Sanctuary Care

Ashgreen House

Inspection report

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Ratings

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

Overall summary

This inspection took place on 25 and 26 November 2014 and was unannounced. At the last inspection on 11 July 2013 we found the provider met all the regulations we inspected.

Ashgreen House accommodates up to 52 people who have elderly nursing, residential, or intermediate care needs (people needing short term nursing or residential care to meet their needs). The accommodation is on three floors and there are four units: two for residential care, one for nursing care and one for intermediate care.

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 and associated Regulations about how the service is run.

We found some concerns about the maintenance of equipment, particularly as one unit had very few working call bells. The manager took steps to address this during the inspection. We also had concerns that medicines were not stored securely or safely at all times. This put people at risk of unsafe care.

Summary of findings

CQC is required to monitor the operation of the Deprivation of Liberty Safeguards. At the time of our inspection no one was subject to the Deprivation of Liberty Safeguards. (These are to protect people's rights when their liberty may be restricted for their safety.) Some staff had not received training on the Mental Capacity Act 2005 or were not aware of the Code of Practice. This meant they may not be aware of their responsibilities under the act. Staff training in other important areas such as first aid and infection control was not always refreshed, meaning there was a risk staff did not have the current skills to deliver safe effective care.

Some records related to people's care and support needs were not always up to date. This put people at risk of inappropriate care. Some records related to the management of the service were not easily located. While audits were carried out to monitor the quality of the service they had not always identified the concerns we found.

People felt safe using the service. Staff were knowledgeable in recognising signs of abuse and the associated reporting procedures. Assessments were undertaken to identify people's health and support needs and any risks to people who used the service and others. Plans were in place to reduce the risks identified and to identify people's support needs.

Staff engaged with people in a caring manner and respected people's privacy, dignity and independence. They understood and responded to people's diverse individual needs and were familiar with people's histories and preferences. We heard mixed views about staffing levels with some people feeling there were not always enough staff available and some who felt the service was staffed sufficiently. We found steps were being taken to address problems with the absence of the regular activities organiser.

People told us they thought the service was well run and organised. There was a complaints procedure in place and the manager had a weekly surgery that people could attend if they had any issues about the service.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe. We found problems with the maintenance of some equipment including call bells which put people at potential risk. Medicines were not always stored safely.

People told us they felt safe. Staff understood how to recognise signs of abuse and how to raise concerns. There were arrangements to deal with emergencies.

We received mixed feedback about the staffing levels at the service. We observed, that at times, there was not always a staff presence in or near the communal areas to respond to people's needs should they arise. The manager consequently made some changes on one floor during the inspection.

Is the service effective?

Requires Improvement

The service was not consistently effective. Staff had not always received regular refresher training to ensure their skills were up to date.

Mental capacity assessments had been completed where relevant; although not all staff had received training for this. Some staff were not fully aware of their responsibilities towards people using the service under the Mental Capacity Act code of practice.

People were supported to have enough to eat and drink and those at risk of malnutrition were monitored and provided with fortified diets if needed, although records were not consistently completed. People's healthcare needs were monitored, and people were referred to a range of suitable healthcare professionals as required.

Is the service caring?

Good

The service was caring. People spoke warmly of the staff and told us they were caring and supportive. Staff knew people's needs well and supported people at their own pace.

People told us they were involved in making decisions about their care and support needs and this was confirmed in records we looked at. Staff were kind, caring and respected people's privacy and dignity sensitively.

Is the service responsive?

Requires Improvement

The service was not always consistently responsive. People told us the support they received met their needs. They had an assessed plan of care which was reviewed frequently. Staff were aware of people's support needs and preferences. Most but not all care records were up to date.

The regular activities organiser had not been available at the service for some time but alternative arrangements had recently been made to address this.

Summary of findings

People and their relatives knew how to raise any concerns. They told us they were sure these would be taken seriously and addressed.

Is the service well-led?

Requires Improvement

The service was not consistently well-led. Records relating to the management of the service were not always maintained. This put people at risk of unsafe or inappropriate care and treatment.

There was a system of audits in place but these had not picked up on the issues we identified at the inspection.

We had some mixed feedback about how the service was managed. The service had a registered manager and people, relatives and staff said he was approachable and available to speak with on any matters. Most people felt the service was well-led others felt there could be some improvements.

Ashgreen House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 25 and 26 November 2014 and was unannounced. The inspection team comprised of two inspectors, a specialist advisor in nursing and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection we looked at the information we held about the service including information from notifications they had sent us about significant events such as safeguarding concerns. We also asked the local authority commissioning team for their views of the service.

