Minster Care Management Limited

Ashgrove Care Home - Humberstone

Inspection report

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Ratings

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

Overall summary

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 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

Ashgrove Care Home provides accommodation for older people who require personal care. There were 34 people living at the home when we visited. The accommodation is provided in single bedrooms, none of which are ensuite. The accommodation has several communal areas, two dining rooms, a kitchen and a laundry. There are approved plans in place to extend the property to

Summary of findings

provide 19 ensuite rooms for people currently living in the home. There are large secure gardens to the front and rear of the property. The home is in a populated area with good access to local amenities and public transport.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service and shares the legal responsibility for meeting the requirements of the law; as does the provider.

People and their relatives told us they were happy with the care provided at the home and their care and social needs were being met. From our observations, and from speaking with staff, people who lived at the home and relatives, we found staff knew people well and were aware of people' preferences and care and support needs.

We found the home required some improvement in the management of medicines. We found medicines had been stored incorrectly. This was a breach of Regulation 13 of the Health and Social Care Act 2008 and we have asked the provider to take action.

We found the home was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS) and staff followed the Mental Capacity Act 2005 for people who lacked capacity to make decisions for themselves.

The registered provider had robust recruitment processes in place which protected people from being supported by unsuitable or unsafe staff.

The home was meeting people's nutritional needs; people were supported to ensure they had enough to eat and drink. People told us the food at the home was good and they had a choice. People were supported to do their own shopping and choose the foods they liked.

Staff involved people in choices about their daily living and treated them with compassion, kindness, and respect. People were supported by staff to maintain their privacy, dignity and independence. Everyone looked clean and well-cared for. People had access to activities and relatives and friends were able to visit the home at any time.

People told us there were enough staff to give them the support they needed. Our observations confirmed this. The local authority told us they had confidence that staff had the appropriate skills to meet people's needs. The majority of staff had received training considered mandatory and had also received specialist training, for example, on dementia care.

We observed care was centred on people's needs and preferences. There was a wide variety of activities available for both individuals and groups.

People knew how to make a complaint and we noted the home openly discussed issues so that any lessons could be learned. People felt they were able to express their views at any time and that they were listed to and acted on.

Leadership and management of the home was good. There were systems in place to effectively monitor the quality of the service and drive a culture of continuous improvement.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was safe but required some improvement in the management of medicines. We found medicines had been stored incorrectly. This was a breach of Regulation 13 of the Health and Social Care Act 2008. You can see what action we told the provider to take at the back of the full version of the report.

People's safety around the home had been assessed.

There was a good standard of cleaning throughout the home.

People who lived at the home told us there were enough staff to meet their needs.

Is the service effective?

Good

The service was effective. Staff received appropriate, up-to-date training and support.

People who lived in the home and their relatives told us they felt the staff had the skills they needed and knew them well.

People told us the food was good. The lunchtime experience was a social occasion with people enjoying banter with each other and the staff.

The home had policies in place that ensured they met the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS).

Is the service caring?

Good

The service was caring. People told us they felt cared for and happy.

We saw that staff interacted well with people.

People were encouraged to express their views about the care they received and felt they were listened to.

Is the service responsive?

Good

The service was responsive. Care plans contained sufficient information about people's health care needs, and what they enjoyed doing.

Activities provided included bingo, karaoke, visiting singing groups, film shows, beetle drives, barbeques and visits to the nearby seaside.

People knew about the complaints policy and were certain any issues would be dealt with by the registered manager.

Is the service well-led?

Good

The service was well-led. The home was well organised which enabled staff to respond to people's needs in a proactive and planned way.

Summary of findings

Regular staff meetings took place and were used to discuss and learn from accidents and incidents.

People living at the home and their relatives were surveyed about their views about the care and the home in general.

Ashgrove Care Home - Humberstone

Detailed findings

Background to this inspection

We visited this service on 17 and 18 July 2014. The inspection team consisted of 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 used this type of service.

Prior to the inspection the registered provider completed a Provider Information Return (PIR). The PIR is a document completed by the registered provider about the performance of the service. The local authority safeguarding and contracts teams and the local Healthwatch organisation were contacted before the inspection, to ask them for their views on the service and whether they had investigated any concerns. They told us they had no current concerns about the service.

We used a number of different methods to help us understand the experiences of the people who lived at the home. We used the Short Observational Framework for Inspection (SOFI) in the main lounge area. SOFI is a way of observing care to help us understand the experiences of people who could not talk with us. We spoke with ten people who lived in the home, three relatives, five care staff, the administrator and registered manager.

