Opus Care Limited

Ashford Nursing Home

Inspection report

407 Hythe Road
Willesborough
Kent
TN24 0JA
Tel: 01233 645370

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Ratings

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

Overall summary

The inspection visit was carried out on 07 and 08 May 2015 and was unannounced. The previous inspection was carried out in February 2014, and there were no concerns.

The home provides accommodation, residential and nursing care for up to 22 older people. There were 17 people receiving nursing care and support on the day of the inspection. Accommodation is provided over two floors with a passenger lift between floors.

The service is run by a registered manager, who was not present on the day of the inspection visit, due to being on maternity leave. 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 and associated Regulations about how the service is run. The deputy manager was present throughout the inspection. The registered manager of the provider's other service in the vicinity was providing additional support while the registered manager was on maternity leave. There was also administrative support from the other service.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty

Summary of findings

Safeguards. The deputy manager and staff understood their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). No applications had been needed to the DoLS department for depriving people of their liberty for their own safety.

Staff had been trained in safeguarding adults, and discussions with them confirmed that they understood the different types of abuse, and knew the action to take in the event of any suspicion of abuse. Staff were aware of the service's whistle-blowing policy, and were confident they could raise any concerns with the deputy manager, or with outside agencies if they needed to do so.

The service had systems in place for on-going monitoring of the environment and facilities. This included maintenance checks, and health and safety checks. Monthly health and safety checks were carried out and identified any new concerns, such as the patio being wet when slippery and needing to be jet-washed. The maintenance staff signed to show when tasks had been completed, but had not dated these records. Each person had general and individual risk assessments in regards to their health and welfare, including a personal emergency evacuation plan. Accidents and incidents were reported and followed up. Actions were put in place to minimise the assessed risks for people.

Staffing numbers provided sufficient staff to care for people effectively. People were confident that there were suitable numbers of staff to provide them with the care and support they needed. People said they felt safe and secure living in the home, and that staff attended to them promptly. People's comments included, "I feel very safe here, I don't have anything to worry about".

Robust staff recruitment procedures were carried out, to ensure that required checks were completed, and staff were suitable for their job roles. Staff induction and training records showed that staff were working to appropriate standards and kept up to date with essential training. Staff told us that they received regular individual supervision, every six to eight weeks, and a yearly appraisal. Records showed that staff had received supervision during January – March 2015; but staff were unable to locate regular records of previous supervisions. Records of yearly appraisals were not available. Staff meetings were held, and staff were encouraged to share their views and to take part in the development of the service.

Nursing staff ensured that medicines were stored and administered to people using safe practices. People told us they received their medicines on time.

People and their relatives said that they knew about their care plans, and had signed to consent to the care provided for them. Records showed when discussions had taken place with people and their family members, and the decisions they had made. This included forms for 'Do not attempt resuscitation' (DNAR), use of bed rails, and use of other equipment such as a recliner chair. Consent was obtained before taking photographs for people's identity or for recording wounds or bruises.

People said that the food was good and they enjoyed it. The menus showed that people were provided with choices which promoted a healthy and nutritious diet. People told us that they could request different items than those on the menu if they wished to do so, and said there was always "plenty of food".

People's health needs were discussed before admission, and assessments were carried out as part of the admission process. Referrals were made to their GP and to other health professionals as needed. The service contained suitable equipment to support people with their health needs, and this was serviced and maintained for safety. Wound care was managed effectively, but recording processes were unclear where people had more than one wound.

Staff were caring and considerate with people, and treated them with respect and dignity. They were supported in making their own choices about where to sit and what to do. People's life histories were recorded in their care plans, and this helped staff to understand them more easily and to engage them in conversation about subjects which interested them. People were encouraged to retain their independence where possible.

The service provided individual activities and an entertainment programme. Many people had high nursing needs and were confined to bed or preferred to stay in their own rooms. An activities co-ordinator spent time with people individually, and kept clear records of how people responded to the time spent with them. We observed that staff spoke to people briefly on the way past the bedrooms where people liked to have their doors open, so as to prevent feelings of social isolation.

Summary of findings

People said they did not have any concerns but would feel confident in raising any issues or complaints. A copy of the complaints procedure was provided to people when they were admitted to the service and was provided in large print. No complaints or concerns had been recorded for the past year.