We spoke with nine people using the service, three relatives, two nurses and the clinical lead nurse, six care staff and the residential team leader, a cook and an activities organiser. We also spoke with the registered manager and regional manager for the service. Not everyone at the service was able to communicate their views to us so we also used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We looked around the building. We looked at eight records of people who used the service and eight staff recruitment and training records. We also looked at records related to the management of the service such as audits.

Requires Improvement

Is the service safe?

Our findings

People and their relatives did not raise any concerns about any equipment problems at the service. However, our findings in relation to the maintenance of equipment did not always match the experiences of people using the service.

The premises were well maintained and clean throughout the inspection. Some equipment at the service was routinely maintained and serviced including hoists, wheelchairs and weighing scales. Essential maintenance and necessary servicing checks were carried out for the lift, fire safety equipment, electrical equipment and boiler.

However, we found some equipment was not functioning during the inspection which posed a potential risk to people's safety and welfare. The call bells in one bathroom and nine bedrooms on one unit did not work when rung. In one person's room the cord was wrapped tightly making the call bell inaccessible. The local authority commissioning report of March 2014 had made reference to problems with call bells in the units. The manager told us that a new call bell system had been installed in May 2014 because of repeated problems with the system. The provider had not replaced the system on one of the three floors, which was the floor where we identified problems. Staff did not appear to be aware of the problems we identified and the problem had not been recorded in the maintenance log. It was unclear how long this problem had gone unnoticed. There was a risk that people may not be able to summon help or support when they needed it.

The manager of the home called contractors as soon as we identified the non-working call bells. However, they were unable to remedy the fault. The manager then completed risk assessments and more frequent checks were carried out for those affected rooms. Following the inspection the manager told us the call bell system had been replaced on the remaining floor and this was being checked regularly to ensure it was in working order.

We found further examples of equipment which was not working which posed a potential risk to staff and people using the service. These problems had also not been recorded in the maintenance log book. We found the lights on one floor did not work in the corridor near the bathroom making the area unsafe for anyone using it when it was dark. Replacement bulbs were fitted by the maintenance staff while we were present. Staff told us this had been the situation "since before the weekend," but no action had been taken to address this.

We heard some alarms on the fire safety door closure devices on two floors during the day. The noise was not conducive to a relaxing atmosphere in which to live or work. The alarm sounding meant the door closure devices were either low in battery or not functioning correctly. It was clear from staff and people using the service that this problem had been occurring for some time. Our inspection of 11 July 2013 had also noted this issue. Staff were aware the alarms were ringing but had not reported the problems in the maintenance log. The manager told us they were testing a new kind of door closure in one room that was aimed at resolving these problems. The manager, arranged for maintenance staff to address the problem.

We were told a system had been set up to check on the safety of bed rails at regular intervals but there were no records available to confirm these checks were completed. The manager told us checks on call bells were random and not recorded. This was despite the fact that call bells had been an identified problem since the local authority commissioning visit in March 2014. Following our findings at this inspection and the nine non-working call bells the manager informed us regular checks of the call bells were now being completed.

These issues were a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Appropriate pre-employment recruitment checks were completed for new staff, such as criminal record checks, proof of qualifications, two references from previous employers and proof of identity. However, we noted that the required photographic identification was missing from four of the eight records we viewed. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Medicines were not always kept securely. We observed that the medicines trolley for one unit was left unlocked and unattended during the time when medicines were administered to people in their rooms. Therefore there was a potential risk that unauthorised people could gain access to the medicines.

Requires Improvement

Is the service safe?

Medicines were not always stored safely. While there were arrangements to secure the medicines trolleys in the units when not in use, we found on one unit the door to the office was unlocked and the trolley had not been secured. This was not in line with procedures as described to us by the manager and regional manager. This posed a potential risk that medicines could be accessed by people unauthorised to do so.

There were temperature checks in place for the designated medicine room and fridges. However we observed during the inspection that medicines trolleys were being kept in the offices on the various units throughout the day. Staff told us they were taken to the medicines rooms at night but we were unable to verify this at the inspection. No temperature checks were being conducted in these rooms to ensure medicines were not stored above recommended temperatures in line with guidance from the Royal Pharmaceutical Society. There was therefore a risk that people's medicines were not stored safely and could deteriorate.

