Mrs Carole Brooke

Ancona Care Home

Inspection report

The Square
Freshwater
Isle of Wight
PO40 9QG
Tel: 01983 753284
Website: www.carehomesuk.net/ancona

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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 took place on 5 and 6 January 2016 and was unannounced. The home provides accommodation for up to 18 people, including some people living with dementia care needs. There were 17 people living at the home when we visited. The home was based on two floors; there was a good choice of communal spaces where people were able to socialise and some bedrooms had en-suite facilities.

There was a registered manager in place. 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.

People's safety was compromised as the risks to their health and safety were not always managed appropriately and action had not always been taken to reduce the level of risk. This included the risks of one

Summary of findings

person choking on their food and the risk of two people having repeated falls. Accidents records were not organised and there was no process in place to identify trends.

Clear recruitment procedures were in place, but these were not always followed. Reference had not been obtained for a staff member who had recently been employed and full employment histories were not always obtained to check staff were suitable to work with the people they supported.

Staff sought consent from people before providing care. However, they had not protected one person's rights as their freedom was being restricted and staff had made decisions on their behalf without following the relevant legislation.

Most people received personalised care from staff who understood and met their needs. Care plans provided detailed information about how they wished to receive care and support although some information in them had not been personalised to the individual. Records relating to continence care did not always contain sufficient information.

People were usually involved in planning the care and support they received, but this was not consistent and people were not involved in reviews of their care.

Effective systems were not in place to assess, monitor and improve aspects of the service, such as infection control, the management of falls and staff training. There was a Duty of Candour policy in place, but this was not always followed. The provider sought and acted on feedback from people, although the results of satisfaction surveys were not analysed or used to identify improvements.

People liked living at the home. Relatives felt it was run well and said they would recommend it to others. There were strong links with the community and the provider promoted a positive culture. Staff understood their roles, were motivated and worked well as a team.

People told us they felt safe. Staff had the knowledge and confidence to keep people safe through procedures they understood well. There were sufficient numbers of suitably trained and experienced staff to ensure people's needs were met. New staff received induction, training and support from experienced members of staff. Staff felt supported by the provider and the registered manager, felt valued and said they were listened to.

People were treated with kindness and compassion and staff showed concern for people's wellbeing. Their privacy was protected and staff treated them with dignity and respect.

Medicines were managed safely and people received their medicines when required. Risks posed by the environment were managed effectively and people were supported to take risks that helped them retain their independence.

People were offered varied and nutritious meals. They were given appropriate support when needed and their intake was monitored. People were supported to access healthcare services when needed to stay healthy and there were good working relations with healthcare professionals.

Staff responded to people's change needs. People were empowered to make choices about how they lived their lives and had access to a range of activities.

We identified breaches of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have taken 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 not always safe.

Risks to the health and safety of people were not always managed effectively. Safe recruitment procedures were not always followed.

People were protected from the risk of abuse. There were enough staff to meet people's needs. Medicines were managed safely.

Requires improvement

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

Staff did not always follow legislation designed to protect people's rights and freedom.

Staff had the knowledge and skills to meet people's needs and were supported appropriately in their work.

People's nutritional and hydration needs were met. They had access to healthcare services when needed.

Requires improvement

Is the service caring?
The service was caring.

Staff treated people with kindness and compassion.

People were encouraged to remain as independent as possible and were usually involved in planning their care.

People's privacy and dignity were protected.

Good

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

Information about people's continence care was not always adequate or accurate.

The provider sought and acted on feedback from people although satisfaction surveys were not analysed or used to improve the service.

Staff delivered personalised care to people. However, information in some care plans had not been tailored to people's individual circumstances.

People had access to a range of activities and were empowered to make choices.

Requires improvement

Is the service well-led?
The service was not always well-led.

Requires improvement

Summary of findings

Effective systems were not in place to monitor all aspects of the service. There was a duty of candour policy in place, although this was not followed fully.

People liked living at the home and felt it was run well. The service promoted a positive culture which staff understood.

There was a clear management structure, staff understood their roles, were motivated and worked well as a team.

Ancona Care 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 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 6 January 2016 and was unannounced. It was conducted by an inspector and an expert by experience in the care of older people. 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 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 previous inspection reports and notifications we had been sent by the provider. A notification is information about important events which the service is required to send us by law.

We spoke with eight people living at the home, three family members and a visiting community nurse. We also spoke with the provider, the registered manager, six care staff, a member of kitchen staff and a staff member responsible for arranging social activities.