We looked around the premises, including people's bedrooms (after seeking their permission), bathrooms, communal areas, the laundry, the sluice facilities, the kitchen and outside areas. Five people's care records were reviewed to track their care. Management records were also looked at, including: four staff files, policies, procedures, audits, accident and incident reports, specialist referrals, complaints, training records, staff rotas and monitoring charts in people's bedrooms.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Requires Improvement

Is the service safe?

Our findings

The service was safe but improvements were needed. The 10 people we spoke with all said they felt safe with the staff and within the home itself. We saw care was delivered in a safe way. For example, one person was helped out of bed by two care workers using a hoist. The staff explained what was happening at every stage, providing reassurance and understanding.

In the medication room we found medicines were stored securely. The staff monitored the temperatures of both the room and the medication fridge. However, we noted the room temperature was consistently above 22°C. Whilst this does not exceed the maximum permitted temperature of 25°C we saw one medicine, Conotrane, was recommended by its manufacturer to be stored at less than 22°C. This meant the medicine may not have been effective in people's treatment.

The fridge that was used to store insulin in particular was recorded as being consistently over 15°C, the maximum being 5°C; the fridge was clearly faulty. This meant people may have received ineffective medicine for some time. We brought this to the registered manager's attention immediately, who contacted the pharmacy to arrange for a new fridge to be delivered. We ensured the stock of insulin was removed for destruction and new stocks were ordered for that day. We noted one of the criteria of a monthly audit carried out by registered manager was, "Are fridge temperatures (max and min) recorded daily and evidence available of action taken if outside 2-8°C?" We felt this audit should have identified this error since the temperature check period had crossed the audit dates.

The controlled drugs register had been kept up-to-date; each entry had been double signed. However, the medicine trolley contained two open bottles where the opening date had not been recorded; the manufacturer's recommendation for these medicines was that it should be used within seven days of opening. There was no way of knowing whether this date had passed. We saw one criteria of the monthly medication audit stated, "Are creams, insulin, eye drops and liquids annotated with date of opening?" We noted this had been ticked as being 'yes' despite us finding these two examples.

The problems we found breached Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

The home had policies in place to protect people from abuse. The staff we spoke with were able to describe these policies and the different types of abuse that may occur. They told us there were robust systems in place to report any suspected abuse and that staff would have no hesitation in approaching the management about concerns; they were confident any concerns they expressed would be acted on without delay. The training records confirmed people had received training in safeguarding adults from abuse within the last two years.

The five care plans we looked at all contained recent assessments of people's capacity to make decisions for themselves. When people had been assessed as being unable to make complex decisions there were records of meetings with the person's family, external health and social work professionals, and senior members of the home's staff. This showed any decisions made on the person's behalf were done so after consideration of what would be in their best interest.

Staff told us they had been trained in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). One member of staff told us, "We have been trained in MCA and we assess the residents regularly. Not many people here lack capacity but we always assess every few months or sooner to keep on top of this." The registered manager told us they worked closely with the local safeguarding team to identify any potential deprivation of people's liberty; at the time of our inspection no one was subject to a DoLS application.

One person's care plan clearly documented their specific religious requirements. Staff we spoke with were all aware of this person's wishes. We confirmed the home had taken steps to respect the person's beliefs by researching the topic extensively on the internet and providing staff with clear guidance to follow.

People's safety around the home had been assessed. For example, each person had a risk assessment for their mobility around the home and each person's care file contained a personal evacuation plan in case of fire which

Is the service safe?

contained information about any mobility difficulties they may have. We noted this information was duplicated in the documents which would be issued to the fire service should there be a fire at the premises.

Care plans contained risk assessments designed to provide staff with information that would protect people from harm. We noted these had been updated monthly to ensure they reflected any changes in people's needs. Members of staff told us they were kept informed of any changes in risk at daily handover meetings so that appropriate care could be provided at all times. Risk assessments included those for: falls; nutrition; the environment; pressure care; and behaviour which may challenge the service. Although the staff demonstrated good understanding of how to deal with varying behaviours, there was no specific training in this area. One member of staff told us, "I think we all know about what to do because many of us are experienced but we haven't had any formal training on the subject. Most of the people here are low level dementia so it doesn't really apply."

Care files showed that when a risk had been identified relevant healthcare professionals had been consulted. In one person's case they had been referred to a tissue viability nurse.