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

Medicines were administered to people safely. People told us they received their medicines on time and as prescribed. Medicines administration records confirmed this. People's preferences for how they wished to take their medicines were recorded and their care reflected this. Controlled drugs were stored and administered safely and these processes checked. Individual risk assessments, for example with regard to any swallowing difficulty, were carried out to reduce the likelihood of risk. There were protocols for administration of medicines when people were away from the unit on day trips or for other reasons. All medicines were reviewed regularly to ensure they met any change in health needs. Allergies were clearly shown on people's records to reduce the risk of inappropriate medicines being prescribed. Regular audits of medicines were completed to monitor and reduce the likelihood of risk. These processes helped protect people from the risks associated with inappropriate use and management of medicines.

People told us they felt safe at the service. One person told us, "Yes, I do feel safe and the staff are very good to me." Another person said, "There's no harassment from anyone here." A third person commented, "I feel safe and living here is good." Relatives expressed confidence that people were safe and were positive about the care provided at the service.

Staff knew how to recognise signs of potential abuse and the relevant reporting procedures. They told us they would challenge any discrimination if they saw this happen. The provider had worked in cooperation with the local authority to carry out any safeguarding investigations. The manager had taken action to put a new procedure in place following a safeguarding alert raised by the London Ambulance Service about difficulty in gaining access via the front gate of the service at night.

Possible hazards to people were identified and guidance provided on how staff should support them to manage the risk of harm. Moving and handling risk assessments were completed and reviewed with instructions on how to support the person concerned. For people with at risk of pressure sores, monthly risk assessments were completed and relevant contributory factors such as diet were assessed and monitored. Falls risk assessments were also carried out and guidance was put in place to reduce the risk of falls for people. Re-assessments were completed following a fall and actions taken to reduce the likelihood of reoccurrence. Referrals were made to other professionals where there were concerns, for example the GP, tissue viability nurse or falls referral team.

There were systems in place to deal with emergencies. A professional fire safety risk assessment had been completed in October 2014 to ensure the service conformed to fire safety standards and no issues had been identified. There was a business contingency plan in place which gave guidance on a range of emergencies, and a grab bag with essential information and equipment was readily available. Medical emergency instructions were displayed in clinical rooms. Staff were able to describe what to do in the event of a fire or medical emergency. They told us they had regular fire drills, which records confirmed. We saw that people had personal emergency evacuation plans in place to guide staff or the emergency services.

We heard mixed views across the units about the staffing levels at the service. Some people told us there were enough staff and they did not need to wait for support. One person said, "Staff always come quickly when I ring my bell day or night." Another person told us, "Staff are busy but

Requires Improvement

Is the service safe?

there are no delays." Other people expressed a different view; one person, who had a working call bell, told us "The response to calls is slow." A second person said, "Usually it is okay but occasionally they come and say can you wait a minute as they are busy with someone else." Relatives also gave mixed views; one relative told us there were always staff available. Another said they thought at the weekends staff numbers seemed low as sometimes no staff were available in the communal areas.

During the inspection we observed that people's needs were attended to promptly and the staffing levels were as shown on the staffing rota. However, on the residential units that had two staff on duty on occasions, we observed staff were fully occupied providing support to people and were not always visible in the communal areas. For example, we saw one member of staff giving people medicines while another was comforting someone who was distressed. This meant if someone in the lounge had required help with personal care there was no one available to do this. On one unit we observed the supper time for 20 minutes. We noted there was one member of staff present as the other staff member was on a break. The member of staff served food and supplied hot and cold drinks. They told us if anyone had needed support with personal care they could ring to another floor.

The manager told us staffing levels were decided with the local authority based on the needs of people at the service, and that extra staff could be added to the rota if people developed a higher dependency level. A team leader was also available on the residential units to help with any additional needs. Agency staff were never used because the provider had a bank of staff that could be called upon at short notice to cover staff sickness. The manager and regional manager agreed to review people's dependency levels on the residential units and look at staffing levels in relation to our findings. In response to the issues raised the manager relocated the team leader to be based permanently on the larger residential unit and reorganised the emergency and respite places so that the units were more comparable in terms of levels of need.

Requires Improvement

Is the service effective?

Our findings

People and their relatives told us they thought staff understood their roles and knew what they were doing. Our findings did not always confirm these views.