We looked at care plans and associated records for six people and records relating to the management of the service. These included staff duty records, staff training and recruitment files, records of complaints, accidents and incidents, and quality assurance records. We also observed care and support being delivered in communal areas.

The home was last inspected on 16 September 2013, when we identified no concerns.

Requires improvement

Is the service safe?

Our findings

Two people had had serious falls and we found the records for these were disorganised. The information had been recorded in a number of different places and had not been collated. Therefore, the provider did not have a clear picture of how the falls had occurred, the action staff had taken in response, or measures that could be put in place to prevent further incidents. In addition, the provider did not have an effective system in place to monitor, review and analyse all falls across the home in order to identify patterns or trends.

Another person had been assessed by a speech and language therapist as they were at risk of choking on their food. A recommendation had been made for the person to receive a soft diet but we found they were not receiving this. Staff told us, the person had requested a normal diet and they then cut the food up small for the person. However, the support the person needed to help ensure their wishes were met safely had not been assessed or recorded. This person, and another person, were using bed rails to prevent them falling out of bed, but risk assessments for their use had not been completed to consider whether they were safe to use.

The failure to assess and mitigate risks to the health and safety of people was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported to take risks to retain their independence whilst any known hazards were minimised to prevent harm. One person told us "I manage [to go to the bathroom] myself during the day. I know [staff] have offered to take me but I feel I want to keep myself independent. With anything in life you've got to take a risk." They said they felt "more wobbly" at night and might need staff to assist them at this time. Staff told us they did this, but the need for staff to assist the person at night was not documented in their care plan.

The provider had clear recruitment procedures in place but these were not always followed. Checks were made with the Disclosure and Barring Service (criminal records checks) to make sure potential staff were suitable to work with vulnerable adults. The provider also conducted checks to confirm that staff members were entitled to work in the UK. However, no references had been provided for a staff member that had been employed through a recruitment agency and the full employment histories for three recently recruited staff members were not available to the provider. Consequently, they were unable to confirm that all staff were suitable to work with people living at the home.

The failure to operate safe and effective recruitment procedures was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People felt safe living at the home. One person told us, "There's nothing that worries me here." A family member said, "I feel [my relative] is safe here; I really do." Another told us, "I know [my relative] is very happy and safe here."

Staff had the knowledge and confidence to identify safeguarding concerns and acted on these to keep people safe. They had received appropriate training and were aware of people who were at particular risk of abuse. For example, one person could be over-familiar with visitors, which put them at risk of physical or sexual abuse. Staff knew this and took steps to keep the person safe when visitors were in the home.

People were supported by sufficient staff with the right skills and knowledge to meet their individual needs. Staffing levels were determined by the number of people using the service and their needs. One person told us, "There are plenty of people to look after me." Another said, "Someone responds within seconds but there is a 10-minute rule. If they take longer to respond we can complain, but it has never happened." The provider was in the process of recruiting additional staff to work at night. This would make their arrangements more robust and avoid the need for nominated live-in care staff to be on call.

There were safe medicine administration procedures in place and people received their medicines when required. People understood the reason and purpose of the medicines they were given. One person told us, "[Staff] tell you what the tablets are for". An effective system was in place to monitor and account for all medicines received into the home through clear stock control processes. This included clear processes to help ensure people completed any prescribed course of antibiotics and that topical creams were not used beyond their safe 'use-by' date. Discussions had taken place with one person's GP about an important medicine they sometimes had difficulty taking. The GP had given permission for it to be crushed, to make it

Requires improvement

Is the service safe?

easier for the person to swallow, although there was a lack of guidance in the person's care plan about when staff should use this approach and some staff told us they did not crush it.

People were supported to take risks that helped them retain their independence and avoid unnecessary restrictions. For example, whilst it might have been safer for one person to ask staff to support them when mobilising in communal areas, they were clear that they preferred to walk slowly using furniture for support where needed. They accepted the risks surrounding this and staff had removed any potential trip hazards.

Plans were in place to minimise the risk of people developing pressure injuries. For example, pressure relieving mattresses and cushions had been supplied and the condition of people's skin was monitored daily. A family member told us, "[Staff] make sure [my relative] spends a couple of hours on the mattress in the afternoon."