Staff were informed about any changes at handovers, and were allocated each day to a specific group of people. Staff were clear about the values of the company, and said they would treat people as they would like their own relatives to be treated. The deputy manager was leading the work in the home during the registered manager's absence, and was committed to ensuring that staff carried out their duties well and gave appropriate care.

An administrator with 'Human Resources' training was in the process of reviewing all of the staff policies and procedures and updating them. However other policies and procedures available were not up to date.

Audits were carried out to assess the on-going progress of the service, including an infection control audit and a health and safety audit. These were appropriately detailed, but had been amended using 'tippex' correction fluid, which meant that records could have been falsified.

The service is required to inform CQC of deaths that take place and other incidents. CQC had not received notification of deaths since May 2013, although deaths had occurred since that time.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this 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?

Good

The service was safe. There were suitable procedures in place for emergency procedures and maintaining people's safety.

General and individual risk assessments were carried out and action was put in place to minimise assessed risks. Accidents and incidents were followed up appropriately. Staff were trained in safeguarding procedures and in raising any concerns.

Staffing numbers were maintained to a suitable standard to provide people with the care and support they needed. New staff were taken through robust recruitment procedures.

Medicines were stored and administered safely.

Is the service effective?

Good

The service was effective. Staff were given suitable training to carry out their job roles effectively, and were supervised.

The deputy manager and staff understood the requirements of the Mental Capacity Act 2005, and ensured that people who lacked mental capacity were appropriately supported if complex decisions were needed about their health and welfare.

People were provided with a variety of food and drink to enable them to have a nutritious diet. People's healthcare needs were assessed and monitored, and they were supported by other health professionals as needed.

Is the service caring?

Good

The service was caring. Staff treated people with care and courtesy, and maintained their privacy and dignity.

Staff supported people in making choices according to their own lifestyles.

People and their relatives said that staff communicated with them well, and kept them informed of any changes.

Is the service responsive?

Requires Improvement

The service was not always responsive. People's care plans showed that they were consulted about their care, but daily records did not clearly reflect people's care and support, and wound care was not always clear.

Staff were informed about people's preferences and choices, and provided them with a range of activities and entertainment.

People were confident that the deputy manager and staff listened to them and would follow up any concerns or complaints appropriately. However, there were insufficient records to show how concerns were dealt with.

Summary of findings

Is the service well-led?

The service was not consistently well-led. Up to date policies and procedures were not available for staff's support.

Staff knew their own responsibilities and carried out effective team work, and were informed about the vision and values of the home.

Recording processes were unsatisfactory. Some records were out of date, some were incomplete, and some could not be found.

Requires Improvement

Ashford Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider was 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 07 and 08 May 2015 and was unannounced. It was carried out by one inspector, and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we looked at previous inspection reports and notifications received by the Care Quality Commission (CQC). A notification is information about important events which the service is required to tell us about by law. We contacted two health and social care professionals for their views of the service, and received feedback from the social care professional before the inspection. We met the health professional during our inspection, who gave us their views about the service, and permission to share their comments.

We viewed all areas of the service, and talked with nine people who were receiving care. Conversations took place with individual people in their own rooms, and in communal areas. We also had conversations with two visitors, and 11 members of staff. These included the deputy manager, administration support, activities person, maintenance staff, care staff, housekeeping and the chef. We talked with the registered manager from the provider's other home on the second day of our inspection.

During the inspection visit, we reviewed a variety of documents. These included three people's care plans, three staff recruitment files, staff training records, staffing rotas for two weeks, medicine administration records, health and safety records, environmental risk assessments, activities records, quality assurance questionnaires, minutes for staff meetings, audits, and some of the home's policies and procedures.

Good

Is the service safe?

Our findings

People said that they felt safe living in the service. Comments included, “I feel very safe and comfortable here in my chair and am quite happy to sit in my room”; “It feels safe here and they do take great care of me”; and “I am more than comfortable here and I've never worried about feeling safe”. A visitor told us, “He is so looked after, the care here is excellent; look how quickly they answered the bell”. Other people told us they had previously fallen at home, and felt much safer living where there were staff to support them.

People told us that staff answered their call bells quickly and we observed this during our visit. One person became uncomfortable and slipped down their bed during a conversation with us. They rang their call bell, and staff attended to the person quickly while we waited outside. On our return to the room, they said, “That feels better”.

