West House Carehome Limited

West House Care Home Limited

Inspection report

West House
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Chester-le-Street
County Durham
DH2 3AA
Tel: 0191 3871533

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Ratings

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

Overall summary

The inspection took place on 20 and 22 October 2015 and was unannounced. This meant the provider or staff did not know about our inspection visit.

We previously inspected West House Care Home on 13 January 2014, at which time the service was compliant with all regulatory standards.

West House Care Home is a residential home in Chester-le-Street providing accommodation for up to 30 older people who require nursing and personal care. There were 26 people using the service at the time of our inspection.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the

Summary of findings

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.

We found that there were sufficient numbers of staff on duty in order to meet people' needs. All people and relatives agreed that staff were attentive and there were sufficient staff on duty each day. We saw that call bells were responded to promptly.

All staff were trained, or had training courses booked, in core areas such as safeguarding, health and safety, moving and handling, infection control, as well as additional training intended to ready staff for potential future needs, for example epilepsy training. The service had a training matrix in place to track which staff had attended training courses and when; the registered manager used this to plan when refresher training courses were due. Understanding and support of mental health needs was an area that could be further developed. The service used a keyworker system and we found that staff had a comprehensive knowledge of people's preferences, needs, likes and dislikes.

We found that the management, administration, storage and disposal of medicines was generally safe and adhered to National Institute for Health and Care Excellence [NICE] guidelines. Where we found isolated errors and areas for improvement the service responded promptly.

We observed dignified and patient interactions during our inspection. Relatives and external stakeholders told us that people were treated well and unanimously agreed that the service was welcoming and effective in their management of people's healthcare needs.

There were effective pre-employment checks of staff in place and effective staff supervision and appraisal processes.

The service was clean. We saw that a recent visit by an infection control team had identified areas to improve immediately. We checked a sample of these issues and saw improvements had been made. Some areas of the service were in need of or in the process of refurbishment and we saw that there had been improvements since the last CQC inspection on 13 January 2014, notably the installation of the ground floor wet room.

People told us they enjoyed the food and we saw that menus were varied and people had choices at each meal as well as being offered alternatives if they did not want the planned options. We saw that the service had successfully implemented a tool to manage the risk of malnutrition and people requiring specialised diets were supported. This was augmented by an additional tool the registered manager had devised to look at wider weight loss trends.

Person-centred care plans had recently been established in all care files and the provider had sought consent from people for the care provided. Regular reviews ensured those who knew people best were consulted and involved in ensuring people's medical, personal and nutritional needs were met. Where we suggested areas of improvements to practice the service was responsive. We also found people were protected from the risk of social isolation through regular encouraging interactions by staff and the service had an activities co-ordinator in place. We saw that relatives supported the activities programme by bringing in arts and crafts projects.

Not all people who used the service had their preferences considered or acted on however and we found the service did not proactively plan activities with people's preferences in mind.

The service had individualised risk assessments in place, quality assurance and auditing processes and policies and procedures to deal with a range of eventualities. Emergency evacuation plans and maintenance of the premises were up to date.

People who used the service, relatives and external professionals were complimentary about the approachability and levels of communication afforded by the registered manager.

The CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS), which applies to care homes. DoLS are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. The registered manager was knowledgeable on the subject of DoLS and we saw that appropriate documentation had been submitted to the local authority.

Summary of findings

During our inspection we found the provider was in breach of a regulation. 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?
The service was safe.

People using the service told us they felt safe, whilst relatives and healthcare professionals told us they had never experienced any concerns with regard to safety.

Medicines were generally administered, stored and disposed of safely and securely, and in line with the National Institute for Health and Care Excellence (NICE) guidance.

Safeguarding training had been completed and staff displayed a good understanding of risk and the types of abuse people could be at risk of, as well as their prospective actions should concerns arise.

Appropriate pre-employment checks were made to help ensure that suitable people were employed to work with vulnerable individuals.

Good

Is the service effective?
The service was effective.

People told us the standard of food was good and there was choice at every meal. People's nutritional and hydration needs were met through the effective monitoring of the risk of malnutrition.

All staff had received training, or training had been scheduled, relevant to their role, as well as receiving additional training that anticipated future needs. Staff were able to talk in detail about the training they had received and its relevance to the care they provided. Staff displayed a good knowledge of the people they care for.

