the daily care record and behavioural charts completed. This lack of recording meant staff were not informed about patterns of behaviour and how to anticipate incidents.

The above demonstrated that records relating to people's care and support were not always up to date, reflecting people's current needs or completed in full.

These issues are a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People were consulted about their preferences throughout the day. They were involved with the planning of their care

Requires Improvement

Is the service responsive?

and discussed the support they needed regularly with staff. This included choices and decisions, and where appropriate, risks associated with their care. Where people requested it, their relatives were invited to review their care with them and with staff. One relative said, "although mum can't tell us exactly what she wants, the staff involve us in her care plan reviews. They respond if we mention something we would like to include in her care".

People had no complaints about the service they received. They felt they could raise concerns if they needed to, and they were confident staff would take complaints seriously. Information was made available to people on how to complain and people knew where to locate this. People knew they could make comments and suggestions and the provider would try and implement these if possible. A complaint the service had received had been responded to according to the home's policy.

Staff were aware of people's needs, and had made changes to people's care in response to their increasing support needs. One person had expressed a preference for only female care staff and this had been respected. However, a male member of staff had endeavoured, in a "softly, softly" manner, to get to know the person. The person's trust had increased in the care staff and the person had since requested the male carer to provide their care and support needs as their preference. Another person had expressed reluctance to be assisted with a bath or shower. Staff had discussed this with the person and had established that the person did not feel confident whilst bathing and felt they might fall. This made them anxious. With the gentle assistance of a male member of staff the person agreed to have a shower, and with increased confidence their anxiety had reduced and they were able to accept assistance to bath regularly.

Two activities co-ordinators were employed by the provider. A pamper session was arranged and people appeared to enjoy the hand massages. This was provided to them in the lounge, or in people's private rooms, if they preferred. The registered manager had built relationships with external organisations such as the local school. Children and teachers had become regular visitors to the home. We saw people had created Christmas decorations and other Christmas activities had been arranged with external organisations, enabling people to remain a part of the community.

Requires Improvement

Is the service well-led?

Our findings

People knew who the registered manager was and they said they could approach her easily. One person told us, "they've made improvements; we've seen it change for the good". A relative told us, "they've really got the residents at heart; it's gone from a care home to their home".

Staff told us the registered manager was visible around the areas of the home where care was being provided. One told us, "we see [the registered manager] most days and she asks how things are going and how we are; she knows us and the residents individually, which is good". All the staff we spoke with felt supported by the registered manager and senior staff. They said "we all support each other from the managers down" and "[the registered manager] is a good leader and we have faith in her, and she has faith in us and acts as if she does; that means a lot". The culture of the home was open and supportive and we observed this between staff members and between staff and people living in the home.

The registered manager had introduced a staffing system which meant short notice staff absence, such as due to sickness, was covered by staff who regularly worked in the home. Staff said, "now all the shifts get covered, even the tea-time ones", which previously had not always been the case if a member of staff was absent. Staff expressed appreciation for this arrangement as it meant they were not "rushed off their feet". Staff discussions were a regular part of the monthly quality assurance procedures the provider had in place. These were themed discussions so a range of topics could be covered across the year. One staff member said they had made a suggestion regarding the key worker system in place. Key workers were named care staff who provided care to people regularly. The registered manager had since implemented a trial of the idea and following this changes had been made so that the system was fairer to staff and more consistent for people using the service.

Staff said the registered manager "welcomes and supports" feedback and ideas from them. Staff meetings were arranged with the management every eight weeks. Minutes taken at a recent meeting showed that areas of concern raised by staff had been addressed by the registered manager. For example, a concern had been raised about the sharing of workloads amongst different staff. In response the registered manager had addressed this and reported back to staff what action they were taking.

Staff knew about whistle-blowing and said they felt confident to approach the registered manager with any concerns they may have. A member of staff had reported an issue which potentially could have affected the level of care provided to people. This had been handled effectively by the registered manager and people continued to receive the care in a safe manner as a result.

The registered manager said "people come first" in the home and we found this ethos in practice by staff we met throughout the home. People had formal opportunities to make suggestions and give feedback to the registered manager. Residents' meetings were arranged regularly and people said they were familiar with these. People's relatives could attend if they wished. People using the service and their relatives were invited to complete an annual survey about the service and from the responses an action plan was created and worked through to make improvements as necessary. The provider ran a "You said, We did" programme in which people could make requests and, where appropriate, the service took action to implement the change or improvement. Examples of people's involvement in improving the service were, making snacks available in the lounge; a display of the names and photographs of care staff; a more varied menu of meals and the provision of internet access throughout the home. A quarterly newsletter was produced outlining changes and improvements to the service, as well as articles on the experiences of people living in the provider's other homes. The newsletter was made available in large print to enable people to read it if they had poor eyesight.

The provider had a strategic plan in place which included the management of risks to the service and people using it. Examples of the areas the plan covered were care of older people in extremes of hot and cold weather; dissemination of safety updates relating to equipment used in the home; and management cover in the event the registered manager was not able to manage the home.

Statutory notifications to the Care Quality Commission were made appropriately and in a timely manner. Staff said improvements had been made following the appointment of a new registered manager. One commented, "it's amazing what [the registered manager] has done. I am very

Requires Improvement

Is the service well-led?

impressed, especially with how things have improved in Petals". The registered manager and deputy manager were clear about their duties as were staff we spoke with in the home. The deputy manager carried out a weekly audit on the response times to call bells. The audit had highlighted that responses could be improved, which was shared with staff. This had resulted in improvements shown in the last two audits. The registered manager was supported by the provider's regional manager who visited the home each month to carry out quality monitoring visits. These covered the analysis of incidents and accidents, themed conversations with staff and people using the service. The results were formulated in to an action plan for the registered manager. We saw the latest action plan and it was evident the registered manager had carried out the actions to make improvements to the home.

However, the audits the registered manager had in place were not effective in identifying and responding to the concerns we found about accuracy of care records, appropriate risk management, safe medicines management and effective implementation of the Mental Capacity Act 2005. As a result, risks to people's health, safety and welfare had been missed.

These issues are a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's policies and procedures available for staff had not been updated since 2007 or 2008. The medicines policy was out of date and the end of life policy referred to a pathway which is not a recommended approach to end of life care. The provider had not ensured staff had access to up to date and relevant information to guide their care and support. We spoke to the registered manager about this and they responded by printing an up to date version of the policies and procedures from the provider's website.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services People were not protected against the risks of inappropriate care because care and support plans, and risk assessments, were not always up to date and relevant to the people's individual needs. Regulation 9 (1) (a) (b) (i) (ii)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers Systems in place to assess and monitor the quality of the service had failed to identify and address concerns that we have identified to be breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Regulation 10 (1) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines Appropriate arrangements were not in place so that all people received medicines when they were required. Procedures for the safe disposal of medicines were not followed. Regulation 13

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
	Arrangements were not in place to ensure people who lacked the capacity to make decisions were cared for appropriately and in their best interests. Regulation 18
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records Records relating to people's care and support were not always up to date, reflecting people's current needs, or completed in full. Regulation 20 (1) (a)