Staff training records showed that all staff had received training in safeguarding adults. They confirmed their understanding of the different types of abuse and what action to take if they suspected abuse might have taken place. A housekeeper told us, “I would ring the buzzer if I was unhappy about anything”; and another staff member said they would speak to the registered manager (when available) or the deputy manager.

Building and environmental risk assessments were in place, and identified where different areas of the building required attention, such as filling in holes in the service’s car park. A maintenance team was shared between the provider’s two homes, which were close to each other. The maintenance staff signed a maintenance records book to show when repairs or redecoration had been completed. However, this was not dated on completion, and so did not show the timescale from the request to the completion. We discussed this with the maintenance person who said it was a “Good point” and he would date the completed tasks in future. Routine checks were carried out for equipment such as bed rails and window restrictors to ensure they were in full working order. Servicing agreements were in place for lift servicing, emergency lighting, nurse call bell system, fire equipment, thermostat checks for radiators, and legionella checks, and showed these were carried out reliably. A fire alarm test and fire drill practices were carried out every one to two weeks.

Each person had risk assessments in regards to their welfare, including risks of choking, risks associated with being given hot food and hot drinks, and risks of developing pressure ulcers. Individual risk assessments were in place for people relevant to their specific needs. These included a fire safety risk assessment (also known as a personal emergency evacuation plan or PEEP); risk assessments for mobility, and risks associated with using a recliner chair or wheelchair. Accident forms were completed for any accidents or incidents which occurred, and were assessed to see if there were any patterns occurring, and if any further action could be taken to minimise risks.

Staffing numbers were kept under review in regards to people’s dependency needs. We observed that staff attended to people promptly and that people felt confident that there were enough staff. A nurse was on duty for each shift throughout the twenty-four hours. Usual numbers of care staff included four care staff in the mornings, three or four in the afternoons, and two at night. Most people needed two staff to help them to move, using a hoist facility. The staffing numbers ensured that there were sufficient care staff to assist people when the nurse was carrying out other duties such as medicines administration. The deputy manager told us that if a person was really ill or had extra needs, that another staff member would be added to the shifts. There were sufficient numbers of staff employed to cover for annual leave and sickness.

Ancillary staff numbers ensured that the premises were kept clean and functioning well. There were three housekeepers on duty in the morning and a chef, and there was support from an administrator from the provider’s other service. A housekeeper told us that there were two housekeepers every day, and sometimes three. When three domestic staff were on duty, one person cleaned upstairs, one cleaned downstairs, and the third housekeeper carried out extra household duties such as cleaning windows and washing curtains.

Staff files demonstrated robust recruitment procedures. These included required checks, such as ensuring the applicant had provided a full employment history; proof of their identity; satisfactory written references; a Disclosure and Barring Service (DBS) criminal record check; and proof of qualifications obtained. Nurses were required to confirm that their nursing ‘PIN’ number was up to date, and provide confirmation of their qualifications.

Good

Is the service safe?

Nurses administered medicines using a medicines trolley. This was stored in a locked room when not in use. Storage cupboards were clean and tidy. The room temperature and medicines' fridge temperature were checked daily to ensure medicines were being stored at the correct temperatures. Most medicines were administered using a monitored dosage system. Bottles of medicines and eye drops were routinely dated on opening to remind staff that they had a limited shelf life. Medicine administration records (MAR charts) were accompanied by a photograph of the person concerned to check their identity. Clear guidelines were in place for medicines which could be given 'as necessary', for example, pain relief. MAR charts on both floors had been accurately completed, showing that people had been given the correct medicines, at the right times. People said that they received their medicines on time. One room had oxygen in use, and the hazard warning notice had fallen off the door. A new hazard notice was put up during the inspection.

Good

Is the service effective?

Our findings

People said that the staff were “very good” and looked after them well. They felt that staff were well trained and knew their jobs. They said that the nurses called for the doctor if they were unwell, and explained things to them clearly.

People said that they liked the food and they felt well cared for. Some of their comments included, “The food is good but I am a bit of a fussy eater. If I don't like it I will tell them and they will get me something different”; and, “The food is good and there is plenty of it”. Another person said that they could ask for anything if they felt hungry. Other people told us “The food is good” and said they were offered a hot drink when they woke up, and before going to bed.