During our visit we observed a good standard of cleaning throughout. The home had received an inspection from an infection control nurse working on behalf of the local clinical commissioning group (CCG) in May 2014 which identified some equipment (hoists and toilet seats) and some air vents needed cleaning. At our inspection we found this work had been carried out and cleaning schedules had been changed to include these items. Records showed 93 % of staff had been assessed for competence in hand hygiene and the use of personal protective equipment (PPE) and all but two staff had received recent training in the prevention and control of infection. Staff we spoke with were able to describe good practice in this area. The home had appointed six members of staff to act as link trainers on infection control across all departments including the kitchen and housekeeping.

We spoke with the cleaner who described the cleaning routine to us and told us how the schedule of deep cleaning people's rooms worked. We observed that mops were not always correctly stored in an inverted position despite clear pictorial signs advising them to do so. Separate, colour coded disposable cloths were used for cleaning. We pointed out to the manager that several light pull cords in the communal bathrooms were heavily stained and needed to be replaced. We also pointed out that the sealed bins used for the disposal of needles and syringes had not been signed to state who had assembled the bin in line with the 'European Union Directive for Safer Sharps'.

People told us there were enough staff to meet people's needs. We observed one person asking a member of staff to take them to the bathroom. We heard the staff member explain they were just completing a task and would be back as soon as possible. The care worker returned within two minutes; this ensured the person was not left in distress.

Staff rotas showed the 34 people who lived at the home were cared for by five care assistants and one senior care assistant in the morning and one senior and three care assistants in the afternoon. At night, one senior and two care assistants were on duty. One member of staff told us, "I've worked in a few care homes and I have to say I think the staffing here is OK. A lot of the residents have low dependency and are able to get out and about so there is time to care for everyone." The registered manager produced documentation showing that each person's dependency levels were assessed monthly. They told us this allowed them to adjust the staffing if necessary. The registered manager told us they had recently introduced an extra member of staff between 4-9pm to assist with people's evening routines. Members of staff told us this had made a huge difference, especially at the time most people wanted to go to bed. People told us there were enough staff to meet their needs. Comments included, "I am well looked after, I need two carers and they come to me as quickly as possible" and "Staff come to me as soon as I buzz."

We looked at records of the monthly 'staffing forum', a meeting attended by the management and senior care assistants to look at people's dependency against staffing levels. This meeting also discussed changes in people's needs and how it affected staffing levels following discharge from hospital. We felt this was an effective way of managing the staff resource against people's needs.

Staff told us they felt they had been recruited into their roles safely. Each of the five staff we spoke with said they had not been permitted to commence their induction

Requires Improvement

Is the service safe?

period until their references had been received and they had been cleared to work with vulnerable adults by the disclosure and barring service (DBS). Staff records confirmed this.

Good

Is the service effective?

Our findings

The service was effective. We reviewed the home's training matrix which was used to monitor the courses staff had undertaken and when they were due to be refreshed. We confirmed that training was up-to-date. We saw the provider considered training in infection control, moving and handling, food hygiene, fire safety, health and safety, dementia, and safeguarding adults all to be mandatory. In addition, the majority of staff had received training in the Mental Capacity Act, diabetes, nutrition, dignity, care planning, pressure care, and end of life care. This meant the staff received the training needed to provide good quality care.

Records showed most of the staff had gained a nationally recognised qualification in care. One member of staff told us they were being supported to take these qualifications, "They are putting me through my NVQ3 training and giving me lots of support. I have also had a lot of training in dementia and diabetes."

People's relatives told us they felt the staff had good skills; one said, "The care staff all seem very knowledgeable about care. I have talked to them quite a lot about dementia and they know exactly what to do." A visiting healthcare professional told us, "The staff here are good at what they do, they always follow instructions and they have a good understanding about pressure care."

Staff told us they received regular supervision meetings with their line manager and an annual review of their personal development. Records of these meetings showed that there was regular discussion about promoting people's dignity, as well as their adherence to the infection control, medication, health and safety, and safeguarding policies. The meetings gave staff the opportunity to share and discuss any concerns they may have. Members of staff told us there were meetings for the care staff approximately every two months. Issues discussed at the meetings were around the best practice in supporting people's needs and promoting their dignity.