People's medical needs were met through ongoing involvement of a range of healthcare professionals.

Good

Is the service caring?
The service was caring.

Interactions between staff and people were patient and dignified, with people and relatives experiencing compassionate care.

People's dignity was maintained and promoted through staff awareness of people's right to private and sensitive support. People's religious beliefs were respected and promoted.

Relatives could visit at any time and were consistently met warmly by staff.

Good

Is the service responsive?
The service was not always responsive.

Requires improvement

Summary of findings

Not all people who used the service had their preferences considered or acted on with regard to planning and delivering activities that were meaningful to them.

People were protected against the risk of social isolation through an inclusive and welcoming atmosphere where interaction was encouraged.

Care plans were reviewed regularly and when people's needs changed, the service promptly ensured that relevant healthcare expertise was sought and people's needs were met.

People and staff were confident they could make a complaint if they needed to.

Is the service well-led?

Good

The service was well-led.

All people using the service, staff, relatives and healthcare professionals agreed the atmosphere of the service was welcoming and homely and that the visibility of management was reassuring. The registered manager had moved from an upstairs office to a desk in the entrance hall of the home.

The registered manager had in place quality assurance and auditing regimes, which had improved aspects of the service through identifying and addressing areas of concern.

Policies and procedures were regularly reviewed and had regard to best practice.

West House Care Home Limited

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We visited the service on 20 and 22 October 2015 and the inspection was unannounced. The inspection team consisted of one Adult Social Care Inspector and one Specialist Advisor. A Specialist Advisor is someone who has professional experience of this type of care service.

We spoke with eight people who used the service. We spoke with nine members of staff: the registered manager, the administrator, five care staff and two nurses. We spoke with seven relatives of people who used the service. We also spoke with one visiting social worker and telephoned four healthcare professionals.

During the inspection visit we looked at six people's care plans, risk assessments, four staff training and recruitment files, a selection of the home's policies and procedures, meeting minutes and maintenance records.

We spent time observing people in the living rooms and dining areas of the home. We inspected the communal areas, bathrooms, toilets, sluice and laundry.

Before our inspection we reviewed all the information we held about the service. We also examined notifications received by the CQC.

Before the inspection we asked the provider to complete a Provider Information Return (PIR). This is a document whereby the provider can give some key information about the service, what the service does well, the challenges it faces and any improvements they plan to make.

Good

Is the service safe?

Our findings

All people we spoke with, relatives and healthcare professionals agreed the service provided a safe standard of care. One person told us, "I'm very safe here," and another, "No concerns whatsoever." When we asked visiting relatives about whether they had ever had cause for concerns about any aspect of the safety of care one said, "Never – never any problems like that," and, "It always feel safe and they always let you know if there are any concerns – that gives you confidence." One social care professional told us there were, "Never any problems," in their experience with regard to people's safety.

People we spoke with also told us they knew how to share any concerns about their safety or wellbeing, should they need to. A recent residents' survey revealed that those who responded were confident they could raise concerns if they needed to. This meant people were enabled and supported to raise concerns should they need to.

We saw comprehensive safeguarding policies and procedures, which acknowledged and set out procedures for managing a range of prospective risks. We saw safeguarding information was clearly on display in communal areas and, when we spoke with staff, they were able to talk in detail about their safeguarding knowledge. Staff were able to clearly explain the range of abuses that vulnerable people could be at risk of and their actions should they have such concerns. This meant appropriate safeguarding training had been delivered and that staff were able to identify situations where it would be applicable.

We reviewed a range of staff records and saw that in all of them pre-employment checks including enhanced Criminal Records Bureau (now the Disclosure and Barring Service) checks had been made. We also saw that the registered manager had asked for at least two references and ensured proof of identity was provided by prospective employees' prior to employment. They had also verified the authenticity of references by telephoning the referee and explored any gaps in a candidate's employment history. This meant that the service had in place a robust and consistent approach to vetting prospective members of staff, reducing the risk of an unsuitable person being employed to work with vulnerable people.

All people using the service, their relatives and staff we spoke with felt staffing levels were appropriate to provide for people's care needs. We saw the number of staff on shift had increased recently as the service reached a full complement of people who used the service. During our inspection we observed people were supported promptly and call bells were answered without delay. This meant people using the service were not put at risk due to understaffing.