There was no up to date training record available to evidence when staff had received training across all aspects of the provider's training. The manager told us a new system had been put in place but he had yet to transfer staff training records to this system. He was unable to verify what training staff had received and whether anyone's training was out of date. We asked him to verify that staff handling medicines had been trained and received refresher training. He was unable to find these records on the day but they were sent to us following the inspection. Appropriate records relating to the staff employed and management of the service were not always fully completed or kept up to date.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

When we looked at the individual training records for five staff members and the manager we found not all the provider's required annual refresher training had not been completed across all the areas the provider considered essential, such as fire safety, safeguarding and infection control. For example, there was no evidence of annual first aid refresher training for two staff members and another two people had not completed food safety refresher training or manual handling refresher training. We found that only nursing staff had received training on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) but the manager and care workers had not attended this training. Staff were not always aware of their responsibilities under the MCA Code of Practice and therefore did not have sufficient guidance to enable them to support people with decision making. For example they were unaware of how to establish if someone had capacity to make a decision. This meant that people's rights may not always be taken into account when making decisions about care and treatment.

We saw from the provider's policy on food that staff should be trained in food hygiene, nutritional assessment and review, assistance with feeding, dysphagia, and diabetes. There was no record to evidence this training was in place, although we were aware that training was provided for staff who supported specialised feeding methods. Staff confirmed they had not received training to cover the range of specific needs of all the people who used the service.

These issues were a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff told us they were experienced care staff who had worked at the service for several years. This was evidenced in staff records. They held recognised national qualifications in care. Checks were made to ensure that nursing staff kept their qualifications and registration up to date. Staff told us that they received training across a range of areas relevant to their work such as manual handling, dementia awareness, safeguarding adults and first aid. One staff member told us, "Sanctuary Care is a good employer. I feel they help me gain the necessary skills to do my job."

Staff said they felt well supported in their work through regular supervision sessions with their line manager and an annual appraisal system to monitor their development.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). We found the provider to be meeting the requirements of DoLS. There had been no applications for DoLS but the manager was able to explain the process of applying for authorisation and circumstances where it might be necessary to apply. However, some improvements were required as the manager was unaware of the supreme court judgment that has altered the definition of what may constitute a deprivation of liberty and was not therefore fully aware of his responsibilities in certain circumstances.

Mental capacity assessments had been carried out where this was appropriate, and best interests meetings were recorded where needed regarding specific decisions about people's care. For example, where people had been assessed as lacking capacity to consent to the use of bedrails their relatives had been involved in a discussion about the use of bed rails if this was felt necessary for someone's safety. People's consent to care and for other specific decisions was recorded.

We recommend that the service consider current guidance on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and respective codes of practice and take action to update their practice accordingly.

Requires Improvement

Is the service effective?

People told us they enjoyed their meals and that they had plenty to eat and drink. One person told us, "I enjoyed the lunch and I had three helpings of pudding. There is always a choice." Another person said, "The food is very nice here." We saw drinks were offered throughout the day on all the units. People were supported to make meal choices each morning and alternatives were available. There was a four weekly menu rotation to provide variety. People could choose where to enjoy their meals. We saw staff were available to support those people who needed some assistance and this was done in a relaxed and supportive way. Some people were prompted to eat as independently as possible as reflected in their care plan.

People's cultural needs were catered for with a range of different cultural dishes throughout the week. There was a separate fridge for halal food. The kitchen staff were familiar with people's individual requirements, personal preferences and any allergies or medical conditions such as the need for fortified food or different textured food if there was a risk from choking. The cook told us that she visited the units frequently to check people were happy with the food and at regular intervals people were asked to complete a survey about the food to inform the menu choices.

We saw from people's care plans that their weight was regularly monitored and that risk assessments were completed if people were identified as at risk of malnutrition. These were regularly reviewed. Referrals were also made to the dietician or to the speech and language team for guidance with swallowing and nutritional care plans provided guidance for staff on diet consistency.

Where risk of malnutrition was identified food and fluid intake charts were maintained and monitored. However, there were some gaps in the records of care and treatment delivered to people. Three of the records for recording people's food and fluid intake had not always been completed or totalled to show the full intake for each day and there were gaps in weight records for someone identified as at risk of losing weight. Accurate records were therefore not always maintained and changes in risk of malnutrition or dehydration may not have be swiftly identified and addressed.

This was also a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People and their relatives told us they had access to health professionals such as the optician and the dentist when required. The service worked with a local hospice regarding people's end of life care needs. The GP visited regularly and told us he came more frequently if necessary. He felt the staff at the service knew people's health needs well. He told us that the low staff turnover and the non-use of agency staff meant the service could work closely and consistently with him and followed any guidance given. We saw timely referrals were made to a wide range of health and social care professionals and records were kept of these appointments and outcomes. Care plans referred to people's health needs and provided information for staff about the potential impact of any health conditions on the care people required. People's health needs and preferences were kept under review.