Newly recruited members of staff told us they had undertaken the provider's induction programme. Their induction packs contained information about dementia, dignity, whistleblowing, and safeguarding. Staff confirmed they had received training in moving and handling before they had been permitted to assist people using a hoist or other mobility aid. One member of staff said, "I had to shadow a more senior carer until I had been signed off to use the hoist and to deliver personal care on my own." This showed people were protected from the risk of receiving care from untrained staff.

All the people we spoke with said the food was good. Comments included, "The food is good. There are good choices but sometimes they overcook it for me and they take it away and ask me if I want something else", "If I don't like something they always cook something else for me" and "There are plenty of choices and I really quite like the food."

We observed the lunchtime experience which was a social occasion with people enjoying banter with each other and the staff. People who were assisted to eat by the staff were done so in a sensitive and dignified manner. We saw a printed menu was on each table for people to choose from and we heard people talking about what they would be having to eat. People with dementia were told verbally about the meals available, although we felt the home might benefit from the introduction of pictures to help people with dementia make a choice. The lunch was well presented and was served quickly so that it remained hot. Although the meal looked appetising, the meals were plated up away from the table so that people were not able to choose the components of their meal or portion size.

People who took longer to eat than others were afforded the time to do so. Lunch was a relaxed and calm experience.

The cook told us how some people needed different textured diets usually following an assessment by the Speech and Language Therapy Team (SALT). The cook was able to describe the varying textures of food and demonstrated a good understanding of people's dietary needs. The care files and kitchen had copies of each person's 'diet requisition and special dietary needs' sheet which gave the cook information about people's likes and dislikes as well as allergies or the need for a fortified diet. We saw this was reviewed regularly.

People's weights were recorded each month in their care files. In addition the home completed the monthly community nutritional risk assessment tool implemented by the local clinical commissioning group (CCG). We noted this informed the monthly evaluation of each person's eating and drinking care plan and also whether people

Good

Is the service effective?

were needed to be placed on a food and fluid chart. We were told that a member of staff had recently implemented a system whereby a visual display was placed in each person's room using symbols to indicate whether they received a fortified diet or whether a food and fluid chart needed to be completed. We saw these symbols were also used on the kitchen noticeboard as a quick reference for the cook. This ensured consistency between the care staff and the kitchen. Records confirmed that people had been referred to dieticians and SALT if weight loss had been consistent over a time period.

We visited the home on a particularly warm day. We observed people were offered drinks regularly and staff were often seen encouraging and supporting people to drink. Jugs of water and juice were available in people's rooms and communal areas.

People's care plans were reviewed monthly. This allowed the home to identify changes in people's needs effectively. Referrals had been made to external health and social care professionals when necessary. We saw referrals had been made to tissue viability nurses, dieticians, the local falls team and GPs. Records showed people had been supported to attend outpatient appointments at the hospital as well as attend GP, dental and optician appointments. People told us the home would support them to access the GP. Comments included, "If I need to see a Doctor, the staff will take me to the appointment, there's never a problem with that" and "If I am ill the home sends for the Doctor without delay." The registered manager confirmed the home had a good relationship with the local GP practices and pharmacies.

Good

Is the service caring?

Our findings

People told us they felt cared for and happy at Ashgrove Care Home. Comments from people included, “Staff are lovely to me and are so caring”, “Staff will do anything for us”, “I like it here very much; I get on with the manager” and “Everyone treats me well.”

People’s relatives who visited the home on the day of our inspection told us, “Mum is treated very well, staff are nice and speak kindly to her”, “We are pleased with the home. We are very happy with her care. Staff are brilliant” and “Staff always speak in a kind way to residents and I have seen how patient they are.”

Throughout the day of our visit we observed staff interacting with people. Staff were always around the communal areas, asking people if they were alright and if they needed anything. It was evident to the inspection team that the staff, including the management, knew all the people well and vice-versa. Following lunch we carried out an observation using the Short Observational Framework for Inspection (SOFI) for 40 minutes. This showed us staff interacted positively with people, showing a genuine interest in what they had to say so that they felt they mattered. There was not one person who was left without any interaction.

Staff we spoke with were able to describe people’s life histories and clearly knew and understood people’s social preferences. Staff told us the care plans gave a lot of information about people and they were encouraged to read them regularly to ensure they knew people well.

People who lived in the home told us they were always asked for their consent before any care tasks were undertaken. One person said, “They [staff] ask me if it’s ok to wash me and dress me; they never just do it.” Two other people told us they were involved in their care plan; comments included, “I know about my care plan and I am asked about it and whether it’s still want I want” and “Yes, I have read the file, I know what it says and I agree with it.”