Specific risks to individuals, for example the risk of falling, were managed through risk assessments that were regularly reviewed and updated. For example, one person's risk of falling was regularly reviewed and, when it was considered to have increased, we saw additional support such as specialist equipment was put in place to mitigate this risk. This meant the service had a structured approached to reviewing individual risks and was able to identify concerns at an early stage and mitigate those risks.

We reviewed care plans for those people at risk of choking and found one care plan to be unsigned and undated. When we spoke with staff about their understanding of managing this area of risk all had some knowledge but they were not aware of the specific instructions on the care plan. The registered manager undertook to review and update all choking care plans and ensure that all staff were aware of each.

With regard to infection control we saw that people's rooms were clean. We saw that a recent visit from the local infection control team had identified areas to improve. When we sampled the areas that required immediate improvement we saw that alterations had been made and that explanatory notices had been put up for staff. This meant the service took seriously the importance of managing the potential spread of infection and put measures in place to reduce the risk of acquired infections.

The registered manager confirmed there had been no recent disciplinary actions or investigations. We saw that the disciplinary policy in place was current and clear and all staff we spoke to were confident in raising concerns should they need to.

With regard to potential emergencies, we saw that Personalised Emergency Evacuation Plans [PEEPS] were in place, both in individual care files and easily accessible in

Good

Is the service safe?

the entrance hall. This meant people could be supported to exit the building by someone who would have access to their individual mobility, communication needs in the event of an emergency.

The Food Standard Agency (FSA) had given the home a 5 out of 5 hygiene rating, meaning food hygiene standards were "Very good." A recent inspection of the kitchen by the local authority had also concluded "Nice clean kitchen; well run." This meant people were protected from the risk of unsanitary food preparation.

Maintenance records showed that Portable Appliance Testing [PAT] was undertaken recently, whilst all lifting and hoist equipment had been serviced recently. There was documentation evidencing the servicing of the gas boiler. We saw that fire extinguishers had been checked recently, fire maintenance checks were in date and the nurse call bell systems were regularly tested and serviced. This meant people were prevented from undue risk through poor maintenance and upkeep of systems.

We found the service had systems in place for ordering, receiving, storing and disposing of medicines, including controlled drugs. Medicines records were maintained and medicines were stored safely in line with good practice. All medicines were within date.

We sampled a range of Medicine Administration Records (MARs). We found a small number of instances of medicines not being signed for as refused by a person on the MAR sheets. When a person refuses a medicine this should always be documented and the registered manager acknowledged this was an error they had failed to identify. We saw that they had already held discussions with the pharmacy in order to produce a more user-friendly document. They undertook to review MAR practices and ensure staff completed MARs in line with best practice guidance.

We observed medicines being administered and saw safe practice was maintained throughout. Nurses communicated effectively with people and sought consent before administering medicines.

Good

Is the service effective?

Our findings

Relatives we spoke with were all agreed that care staff understood the needs of people who used the service. One relative said, "Staff know you and the people they look after," whilst another told us, "They know how to care for [person] and understand [person's] needs." When we spoke with staff they were able to show a detailed knowledge of people's needs. One person who used the service told us, "They most certainly know what they're doing."

Staff told us they were supported and trained to carry out their roles. We saw that training was relevant to people's needs, with all members of care staff either having completed or due to complete safeguarding, person-centred care, Mental Capacity Act, equality and diversity, health and safety, manual handling, control of substances hazardous to health (COSHH), dignity and respect, food hygiene, infection control training. Some staff had also completed training that would contribute to the service being ready to support people with different needs using the service in future, for example epilepsy training. Staff told us they felt they would benefit from more mental health training and, when we asked the registered manager about this, she acknowledged this was an area the service would look to improve on, as well as exploring the use of memory tools in memory assessments. We saw the administrator undertook the same training as care colleagues to ensure they were aware of developments in the sector but also to provide additional staffing cover in the event of unforeseen circumstances. We saw that staff who administered medicines were appropriately trained. Members of staff new to the service had completed an induction that covered a range of the provider's mandatory training and familiarisation with policies and procedures. We saw a new member of staff was in the process of completing the Care Certificate and the registered manager was in the process of using one section of this to refresh existing staff knowledge. This meant staff had the knowledge and skills to carry out their role and meet the needs of people using the service.