Risks associated with the environment were assessed and managed effectively. First floor windows had restrictors in place to prevent people falling out and fire exits were alarmed to alert staff if people exited the home through them. Equipment, including portable electrical appliances and fire safety equipment, were tested regularly. There were arrangements in place to keep people safe in an emergency; staff understood these and knew where to access the information. Following a recent review of fire safety procedures, staff had received additional training which included using the evacuation chutes. Personal evacuation plans were available for all people and included details of the support each person would need if they had to be evacuated. Records showed that lessons had been learnt from a recent fire drill; for example, some furniture had been moved to make it easier for people to access the fire exits.

Requires improvement

Is the service effective?

Our findings

Staff sought verbal consent from people before providing care by using simple questions and giving them time to respond. However, they did not always follow the Mental Capacity Act, 2005 (MCA) or its code of practice. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When people are assessed as not having the capacity to make a decision, a best interest decision should be made involving people who know the person well and other professionals , where relevant. Most people living at the home had full capacity to make day to day decisions. However, the care records for one person showed they were not able to make decisions about the care and support they received. Staff had made decisions on behalf of this person in relation to their diet, the delivery of personal care and the administration of medicines. They had not assessed the person's capacity to make these individual decisions or consulted with people close to them. Therefore, the provider was unable to show that the decisions had been made in the person's best interests.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the provider was not always following the necessary requirements. An application had been made for one person following advice from medical staff following the person's discharge from hospital. However, an application had not been made for another person who was subject to continuous supervision and control. They had been assessed by their GP as lacking the capacity to make important decisions. A letter from the GP stated "In my opinion it would be unsafe for [the person] to be allowed out unsupervised." Staff did not allow the person to leave the home unsupervised, but had not taken action to protect the person's freedom. We raised this with the provider who agreed to review the need to apply for a DoLS authorisation for this person.

People were supported by staff who had access to a range of training to develop the skills and knowledge they needed to meet people's needs. One person said of the staff, "They look after me well; they're wonderful." A family member told us, "[Staff] worked hard to get [my relative] back on their feet after a fall. They encouraged her and persevered to help her mobilise." Another family members said, "I can't fault the way [my relative] is cared for. She's always immaculately clean; I could ask for better staff."

New staff completed a comprehensive induction programme before working on their own. A new staff member told us, "I did shadowing with experienced staff. If I didn't understand something there was always someone I could ask. I feel well trained." Arrangements were in place for staff new to care to complete the Care Certificate. This is awarded to staff who complete a learning programme designed to enable them to provide safe and compassionate care to people. Following this, staff told us, they were supported to study for nationally recognised qualifications in health and social care.

While staff were knowledgeable and suitably skilled, we found staff training records were not organised well. The provider told us, staff were required to refresh their training according to a set frequency. They monitored this by "everyone going on the training at the same time." However, this was not always effective. For example, we identified that one staff member was overdue refresher training in moving and handling and another had not received recent training in infection control. Consequently, there was a risk their practices could become out of date.

Staff were knowledgeable about supporting people with diabetes. Detailed care plans were in place for all people with the condition and emergency medicines were available. Staff supported people to access a suitable diet and monitored people's blood sugar levels effectively. One person told us, they chose to test their blood sugar levels four times a day, including during the night, and that staff supported them to do this. They said, "I had a hypo once and they're not nice, so I like to keep on top of it." A visiting community nurse told us, staff had responded well when the person had experienced a sudden drop in their blood sugar levels. They said, "They managed the situation very well and took all appropriate action." Staff were also skilled at supporting people living with dementia and used distraction appropriately when a person became anxious and unsettled. They supported the person to start some art

work, which made them visibly relax. One staff member told us, "We also make good use of colours with [one person]. For example, if we use a coloured table cloth we find they notice the food more and eat better."

Staff told us, they were supported appropriately in their role by the provider and the registered manager and said they felt valued. They received regular supervisions and yearly appraisals. Supervisions provide an opportunity for managers to meet with staff, feedback on their performance, identify any concerns, offer support, and discuss training needs. One staff member said, "I asked for some extra training during one of my supervisions and got it." Another told us, "If I do anything I like to have feedback, and I do. It's delivered in a supportive way so I can improve."

People told us, they liked the food and were able to make choices about what they had to eat. One person said, "There is a fair choice of food. I have different things for breakfast on some day." Another person told us, "I had biscuits and cheese today because I did not want the lamb." A family member told us, "[My relative] won't eat pureed food, but needs it chopping fine. I gave [staff] a special mincer and they use it to prepare her food just as she likes it. The chef asks her what she wants. She eats well because it's what she likes."