Staff training records showed that all staff received essential training in subjects such as fire awareness, moving and handling, infection control, first aid, health and safety and food hygiene, and had refresher courses to keep them up to date. These courses were carried out as part of a comprehensive induction programme. Other relevant training courses included communication, Mental Capacity Act 2005, Deprivation of Liberty Safeguards (DoLS) and dementia care. This helped staff to know how to empathise with people who had old age confusion as well as people living with dementia. Most care staff had completed formal training for National Vocational Qualifications (NVQ) or diplomas in level 2 for health and social care. (NVQs are work based awards that are achieved through assessment and training. To achieve an NVQ, candidates must prove that they have the ability to carry out their job to the required standard). Nurses were enabled to keep their skills and knowledge up to date, with training in subjects such as wound care, medicines and ‘PEG’ tube feeding. (A ‘PEG’ is a Percutaneous endoscopic gastrostomy which is when a feeding tube is inserted directly into the person’s stomach when they cannot maintain adequate nutrition with oral intake).

Staff demonstrated their understanding of applying the Mental Capacity Act, as they offered people choice, and ensured that people were given the least restrictive options. Nursing staff carried out mental capacity assessments to ensure that people could fully understand the relevant information when they needed to make decisions. People sometimes lacked full mental capacity to make difficult decisions about their care, but were able to make day to day choices such as the clothes they wanted to wear or menu choices. Staff promoted people’s independence, but had arrangements in place for supporting people if complex decisions were needed in regards to their care and treatment. This included meetings with their next of kin, representative or advocate, and with health and social care professionals, to make decisions on their behalf and in their best interests. No applications had been required to be made to the local authority for DoLS authorisation.

Care plans confirmed that people were asked for their consent to their care and treatment, and people or their relatives (as appropriate) had signed their consent. Some people had given their verbal consent and had asked their relative to sign on their behalf. Consent forms were in place for taking photographs for identity purposes, and for any wounds or bruises. People were also asked for their consent each year for a flu or pneumonia vaccination as requested by their GP.

People’s dietary needs were discussed before admission and the chef was informed. The chef met new people and discussed their needs, and their likes and dislikes. The chef was familiar with different diets, such as diabetic diets and vegetarian. Some people needed to have their food fortified to increase their calorie intake if they had low weights. Care staff weighed people monthly and recorded the weights in their care plans. They informed the nurses of any significant weight gains or losses, so that the nurses could refer people to the doctor for any treatment required.

People had a choice of breakfast items, including a range of grilled foods as well as toast, porridge and cereals. There was a choice of main courses and desserts at lunch and tea times, and the chef would prepare something different for people if they requested this. People said that the menus gave a good variety. The chef liaised with the catering staff at the provider’s other service to discuss menu changes, as well as discussing them with people living at the service. Quality assurance questionnaires were also used to obtain people’s feedback in regards to food management, and there had been positive results from a recent survey. The surveys showed that people considered the menus to be nutritious and varied, and said that food was well presented. Hot and cold drinks were offered throughout the day, and people knew they could ask for a snack at any time.

The kitchen was visibly clean and well organised, and a notice board recorded people’s likes and dislikes, soft and

Good

Is the service effective?

puree diets and if people had any allergies. Puree foods were presented as separate food items on people's plates to aid the presentation. People said that food was well presented and was served suitably hot or cold. Staff were cheerful and friendly, and reminded people of their menu choices. They offered people a choice of drinks. Some people were able to eat independently, and had specialised equipment such as plate guards or beakers with handles to help them. Some people needed assistance to eat and drink. Staff helped people discreetly and carried out a gentle flow of conversation to make the meal a more social time. Most people preferred to eat in their own rooms. A dining room was available, but other people chose to eat from tables in front of their armchairs in the lounge.

Nursing staff requested visits from people's GPs as needed, and made referrals to other health professionals. These included physiotherapists, occupational therapists, speech and language therapists, dieticians, dentists and chiropodists. Visits from health professionals were recorded in people's care plans, and showed the outcome and any action to be taken in response. A GP told us, "I think the standard of nursing care here is good, and the nurses know when to contact me. They are reliable and carry out any procedures requested. They recognise if someone is unwell, and if a review of their care is needed."

Care plans included assessments for people's pressure areas, skin care, nutrition, continence, and mobility. These included specific instructions such as the use of hoisting equipment to move people; management of urinary catheters; use of pressure-relieving mattresses and cushions; and people's specific dietary needs. Some people had on-going wound care, and the records showed the dressings to be used and how often they should be changed. Wound care was recorded after each dressing change to show how the wounds were healing.