Staff were sensitive when caring for people with limited communication and understanding due to dementia. They spoke softly and calmly and gave people time to respond. They took steps to ensure people had understood using verbal and non-verbal methods of communication.

During our visit we observed all staff speaking to people in a kind, positive and respectful way. All 10 people we spoke with thought highly of the staff. We observed staff were consistently available in communal areas and in people’s rooms to respond to their requests and to encourage them in conversation.

People’s relatives told us they were free to visit the home whenever they wished; many said they had been given the electronic access code for the front door to facilitate this. One relative told us they often visited the home in the morning and were always asked if they would like to stay for lunch with their relative. They felt this was extremely positive and showed the home had, “A caring approach which makes all the difference to me and my relative.”

We observed people were well dressed and appeared well cared for. One person who lived at the home said, “We can take a bath whenever we want really and a hairdresser comes to do our hair. We all like to keep looking nice and the staff help us with that.”

We observed members of staff asking people if they needed assistance in a quiet, discreet way. All of the 10 people we spoke with said they felt they were treated with respect and that their privacy was respected. The home had appointed 10 members of staff from all departments of the home as ‘dignity champions’. The registered manager told us their role was to promote dignity and respect and advise staff when they observed poor practice.

People told us they were encouraged to maintain their independence as much as possible by carrying out tasks for themselves or by going out for walks. One person said, “I go out for a walk down the road, they [staff] encourage me to go to keep my legs moving.”

Good

Is the service responsive?

Our findings

Care plans contained sufficient information about people's health care needs, what they enjoyed doing, and their daily routine preferences such as what time they liked to get up and what time they would like to have breakfast. We spoke with people who were able to tell us about their interests and routines; we confirmed this information had been recorded in the care plans. Care plans were well ordered, easy to read and person centred. They demonstrated a comprehensive, multi-disciplinary, best interest process where required. Some people had agreed to 'Do Not Attempt Cardio Pulmonary Resuscitation' agreements due to ill health and where relevant, this was clearly visible at the front of care plans.

People's care plans were reviewed monthly; this ensured their choices and views were recorded and remained relevant to the needs of the person. People told us they were included in these discussions. One person told us the home had recently purchased two new armchairs specifically for them since they sat for long periods and were at risk of developing pressure sores. They told us one had been placed in their room and the other in the lounge. This showed the home reacted to people's individual needs.

People told us there were a number of activities organised throughout the week. The activity programme we looked at confirmed activities provided included bingo, karaoke, visiting singing groups, film shows, beetle drives, barbeques and visits to the nearby seaside. We were told the home held three fetes a year for which the people who lived at the home made things to sell. One person told us, "We have a Christmas meal to which all of our families are invited, it's a great occasion. The staff also put on a Mother's Day lunch and we invite our children, that's really special." People living at the home were particularly keen to tell us about the sports day they had participated in; comments included, "We did the sack race and the egg and spoon race, it was so much fun", "The sports day was great, nearly all of us had a go at something. We also had a Wimbledon event when we had strawberries and cream, some residents even played tennis!"

We spoke with the activities coordinator who told us they would spend the first part of their day talking with people who were in their rooms to ensure people were not becoming socially isolated. They told us some people did not wish to participate in any group activity and that one person was being looked after in bed. In both cases the coordinator told us they would read books to them or, "Just chat with them about how they're feeling or anything they just want to talk about." The coordinator told us they had received training in the development of meaningful activities for people with dementia and that they held reminiscence sessions as well as encouraging people to keep their minds active with things they enjoyed. People's participation in activities was recorded to ensure people were not becoming isolated. We confirmed the home was a member of the National Association for Providers of Activities for Older People (NAPA) from which they received support, activity materials and advice.

People were encouraged to express their views about the care they received. We looked at the records of the quarterly 'quality assurance meeting' to which the people who lived at the home, their families and relevant staff were invited. We noted the meetings discussed issues relating to missing laundry and the quality and choice of food. Following the meeting we saw the registered manager had issued a memo to staff to address people's concerns. In the case of the missing laundry, the registered manager purchased an individual laundry bag for each person. People told us this action had largely solved the problem.

In addition to the 'quality assurance meeting', people living in the home and their relatives were invited to a bi-monthly 'residents and relatives meeting'. The notes from the last meeting showed discussions were held about a perceived imbalance on shifts between the experience levels of staff. Following the meeting the registered manager adjusted shifts and moved an experienced senior care worker from the night to day shift in order to establish better leadership and a better balance of staff experience. The rotas we reviewed confirmed this. This showed the home had listened to people's views about their care and reacted to address concerns.