People were offered varied and nutritious meals appropriate to the seasons, including cooked breakfasts daily. Alternatives were offered if people did not like the menu options of the day. One person preferred to take the main meal of the day in the evening and staff accommodated this. Meals were served in various portion sizes according to people's appetites. Drinks were available and in reach throughout the day and staff prompted people to drink often. People were encouraged to eat and staff provided appropriate support where needed, for example by offering to help people cut up their food or by being given equipment, such as adapted cutlery, plate guards and beakers to suit people's individual needs. A staff member told us, "Some people just need a little prompting, for example [one person] responds if you just put a little bit of food on their spoon, then they manage on their own." At lunchtime, staff played a CD of familiar songs. Two people at the dining table sang along and a staff member joined in. This created a pleasant lunch-time atmosphere for people.

Staff monitored what people ate and drank through the use of food and fluid charts and by weighing people regularly. Prompt action was taken when people started to lose weight. However, the fluid charts were not detailed and did not record the amount people drank on a daily basis. We drew this to the attention of the provider, who took immediate steps to address this.

People were supported to access healthcare services when needed to stay healthy. Records confirmed that people were seen regularly by doctors, specialist nurses and chiropodists. When people presented as confused or anxious, staff recognised this may be due to an infection and referred people promptly to their GPs. A visiting community nurse told us, "This is one of the better homes; I have no concerns about it."

Good

Is the service caring?

Our findings

When people moved to the home, they, and their families where appropriate, were usually involved in assessing and planning the care and support they needed. A family member told us, "We've seen the care plan and discussed it [with staff]." One person had signed relevant sections of their care plan and people were notified when appointments had been made for doctors to review their medicines, so that they could contribute to the reviews. However, some people told us they had not been involved in planning the care they received and were not consulted when their care plans were reviewed. We discussed this with the provider who agreed to explore ways to involve people in care plan reviews.

People were treated with kindness and compassion in their day-to-day care. One person said, "On the whole they are lovely staff. They try to be cheerful, I have no complaints." A family member said of the staff "They're very kind to [my relative]." Another told us, "The best thing about the home is the family feel. [Staff] all know us and my kids and you can tell that they're sad when they lose someone as they are part of the family." A card of thanks sent to the home recently said, "Thanks for the care and kindness during [the person's] stay. They were very happy and this has been a great comfort to us."

Staff showed concern for people's wellbeing in a caring and meaningful way. For example a staff member noticed that a person had fallen asleep in front of a cup of tea. They approached the person quietly, touched their arm, woke them gently using their name and encouraged the person to drink their tea while it was hot. The person smiled warmly on seeing the staff member and thanked them for the reminder. They were still a little sleepy, so the staff member sat with them and offered to help the person to drink by supporting them to hold the cup. On other occasions staff offered cushions to people who did not appear comfortable and adjusted them to suit.

People's care was not rushed enabling staff to spend quality time with them. One person was partially sighted and we saw staff approach them slowly, in a way that helped the person identify them; they held the person's hand and announced themselves. This immediately reassured the person and it was clear that they were comfortable with the staff member. Another staff member wished everyone a "Happy New Year" when they arrived for work, which helped orientate people to the time of year. One person replied, "Happy New Year with knobs on and God bless you." It was clear that the person enjoyed a relaxed relationship with staff.

Staff supported people to build positive relationships. Several people had formed close relationships with others living in the home. Staff were aware of these and made arrangements for these people to sit together at meal times, read together, or watch television together. One person told us, they appreciated this and said, "I was alone; now I have company." Care plans included information about people's backgrounds and interests. We heard staff using this information to strike up meaningful conversations with people and helping them to reminisce. A staff member told us, "I like talking with [people] about their lives; they're so interesting."

The home was spacious and allowed people to spend time on their own if they wished. Many chose to spend the majority of time on their rooms, but there was a good range of communal spaces where people were able to socialise and take part in activities. People's bedrooms were personalised with items important to them, such as photographs and mementos. One person had an eye condition that required special lighting and we saw this had been provided. Another person told us, "I have a quiet room with lovely views. I can watch the birds and sea gulls".

People were supported to be as independent as possible to the full extent of their abilities. They were able to move freely around the house and choose where they spent their time. Staff encouraged people to choose where and how they spent their day and which television channels they watched.

People's privacy was protected. A private area was available for people to meet with friends and family. Staff knocked and waited for a response before entering people's rooms. They helped ensure people's privacy by closing doors when personal care was being delivered and en-suite areas within bedrooms were curtained off. Staff described practical steps they took to maintain people's dignity, such as partially covering them with towels when delivering personal care. Confidential information, such as care records, was kept securely and only accessed by staff authorised to view it.