Good

Is the service caring?

Our findings

People said that the staff were “Excellent”, “Caring”, “Friendly” and “Very nice here, very pleasant”. Other comments included, “The staff are lovely and talk to me”; and “They chat to me and are nice, and one of the staff gets knitting wool for me as I never stop knitting, I always have done”. A visitor told us, “The care is excellent as my relative can't do things for himself anymore. Nothing is too much trouble for the staff”.

We observed that staff were aware of people’s needs and anticipated them, asking them discreetly if they wanted to use the toilet, or if they would like the television turned off during lunch time. They were caring and considerate when they spoke to people and had a friendly manner. Housekeepers carried out their duties quietly and considerately when people were ill in bed, and engaged people in gentle conversation if they wanted this.

Staff were mindful of respecting people’s privacy and dignity. There were notices on all bedroom doors with the person’s name, and a request to knock before entering. Staff always knocked on doors and waited for a response before entering if people had their doors closed. Staff were unhurried but answered call bells quickly and in a considerate way. For example, one person asked for help to be made more comfortable. Staff asked if he wanted to sit up or lie down, plumped up his pillows and made him comfortable again. They talked with him about what they were doing, and treated him kindly and respectfully.

During the lunch period staff assisted some people who needed help, and also checked on others who were more able to help themselves. One person in the lounge was falling asleep with her lunch in front of her. Staff gently removed her plate and told her she could rest (which she said she would like to do), and have her lunch when she wanted it.

People told us that staff helped them to retain their independence. This included allowing them to wash their own hands and face, or wash parts of their body that they could easily reach. One person said, “They have to help me with my back, but they know I like to be independent if I can”. Another person said, “I need help with washing and dressing but I do like to do some things myself”.

People said that staff gave them clear explanations before carrying out any personal care, or any nursing procedures. For example, one person had a catheter bag which needed changing. Staff explained what they were going to do, and the procedure was carried out quickly and discreetly in the person’s own room. The person expressed their appreciation of this. Staff asked them if they had everything they needed before leaving their room and said, “We’ll come back and see if you are alright in half an hour”. The response was, “Thank you very much for your help”.

People were able to bring in items to personalise their rooms, and a record of their belongings was completed on admission. Most of the bedrooms were for single use. There were four shared rooms, but some of these were being used as single rooms. People only shared a room if they wished to do so, and were introduced to the other person before making a decision. People said that they liked their rooms, and several people told us they found their beds to be very comfortable.

People were able to get up and go to bed as they wished, and to stay in their own rooms or use the communal rooms. Each person had a “Getting to know me” form in their care plan which provided staff with a summary of their family history, their previous occupation, their interests, and their social preferences. These identified if people had any specific cultural or religious needs so that staff could respect their individual wishes.

People had signed their own care plans or asked a family member to act on their behalf. No one currently had the need for advocacy services, but details of these were available on request.

Requires Improvement

Is the service responsive?

Our findings

People's care plans included a summary of their background and interests, as well as their medical history and specific needs. Each care plan was person centred, concentrating on that person's own lifestyle. People and their relatives confirmed that they were involved in their care planning, and that staff responded to their personal likes and dislikes. One person said, "I regret that I am inactive now, but I have my newspaper to read, and staff stop and spend time with me and discuss what is going on in the world". Another person told us they did not like to go to bed too early and said, "I just tell them when I am ready and they come and help me". A third person said, "I would ask for something if I wanted to, nothing is too much trouble for the girls". Someone else expressed a concern about their eyesight to us and we told the deputy manager. She immediately responded, and went to see what the problem was.

We observed that people were supported to have their hair brushed, wore clean clothes and had clean sheets, but this was not reflected in the daily reports that staff were required to write each day. They did not give a clear account of the person throughout the 24 hour period, as there was often only one report each day, and no report at night. The nursing staff did not routinely write reports, only if there was a change in care or an incident to report. Care staff had a tick list to complete for people's care plans for the day and night shifts, but this did not inform the reader. There were minimal records at night or no records of care staff's intervention and care, and no record of people's moods, personal care or eating and drinking. Some reports included phrases such as 'No issues' or 'Personal care given'. This did not explain if the person had had a bath, wash or shower, if they had had their hair washed, dentures cleaned, shave given and other details. There was no record to show how often people confined to bed were checked during the day, or how often night checks were carried out. Each daily report was written on a new page for each day with a gap at the bottom of the page.