With regard to nutrition, people were unanimous in their praise for the food. One person told us, "The food is excellent" and people we spoke with about their breakfast and lunch had enjoyed their chosen meals. People and relatives confirmed that when the choice of meals was not satisfactory the cook would make something else. One relative told us that they had brought in some salmon and the chef had made the person's favourite recipe with it. Another person stated they liked the fact they could always have the option of a cooked breakfast. We saw optional drinks of tea, snacks and fresh fruit were offered throughout the day. The kitchen was clean and we saw information regarding specialised diets and the need for supplements clearly displayed. Anyone noted as at high risk of malnutrition via the Malnutrition Universal Screening Tool (MUST), was supported with a fortified diet. MUST is a screening tool using people's weight and height to identify those at risk of malnutrition. This meant the service managed risks of malnourishment.

We saw the food served was hot and people confirmed this was always the case, and that they enjoyed mealtimes when we spoke with them. The dining experiences we observed during our inspection visit were unhurried, with people who required additional support being helped in a dignified manner. This meant people found mealtimes pleasurable.

Care plans were regularly updated. We saw that some recording was not in line with NMC best practice, for example some entries were not signed. The registered manager acknowledged this and, during our inspection, entered a reminder document into each care file to remind staff of best practice with regard to note-taking. This meant, whilst there were areas where care planning documentation could be improved, the registered manager took this seriously and took prompt corrective action.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS), which applies to care homes. DoLS are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. Where that freedom is restricted a good understanding of DoLS ensures that any restrictions are in the best interests of people who do not have the capacity to make such a decision at that time. The registered manager demonstrated a good understanding of Mental Capacity issues, including DoLS, as did members of care staff when we asked them about putting the principles of the MCA into practice. We reviewed care planning information and saw that documentation describing people's capacity could be improved to ensure it clearly reflected their capacity to make specific decisions. The registered manager acknowledged this and undertook to

Good

Is the service effective?

review such wording. This meant the service had embedded sound understanding of the MCA and DoLS principals, and responded to feedback to ensure documentation reflected practice accurately.

We saw that staff supervisions occurred between three and four times a year along with annual appraisals. All staff we spoke with were positive about the support received through these meetings and told us they had ample opportunity to identify any training needs or concerns. This meant people could be assured they were cared for by staff who were adequately supported.

With regard to the premises, signage was clear and people's rooms benefitted from a picture outside their door. We also saw renovations had taken place in a downstairs storage room since the last CQC inspection. This had been converted into a wet room. This meant the service had adapted the premises in order to improve the quality of care for people who used the service.

We saw that people who had a 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) decision in place had been involved in the decision, as had family members and local medical professionals. A DNACPR is an advanced decision not to attempt cardiopulmonary resuscitation in the event of cardiac arrest. This meant people's needs had been reviewed appropriately with their involvement and those who know them best.

We found evidence that people were supported to maintain health through accessing external healthcare such as speech and language therapy, opticians, dentists, GP appointments and District Nurse visits. A number of relatives commented on the timeliness of these referrals and cited positive impacts on the wellbeing of people using the service as a result. Likewise one healthcare professional we spoke with said they had been impressed with the diligence of one member of staff who had encouraged a person receiving physiotherapy treatment to remember their exercises. This meant the service ensure people's healthcare needs were met through effective liaison with external professionals.

Good

Is the service caring?

Our findings

People who used the service were unanimous in their praise for the caring and compassionate attitudes of staff. One person we spoke with said, "The staff are lovely and the care is lovely." Another person said, "Staff are excellent – they make you feel more than welcome."

One relative told us, "The girls are fabulous; they go above and beyond," whilst another attributed the inclusive and attentive approach by staff as having a positive impact on a person who used the service, stating, "[Person] is happier now that they have been in years – they get so much care and attention." Another relative said they considered the care provided to be "Top class."

We spoke with external health and social care professionals who had visited the service and they were similarly complimentary about the standard of caring. One said, "It's a very caring service."

Other evidence we saw, such as thank-you cards from families and comments in the latest residents' survey also attested to a high standard of care, with all respondents confirming they were happy with the caring approach of staff. This meant people who used the service and those who knew them best felt the care they received was genuinely compassionate.