Good

Is the service caring?

Our findings

People told us that they felt well cared for and that staff were attentive and kind. They chose where they wished to be throughout the day and said that they could get up and go to bed when they wanted. One person told us, "The staff are very considerate and don't rush me." Another person said, "I am generally very happy here." Most relatives told us staff made them feel welcome and were patient and helpful. One relative told us, "The staff do interact with residents and are very friendly towards relatives; we can come at any time." Another commented, "The staff are very caring and we are kept well informed."

We observed that staff were calm and confident in carrying out their roles. They interacted positively with people throughout the day and all the staff including the clinical lead and team leader knew people well. We saw if someone was distressed they received prompt reassurance and comfort. People were supported with their care at their own pace and were not hurried. Staff told us they encouraged people to do as much as they could independently. We saw information in people's care plans to guide staff about what people might safely manage and those areas where they required assistance. One person told us, "This place is the best. I get up when I like and all the staff are so kind and caring." People we saw throughout the day looked physically well cared for and relatives told us this was the case when they visited.

There was a detailed life history in each care plan for staff which included for example details of people's preferred name, past occupations and previous pets. Staff told us this helped them to get to know people and communicate more effectively. There were memory boxes of significant items for people and mementoes to aid memory and encourage interaction between staff and people at the service. There were also props on display throughout the service to encourage memories, such as a Punch and Judy beach scene and shopping street. People's spiritual needs were recognised and there were visits to the service from representatives of different religions.

Some people told us they were involved in planning their care. One person said, "They do ask and talk to me about my care." Another person told us. "They do talk to me about my care needs and listen to what I think." A third person commented, "I get to see my care plan and the care suits me." Relatives confirmed they were kept informed about any changes and involved in discussing any changes to the care plan. However, while people's involvement in drawing up the care plan was usually evident in the plan, people's involvement in reviews of their care was not always recorded.

We saw a number of dementia awareness sessions were advertised at the service for friends and relatives to provide them with additional information about the effects of dementia.

People told us that staff treated them respectfully and were mindful of their dignity. Our observations confirmed that nursing and care staff always knocked on people's doors and waited for a response before entering. We observed that staff were discreet when they supported people with personal care and spoke with people using their preferred names. People told us how staff respected their dignity by shutting the bedroom door and keeping the curtains drawn before starting to support them with personal care. One person said, "They do treat me with dignity; they always shut the door before attending to me." One member of staff told us, "Your heart has to be where you are working. We must treat people as we would hope to be treated."

Requires Improvement

Is the service responsive?

Our findings

People and their relatives said they felt the care delivered was individualised and suited to their needs. One person told us, "I could not walk before coming into the home, now I can walk and it is down to the staff." A relative told us. "They do give person-centred care here."

We saw that a pre-assessment of people's needs had been carried out to ensure the service could meet them. Care plans guided staff on how to provide personalised care to people. They covered a range of needs such as communication, night time care, mobility and communication. Care plans were regularly reviewed although evidence of people's and or their relative's involvement in reviews was not always recorded. Most but not all care plans had been revised to reflect a change in people's needs. However, in two people's care plans, although a change of need had been identified, for example an increased need of support with personal care, their care plan had not been updated to reflect this; although we saw that the care provided had been changed as needed. This meant staff did not have an accurate up to date guidance on how to provide care.

We saw a note in a daily record where someone had displayed a medical symptom along with the nurse's advice for treatment. However, there was no further record to show if the symptoms had continued or abated. We checked with staff and found other evidence that this had been investigated but there was no recorded outcome to establish what action had been taken and that this was no longer a concern.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We spoke with staff about people's needs and it was clear from their responses that they knew people well. They were aware of people's preferences including gender preferences for care and aspects of their previous histories. People's individual needs were recorded in an individualised way. For example, there were details of the brand of toiletries they enjoyed, their cultural or dietary needs or preferences, preferred frequency of bath or shower and preferred clothing.