People's dignity was respected by staff. They used people's preferred names. For example, one person liked to be

Good

Is the service caring?

addressed using a formal name; staff used this name at all times, including when talking to us about the person in private. People had been asked whether they had a preference for male or female care staff; their preferences were recorded in care plans, known to staff and respected. A male staff member told us, "I always get one of the girls to ask people if they're happy with a male carer as they may feel uncomfortable and not want to offend me if I asked them." Another staff member said, "It's not just a case of whether [people] prefer a male or a female carer. Some people prefer to receive personal care from particular staff, so we try to accommodate that too."

Requires improvement

Is the service responsive?

Our findings

Most people received personalised care from staff who understood and met their needs well. One person said, "In the morning some girls come in early so I get up when I want without much of a wait". Another person said of the staff "They look after us well; I can do whatever I want."

People had their needs assessed before they moved to the home. Information had been sought from the person, their relatives and other professionals involved in their care and this had informed the plan of care. Care plans provided detailed information about how people wished to receive care and support. For example, guidance for staff about the support people needed with personal care was clear and specified when people liked to get up and go to bed. Information about the signs people presented when they needed pain relief were personalised, particularly for people who could not verbalise their pain. A family member told us, "[Staff] were marvellous when [my relative] was in pain. We can't fault the way they responded."

However, some aspects of people's care plans contained generalised information that had not been personalised to the individual. For example, information about the way people preferred to take their medicines was duplicated in most of the care plans viewed, as was information about the risks associated with activities. Some people did not take part in the activities mentioned, such as attending church, and the wrong names were sometimes recorded in these parts of people's care plans. One person had requested two hourly checks during the night, but records showed they were checked hourly, which may have disturbed them.

One person had had a catheter fitted to support their continence. The registered manager was clear about the need to ensure a good intake of fluid and to monitor the person's output for indications that the catheter might be blocked. However, there was no catheter care plan in place to guide other staff and action was not always taken when the person's output became abnormally low, which was an indicator that their catheter may have become blocked. Consequently, they may not have received safe and consistent catheter care. 'Night report' forms were used to record how people had spent the night. These recorded the number of occasions that a person had received support with their continence during the night but not the times the support was given. This could make it difficult for health professionals to assess a person's continence needs. The entries also conflicted with other information on the night report forms that indicated people had been asleep all night, which was not accurate. We discussed these issues with the provider who agreed they were areas for improvement.

Staff responded appropriately to people's changing needs. For example, one person was not feeling well and declined their daily shower; so staff offered them a full body wash instead, which they accepted. Another person's mobility changed as they became frailer, so staff cared the person in bed, ensuring they were turned and cleaned regularly to keep their skin healthy. A further person asked if they could arrange to have their tea at 5:00pm. As this was the normal tea time, staff sensed the person might have been hungry, so offered to give the person their tea earlier, which they accepted.

People were empowered to make choices and have as much control and independence as possible. Staff were clear that they were led by people's individual wishes and aimed to meet them wherever possible. One staff member told us, "Most people prefer baths, but we still offer them the choice of a shower instead. Similarly, they have set times for baths, but if they want them at a different time we arrange it." People confirmed this was the case and said staff supported them to bathe as often as they wished. A family member told us, "[My relative] is always offered choices and is able to make decisions. I asked [staff] if she could have an extra bath and now they do."

People had a range of activities they could be involved in. One person told us, they had "made a little doll" and enjoyed "going into the garden and reading". A family member told us, "There's lots going on. They get [people] out in the summer and push them down to the bay. They have a fete and [people] use the garden a lot." Some people chose to remain in their rooms and declined to take part in group activities. One person said, "Because I am long sighted I can see the birds and have an excellent view of the downs [from my bedroom]. I do enjoy sitting here." Staff provided people with suitable resources and materials if they chose to entertain themselves. One person enjoyed writing letters and had access to writing materials; another liked to read and had access to a daily newspaper and a range of books. A further person was keen on sports and the provider had arranged for a subscription-based TV

Requires improvement

Is the service responsive?

service to be installed so the person could watch live sports events. A family member told us, "They get everyone singing and they had a party for [my relative's] birthday where they sang [her favourite songs]." Staff told us about other activities including an owl that visited the home and photographs confirmed this had been a popular event.