A significant majority of people we spoke with commented specifically on the welcoming atmosphere in the home and during our observations we noted relatives visiting at various times and welcomed by their first names. Two relatives also stated that they were always offered cups of tea when visiting. Family members confirmed there were no restrictions on their visiting times and they were free to come and go as was convenient for them and the person who used the service. This meant people who used the service were able to consider the service a home and not be restricted by set visiting hours.

One healthcare professional we spoke with said, "There's a warm welcome." With regard to the nature of the care provided they went on to state, "When we go in to undertake a review they make time. They always make sure the person has the time to be in their own room so they've some privacy while we're doing the review – it's good that they instigate that." This meant people's right to privacy was being respected and enabled through a dignified approach to the delivery and review of personal care.

We asked people who used the service and families whether their views were listened to. They confirmed they were. All people we spoke with told us they were involved in decisions and felt included in the planning of care. One relative said, "They encourage [Person] and me to be involved."

We saw information regarding advocacy services was available in the Service User Guide, a copy of which was available in people's rooms. At the time of our inspection no one who used the service had an advocate but one person's DoLS application had been authorised and the registered manager was liaising with the local authority to prepare for prospective advocacy support being in place. This meant people's best interests could be supported through the service recognising the importance of advocacy services.

We saw that people's personal sensitive information was securely stored in locked cabinets in the treatment room, which was also locked when not staffed. People who used the service were also asked for their consent for such information to be stored and, where appropriate, shared with other healthcare professionals. This meant people could be assured their confidential information was treated carefully and in line with the Data Protection Act.

We observed numerous dignified and patient interactions during inspection. For example, when people required help with personal care we saw staff discreetly and sensitively support them away from a communal space in order that their needs could be met in a dignified manner. We also saw care staff knock on people's doors and wait for a response before entering. This meant people were treated with dignity and respect.

The Service User Guide stated that all faith denominations were welcome and we saw a Church of England minister regularly attended the home, whilst a Catholic layperson also visited to give communion. We saw that the registered manager had written a guidance document for staff, which set out the service's approach to respecting and enabling people's religious needs in life but also when dying and after death. This meant people's right to religious beliefs and freedoms were respected and enabled.

Requires improvement

Is the service responsive?

Our findings

We found the service to be responsive to the changing medical needs of people who used the service but that people's diverse interests, such as hobbies, were not always responded to.

The service prevented against the risk of social isolation through the inclusive and welcoming atmosphere it had developed, with numerous people commenting on the positive impact on people's wellbeing. One relative said, "[Person's] socialising now whereas before they would never leave the house; they're 100% happier." One person using the service said "I mix with people; have a chat and talk about the world," whilst we spoke to two relatives who were content that people received support to pursue activities meaningful to them, for example listening to music in their room and reading. This meant the service was able to provide some meaningful activities for people who used the service, where their preference was to remain in their room or pursue interests that could easily be facilitated.

We saw there was an activities co-ordinator in place but the amount of time they dedicated to people engaging them in activities was limited. We saw the provision of meaningful activities had been acknowledged as in need of improvement at two meetings in recent months by the service but significant changes had not been made. People who used the service described one enjoyable activity as, "Fizzling out," whilst one person said there were, "No activities." Relatives told us, "They could do with more activities to stimulate the mind," and "Activities? They just don't do it."

We saw that some of the most popular group activities were facilitated by visiting relatives who had brought in Halloween and Christmas craft materials. We looked through people's care records and saw that, at the admission stage, people's preferences had been requested and that people had documents in place that gave the reader an awareness of their likes, dislikes and life history. We asked if these preferences were used to plan activities, for example a number of people had expressed a like for knitting and other crafts. The registered manager confirmed this was not happening at the time of our inspection and that activity planning with regard to people's personal preferences was an area the service needed to improve. The registered manager showed us a recently devised checklist which documented what activities had been offered and what activities had been "Refused" by people. There were however no personalised activity plans in place taking into account people's preferences.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The pre-admission assessment in every care file we looked at documented people's life history, likes, dislikes and a range of information regarding medical, dietary, religious, mobility and other needs. Each care plan we reviewed contained a photograph and keyworker information. We saw that care plans were reviewed monthly and it was clear through discussions with care staff they had a good understanding of people's needs. We saw evidence that people had been promptly referred to external specialists when needs changed. This meant people's health needs were regularly assessed and consistently met.