The lack of adequate recording for people's daily care reports was a breach of Regulation 17 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Wound care was recorded, but the recording processes were less clear when people had more than one wound, although the information had been recorded. For example, two people had wound care for both legs, and this was recorded on one chart for both legs. It would improve clarity if there was a separate chart for each wound identified.

The lack of clarity about mitigating risks in regards to safe care and treatment was a breach of Regulation 12 (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service did not have a system in place for recording minor complaints or concerns, except in people's care plans. For example, during the inspection a relative asked about reducing the heating in someone's bedroom. This made it difficult to assess how quickly people's concerns were dealt with.

This was a breach of Regulation 16 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care plans were discussed with them when they moved into the home, and were reviewed each month. People's relatives were invited to take part in care planning and reviews if the person wished them to do so. Staff had discussed all aspects of people's care and risk assessments with them, and any changes made to their care plans. Assessments were carried out before admission, to ensure that the service would be able to meet the person's needs.

Care plans contained information about all aspects of care, such as people's personal hygiene needs, ability to communicate, nutrition, continence, mobility, skin integrity, medicines and mental state. Clear directions were recorded, such as identifying that someone was at risk of sacral pressure ulcers as they liked to sit up day and night. Measures were in place to relieve the pressure and minimise this risk. Care plans for sleeping included directions such as, 'Ensure call bell is in reach, ensure drink is nearby. Likes TV on quietly at night and light on.' A care plan for a person's mental state included, 'Able to take decisions regarding their care and welfare, and expresses opinions clearly'. Care plans for pain relief gave clear directions for when this should be given, and what for. Relatives said that the staff kept them well informed about any changes, such as if a person became ill or had a fall. Records of health professionals' visits and the outcome were clearly recorded.

Requires Improvement

Is the service responsive?

Staff encouraged people to follow their individual interests and hobbies within the limits of their nursing needs. Most people remained in their bedrooms due to their medical conditions or as a preference. Activities were therefore carried out on an individual basis, and an activities co-ordinator spent time with people in their own rooms. This included activities such as reading newspapers with people, doing crosswords, giving them a manicure or just chatting with them. Some people liked to watch television, listen to music, read or knit and staff supported them in ensuring they had the things that they needed. People were able to bring their pets in with them (within a risk-assessed framework), as the ethos was that people should be able to live their lives as they would at home, in so far as possible. There was a cat belonging to the service which was in the lounge during the day, and some people said they loved to have it on their laps.

People and staff told us that the service had events and entertainment during the year, including a BBQ, birthday parties and special events at Christmas and Easter. A staff member said, “We give them a present on their breakfast tray for birthdays and Christmas so they don't miss out on special occasions”. They also said they took photographs of the Christmas decorations in the home for people who were confined to bed, so that they could “Feel a part of it”. People said that visitors were “Always made welcome” and encouraged to join in with anything going on.

People were confident that the deputy manager and staff listened to any concerns or complaints and dealt with them appropriately. One person said, “I am waiting for a new mattress like I had in hospital as the one here wasn't working properly, but this is being sorted for me”. Another person said, “I would ask for something if I wanted to; nothing is too much trouble for them”.

A copy of the complaints procedure was given to people when they were admitted, and they knew that they could speak to any of the staff. The last recorded complaint was in March 2014, and we saw that this had been investigated and had been responded to appropriately.

Requires Improvement

Is the service well-led?

Our findings

People were confident that their care needs were met and that staff cared for them well. They recognised that staff had "Good team work" and said the staff attended to them promptly and worked well together.

The registered manager was on maternity leave. The deputy manager was knowledgeable about people's care and nursing needs and was available to talk with staff as well as with people and their relatives. She received support from the provider's other service in regards to oversight from the service's registered manager, and from their administration department.

Care services are required by law to inform CQC of formal notifications about important events in the service. This includes deaths of people living in the service. CQC had not received any notifications of death since May 2013, although we were informed during the inspection that people had died since then, including two people during 2015. Other required notifications include serious injuries, and events that stop the service from running as usual. CQC had received one notification in June 2014 for a serious injury. No other notifications had been received since that time.