One person told us, they liked "knitting, reading and colouring", and we saw them doing some painting. We also observed a singing and reminiscing activity which four people took part in and led to discussions about people's previous jobs and positive social interaction between those taking part. New staff had been appointed to run social activities and outlined ways they planned to meet people's individual interests.

The provider sought feedback from people by talking to people on a daily basis. People told us they were listened to. One person had asked for salmon to be introduced to the menu and we saw it had been. A family member told us, "We are listened to [by the provider]. For example, if a drawer gets broken they sort it straight away; when the toilet broke, it was working again within hours." The provider also conducted satisfaction surveys. However, the completed forms were placed in people's individual care plans and not analysed or used to change or improve the service. We noted that one person had given a low score for a particular area of the service, but the provider did not know whether this was a theme, identified by other people, or not.

There was an appropriate complaints policy in place. People told us, they knew how to make a complaint and that any concerns would be taken seriously and acted on. No formal complaints had been recorded in the past year.

Requires improvement

Is the service well-led?

Our findings

Effective systems were not in place to monitor and assess all aspects of the service; these included infection control, the management of falls, the operation of recruitment procedures, the implementation of the MCA, staff training, the recording of the care and support delivered, and the analysis of feedback from satisfaction surveys. Consequently, the provider was not able to identify and implement any required improvements. We discussed this with the provider who told us they were planning to review their quality assurance processes as a priority.

The administration of medicines was audited each month to ensure they were properly administered and accounted for. In addition, a community pharmacist had reviewed the arrangements for managing medicines and confirmed that they were appropriate and effective. Care plans were also reviewed monthly in order to check they remained up to date with people's current needs.

The provider had a Duty of Candour policy in place which required them to be open about serious incidents when they occurred. One person had fallen and suffered a serious injury. Staff had discussed the causes of the fall with the person and notified the person's family about the incident. However, they had not sent a written letter of apology to the person as required by their policy. The registered manager had notified CQC about significant events. We used this information to monitor the service and ensure they responded appropriately to keep people safe.

People liked living at the home and felt it was well-led. One person said, "I can't find any fault. Everything is well-organised." Another person told us "The lady who owns the place is very good." Family members agreed. One said, "Communication with staff was always pretty good. We could visit at any time and [a member of staff] always came to see me to welcome me." Relatives told us they would be happy to recommend the home to other people. One family member told us "I have recommended it to a friend just recently." Another said, "The home would be my preferred choice if I needed one again."

The service had strong links to the community. Many people had previously lived nearby and were visited often by friends and family members or taken out on trips to the local community. Care records included plans to help people maintain these links. Church services were arranged every three months and ministers from a range of faith groups visited people regularly.

The service promoted a positive culture. The provider was actively involved in the running of the home and told us their aim was to create a small, friendly, homely environment where people could feel relaxed. They said, "It's nice that we're small. I like the fact that I've got control and know what's going on. Staff understood this vision and were committed to delivering it. One staff member said, "We try to keep the home as homely as possible. If people want to have relatives for lunch, they can; just as they would if they were at home because this is their home now." The home had a whistle-blowing policy which provided details of external organisations where staff could raise concerns if they felt unable to raise them internally. Staff understood this and told us they would have no hesitation in raising concerns.

There was a clear management structure in place which included the provider, the registered manager, senior care staff, care staff and ancillary staff. The registered manager told us they received a high level of support from the provider. They and the provider were members of the local care homes association which gave them access to external training events and helped them to keep up to date with changes in best practice.

People benefitted from staff who understood their roles, were motivated, and worked well as a team. One member of staff told us, "I like working here. The provider is a really nice person. It's a small home and everyone gets on well." Staff were complimentary about the provider and the registered manager, who they described as "supportive" and "approachable". One staff member told us, "I feel I'm valued. [The provider] asks what we think; you can give an opinion and you feel listened to. Staff meetings are good and allow us to resolve any issues." Another said, "The managers are really, really good. We always get a good response when we ask for help and if I have any worries I know who to speak to."

Handover meetings between staff at the start of each shift ensured that important information was shared, acted upon where necessary and recorded to ensure people's progress was monitored. To support this, a communications board and a communications book were also used to pass important information between staff.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider failed to ensure that all risks to the health and safety of people were assessed, managed and mitigated effectively. Regulation 12(1) & 12(2)(a)&(b).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **The provider failed to operate appropriate and effective recruitment procedures. Regulation 19(1)(a)&(b), 19(2)(a) & 19(3a).**