We had some mixed feedback about how the service met people's needs for social contact and stimulation. Some people told us there was a good range of activities on offer. We saw people were encouraged where possible to access the local community, for example there were occasional seasonal trips to the coast or theatre. Other people told us they had not been enjoying regular activities for some time as the activities organiser was unwell. Three people spent the day in their rooms but we did not find evidence of regular activities being offered to these people. The manager told us the activities organiser had been absent unexpectedly from the service for some time. He had recently started to address the issue and organised a member of care staff to temporarily take over the activities. During the inspection we saw people were actively engaged in an arts and crafts activity on one floor. The temporary activities organiser told us they were just getting used to their role and they usually managed to get to each unit in the course of a day and would try and fit individual activities in for those who preferred this, although we were unable to evidence this during the inspection.

People and their relatives told us they knew how to complain and would do so if they needed to but it had not been necessary. One person told us, "If I had a concern, I would speak to the unit manager, they would listen to complaints." Another said, "I know I can just tell a member of staff and they will sort it out." The complaints policy included who to go to if you were unhappy with the response from the service. Complaints were responded to appropriately. We found one complaint recorded since the last inspection, which had been responded to in line with the provider's policy.

Regular 'resident' and relatives meetings had been arranged by the activities organiser but had not been held in the last three months. The manager told us they were being restarted in January once the temporary activities organiser had established themselves. The manager advertised a weekly surgery for anyone to attend with any issues. People were aware of the surgery although the manager told us no one had made use of it in recent months. People said they were sure any complaints would be taken seriously and addressed.

Requires Improvement

Is the service well-led?

Our findings

We had some mixed feedback about how well run the service was. Most people told us they felt the service was well run and organised. Most relatives said they thought staff at the service were organised, knew what they were doing and they were always made welcome. One relative said, "It's a lovely home, it's well managed." However, one relative said they thought the management of the service could be improved as they had not met the manager when they visited. Two people at the service told us they knew the unit leads well but had less contact with the manager. Six people said they felt the manager was available and approachable. They knew who he was and said he spent time speaking with them, "The manager is friendly and visits and knows everyone's names." We observed the manager was visible on each unit during our inspection and knew the names of people he was in discussion with at the service.

People were asked for their views about a number of aspects of the service. An annual survey was carried out of people who used the service and relatives, and the results of the survey were made available. There was oversight from visits from regional managers to address how the findings from the survey fed into improvements at the service.

Staff told us that they felt the service worked in a person centred way and that there were opportunities to give their views and these were listened to. Staff said the service was well managed. One staff member told us, "The manager is very good; he is very supportive and hands on." Another said, "He is fantastic and very approachable." They told us the manager visited each unit every day and held a brief catch up meeting with staff. There were opportunities for staff to raise issues that concerned them. There were twice daily handover meetings for staff to update on any changes and there was also a weekly managers' meeting for all aspects of the service. The provider had a staff council where issues were discussed across the organisation and the service was represented on the council.

The manager understood their responsibilities as registered manager and relevant notifications had been submitted to CQC as required. There were monitoring visits carried out by the regional manager and the provider's quality assurance team as well as the local authority. The local authority had last visited in March 2014 and an action plan had been identified to address issues raised at that visit. This included the installation of the new call bell system; although when this work was carried out it was only on two of the three floors. The manager told us he was unclear why the new system had not been installed on all three floors in May 2014 but we were not shown any evidence that this issue had been followed up with the provider.

There was a system of audits to monitor the quality of the service although the system required some improvement to ensure it identified issues about quality and safety consistently as the breaches of regulations we found during this inspection had not been identified by the provider before our visit.

There was an analysis of accidents and incidents available which was produced electronically on a monthly basis. This meant any possible patterns were identified and plans could be put in place to reduce reoccurrence. At the inspection no patterns had yet been identified although actions were taken on an individual basis to reduce risk. Regular health and safety checks were carried out on people's rooms and the communal areas for any maintenance issues. Infection control and medicines audits were completed regularly.

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 Treatment of disease, disorder or injury	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment **Suitable arrangements were not in place to protect service users and others against the risks associated with unsafe or unsuitable equipment.** **Regulation 16 (1) (a) and (3)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **Service users were not protected against the risks associated with the unsafe management of medicines.** **Regulation 13**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **The registered person did not have suitable arrangements in place to ensure that staff were appropriately supported to deliver care and treatment safely and to an appropriate standard through receiving appropriate training.** **Regulation 23(1)(a)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records **The registered person did not ensure that service users were protected against the risks of unsafe or**

This section is primarily information for the provider

Action we have told the provider to take

inappropriate care and treatment arising from a lack of proper information about them by the maintenance of an accurate record in respect of each service user and records appropriate to persons employed.

Regulation 20(1)(a)(b)(i)(ii)