All relatives we spoke with expressed confidence and satisfaction in the responsiveness of the service in this regard. For example, one relative told us, "If [Person] is unwell or takes a turn they ring straight away," whilst a healthcare professional we spoke with told us, "They do ask if they have any concerns." One relative told us how the service had monitored and acted quickly when they noticed a cold was proving difficult to overcome. They stated, "They were very responsive what with linking up with the hospital." They went on to say, "[Person's] much better now than when they came here." Another relative referenced a time when a splint had become loose on one person's arm and how a member of staff had stopped what they were doing and immediately arranged an appointment for this person. This meant relatives were able to give clear examples of when the service's responsive approach to people's healthcare needs had a beneficial impact on their health and wellbeing.

During our inspection we saw the hairdresser visited and people told us this was a popular service. One person told us this was a, "Very nice part of living here."

We saw the service had a complaints policy in place and had received two complaints. We saw these had been reviewed and responded to promptly in line with the complaints procedure. We saw that the complaints procedure was clearly displayed in the Service User Guide.

Requires improvement

Is the service responsive?

When we asked people who used the service and their relatives if they knew how to complain and who to they were confident. This meant people were supported to raise concerns and were confident in doing so.

When people moved between different services each person had personal health and communication information completed that was unique to them. This contributed to ensuring people were afforded a continuity of care if they moved to another service.

Good

Is the service well-led?

Our findings

One member of staff told us, "I feel supported and in turn we support [registered manager] with what they're trying to do." The registered manager had been in place for over two years and we saw they had been instrumental in leading changes to aspects of care, such as person-centred care plans. One member of staff told us, "They've come in with some very good ideas."

People we spoke with knew who the registered manager was and told us they thought they were, "Very nice – always around." One relative said, "The communication is always great." We saw the registered manager had set up an office space in the entrance lobby having previously been in an upstairs office. Relatives we spoke with said they thought this was a positive move whilst the vast majority of staff welcomed this move in terms of increased managerial presence and also their own accountability.

The registered manager had an extensive knowledge of all people who used the service and was actively involved in the day-to-day running of the service. They acknowledged that having oversight of all aspects of the service presented challenges and that they were planning to delegate aspects of their role, such as responsibilities for completing supervisions and completion of audits. This meant the registered manager was aware of the need to sustain a high level of care and to ensure that resources needed to be planned accordingly.

All visitors we spoke with agreed the culture at the home was welcoming and positive. We found the registered manager had successfully ensured care continued to be provided within an environment that was consistently acknowledged as homely. One visiting healthcare professional said, "It's very relaxed – if feels like their home, as it should." This meant people could feel at home in a service whose leadership had defined homeliness as a key aim, as described in the Statement of Purpose.

Policies and procedures we reviewed were clear and comprehensive and nurse care recording systems showed evidence of being recently updated in line with a recognised nursing assessment model. This meant the registered manager had regard to aspects of relevant best practice.

We saw the registered manager had in place a range of audits to assure an additional level of safety with regard to areas such as fire alarms, emergency lighting, the nurse call system, water temperature audits and staff training audits. This meant the service scrutinised its own standards to identify where improvements could be made.

Staff meetings occurred intermittently. When we asked staff about this the majority were clear that they were appropriately supported and described positive working relationships whereby they could raise any concerns on an ad hoc basis, as well as at staff supervision meetings. This meant the registered manager ensured staff had a range of forums in which to raise concerns or potential areas for professional development.

During the inspection we asked for a variety of documents to be made accessible to us. These were promptly provided and well maintained. We found records to be easily accessible and contemporaneous. Policies and procedures were regularly reviewed and we saw the registered manager had sought guidance from external sources to inform these policies.

Community links had been maintained by the registered manager, notably with a range of local churches, whilst a local youth group had helped to paint the dining room recently and a local MP visited on occasion. This meant the service maintained links with the local community, from which the majority of the people living there all came.

The registered manager ensured surveys were sent to staff and residents. We reviewed the most recent surveys and, whilst the staff returns were inconclusive, with only two being returned, the resident surveys indicated high levels of satisfaction with the service, with one area of improvement being suggested, namely activities. This meant the registered manager involved staff and people who used the service in considering how the service could continue to improve.

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 9 HSCA (RA) Regulations 2014 Person-centred care **The provider did not have in place personalised activity plans which met people's needs and reflected their preferences. Regulation 9 (1) (b) and (c).**