Each of the 10 people we spoke with told us they had had no cause to complain about the home but felt able to do so if necessary. They told us they knew about the complaints policy and would be certain any issues would be dealt with by the registered manager. One person said, "If I had any concerns, I would go straight to Jane [the registered manager] who would sort it out for me." We saw the complaints policy was displayed in the reception area and was also available in each person's 'residents' guide'.

Good

Is the service well-led?

Our findings

There were effective systems in place to monitor the quality of the service. The home was well organised which enabled staff to respond to people's needs in a proactive and planned way.

The registered manager had been registered with the Care Quality Commission since July 2011. They told us they had a National Vocational Qualification (NVQ) level 4 in leadership and management.

We reviewed the results and evaluation of surveys sent to people living at the home and to staff in June 2014. 20 people living at the home responded to the survey. Everyone indicated they felt the staff were helpful and all said they felt their privacy was maintained. All respondents stated they felt unrushed when staff were assisting them and everyone said their needs were met. We looked at the action plan the registered manager developed following the survey. This gave specific timescales for the completion of actions.

We reviewed the results of the staff survey. 34 surveys were returned from the 35 issued. The responses were more varied than those received from the people living at the home. Whilst most staff felt people's dignity was upheld, one person did not. One staff member felt the care was poor and two felt it was only satisfactory. We saw the registered manager had developed an action plan grouped into four areas: activities, menus, environment, and staffing. Each action had specific timescales attached to it. During our inspection we observed progress had been made on a number of specific issues.

The registered manager produced a regular newsletter which provided information about the achievements of the service, people's birthdays, news about trips and outings, improvements made, future plans for the service and any other celebrations. Recent newsletters gave people updates on the building plans for 19 new ensuite rooms.

Members of staff we spoke with generally thought the management of the home was responsive and supportive; one said, "I think the manager is good, we can approach her but we have had some issues that are ok now." The registered manager explained there had been some problems with some staff working as a team and that they had changed the personnel within teams and used other management tools such as warnings to address this. As a result they felt the team ethos had improved considerably. Throughout our visit the inspection team observed staff working well as a team, providing care in an organised, calm and caring manner. This showed the registered manager had acted to resolve issues so that people's care was not compromised.

Records showed accidents and incidents were being recorded and appropriate immediate actions taken. An analysis of the cause, time and place of accidents and incidents took place to identify patterns and trends in order to reduce the risk of any further incidents.

Records showed regular staff meetings were held for the daytime care staff, the kitchen staff, the ancillary staff such as domestics and cleaners, and the night-time care staff. The minutes showed the registered manager openly discussed issues and concerns. We saw action plans were developed when appropriate. For example, the minutes from one meeting showed the daytime care staff were concerned about having a more defined role; we noted action had been taken to work with staff to define their roles more clearly. Staff confirmed to us this had taken place.

The registered manager showed us the audits they undertook each month; these included audits of the kitchen, the environment, infection control, and staff working practise. 10% of people's care plans were audited each week and 10% of staff personnel files were reviewed each month. However, the monthly medication audit had failed to identify some of the issues to do with the storage of medicines.

We reviewed the 'dementia quality audit' which was used not only to confirm staff were using appropriate skills and knowledge but also to check the environment and activities were relevant to the needs of each person with dementia. We also looked at the monthly mattress audit which showed the exact location and condition of each numbered mattress so that mattresses could be replaced before they became uncomfortable for the people sleeping on them.

We saw the registered provider required the home to be regularly audited by a senior manager (not connected with the home itself) to identify any shortcomings in care, the

Good

Is the service well-led?

environment or the overall management of the home. We noted the outcome of these audits determined the frequency of subsequent visits. We saw actions plans from these audits had been created and followed up.

The registered manager showed us the complaints and compliments log. We saw the home recorded the number of complaints each month and had followed them up with actions and acknowledgements to complainants. Members of staff told us that any complaints were discussed openly in staff meetings and actions were always taken to rectify any issues.

We asked the staff what they were most proud of at the home; comments included, “We listen to each other and our residents and we then act”, “We don’t treat people as if they are in an institution”, “We all work well as a team”, “We have an open door policy that works” and “We are very good at working with families and supporting them.”

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The registered person did not protect service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purposes of the regulated activity.