As CQC had not been notified of deaths that had taken place, this was a breach of Regulation 16 (2) of the Health and Social Care Act 2008 (Registration) Regulations 2009.

Some of the recording processes were unsatisfactory. Staff supervision and appraisal records were seen for January – March 2015, but consistent records for supervision before this time could not be found. Three staff files had supervision records for random occasions such as a supervision session in 2011, two in 2013 and one in 2014; although staff told us they had received regular supervision.

We viewed groups of files for policies and procedures in the manager's office and in the nurses' office area. These were dated as far back as 2005 and 2008. We saw one policy which had been updated in 2013. Other policies and procedures available were not up to date. We discussed this with the registered manager for the company's other home, who told us that the provider expected policies and procedures to be updated every year. However, no updated policies and procedures were found in paper format or on the computer records. This meant that updated policies and procedures about clinical care, health and safety and general matters were not made available to staff. An administrator with 'Human Resources' training was in the process of reviewing all of the staff policies and procedures and updating them.

The service had auditing systems in place for monitoring the progress of the service. These included monthly infection control audits and monthly health and safety checks. The infection control audit contained detailed information, including an assessment of staff hand hygiene; checks for different areas such as the clinical room, bathrooms, and sluice; use of personal protective equipment; clinical practices, waste disposal and management of outbreaks and infections. Each audit showed the month when it had been carried out, but the audits had not been signed or dated, and so did not specify who had completed these. The health and safety audit showed items which needed to be attended to and if they had been completed, such as removing equipment from a bathroom that should not have been stored in there. Both audits had had extensive use of 'tippex' correction fluid, which meant that the records could not be regarded as accurate as they could have been falsified. Other audits had failed to identify that record-keeping for daily reports was unsatisfactory.

Unsatisfactory completion of records was a breach of Regulation 17 (2) (a,d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff showed that they understood the values of the home to "Put people first" and were clear about how they managed the work. A staff member explained that the nurse led the way for each shift at handover, and allocated care staff to look after a specific group of people for that shift. The allocations were colour-coded for red, blue, green or yellow, and staff knew which people came into each category. This provided clear accountability on each shift for the care given to people. Care staff said that they always informed the nurse on duty of any changes they noticed in people's care needs, such as changes in skin condition, mood or behaviour, and said, "The nurse's handover in the morning is very comprehensive".

Staff carried out their duties calmly and efficiently, and demonstrated effective team work. Most people required two staff to help them to move, and staff worked well with each other to ensure that people were not left waiting for

Requires Improvement

Is the service well-led?

assistance for long periods of time. Some of the staff had worked at the home for several years. They said they liked working in a smaller environment, and could give individual attention to people.

Staff told us that they had regular staff meetings and were able to raise any topics at these meetings. An administrator told us she had attended a recent staff meeting when staffing matters had been discussed. A staff handbook was provided, and staff could access this on the premises, or have their own copy if they wished to do so.

People's views were obtained every day as staff talked with people and asked them how they felt and if there was anything they needed. Quality assurance questionnaires were used to enable people to share their views about specific topics. These could be completed anonymously if wished. A recent survey had been completed in regards to food, housekeeping, laundry and maintenance. People's responses had mostly been positive, and people were able to add additional comments. These included, "I think the standard of cleanliness is excellent"; and "Staff make visitors feel welcome and offer them refreshment." One person had made some suggestions about the food, and these had been passed on to the chef. This demonstrated that people's comments were taken into consideration and used for the improvement of the service.

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 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** How the regulation was not being met: **The registered person had not ensured that accurate, complete and contemporaneous records were provided for each service user in regards to their daily reports.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** How the regulation was not being met: **The lack of clarity about wound care constituted a risk to providing safe care and treatment.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **Regulation 16 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** How the regulation was not being met:

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Action we have told the provider to take

The provider did not have a clear system in place to identify and record minor concerns, and how these were dealt with.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 CQC (Registration) Regulations 2009 Notification of death of a person who uses services Regulation 16 (2) of the Health and Social Care Act 2008 (Registration) Regulations 2009. How the regulation was not being met: The registered person had not consistently reported deaths of service users to the Care Quality Commission.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. How the regulation was not being met: The registered person had not completed accurate records to assess, monitor and improve the quality and safety of the services provided.