Four Seasons (No 7) Limited

Charlton Park Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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?	**Requires Improvement**

Summary of findings

Overall summary

This unannounced inspection took place on 14 and 15 March 2017. Charlton Park Care Home is a care home service with nursing for up to 66 older people. There were 58 people using the service at the time of our inspection. We previously carried out an unannounced inspection of this service on 14 and 17 July 2015. At that inspection we found the service was meeting all the regulations that we assessed.

This inspection was prompted in part by information shared with CQC about potential concerns in relation to the arrangements for the management of risks associated with choking. The inspection was undertaken to make sure people currently using the service were safe.

Risk assessments did not provide clear guidance for staff to advice when a person was assessed as being at 'medium' risk for choking and there was no clarity about what issues needed to be taken into account to prompt a Speech and Language Therapist (SALT) referral. This could place people at potential risk of choking.
This issue was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014).

The service had an effective system and process to assess and monitor the quality of the care people received. This included audits covering areas such as the administration of medicine, health and safety, accidents and incidents, house maintenance, care plans, risk assessments, infection control, and complaints monitoring by the registered manager. We noted that improvements had been made in response to audit findings.

However, we found that the provider had not notified to the Care Quality Commission (CQC) as required, of the authorisations of Deprivation of Liberty Safeguards (DoLS) because some people required continuous supervision by staff. When asked, the registered manager told us this has been an oversight, and in future they would notify CQC in a timely manner. Also, the provider's audit had not picked up that they had not notified CQC about people's DoLS authorisations. As a result of the inspection feedback, the registered manager confirmed that in future they would complete notifications to the CQC.

This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

People who used the service told us they felt safe and that staff and the registered manager treated them well. The service had clear procedures to support staff to recognise and respond to abuse. The service had arrangements in place to deal with emergencies. The service carried out comprehensive background checks of staff before they started working and there were enough staff on duty to support to people when required. Medicines were managed, administered and stored safely.

Senior staff completed risk assessments for every person who used the service. These covered areas including manual handling, falls, eating and drinking, and skin integrity. We reviewed 10 people's risk

assessments and all were up to date with detailed guidance for staff on how to reduce identified risks.

Staff assessed people's nutritional needs and supported them to have a balanced diet. Staff supported people to access the healthcare services they required and monitored their healthcare appointments.

People and their relatives where appropriate, were involved in the assessment, planning and review of their care. Staff considered people's choices, health and social care needs, and their general wellbeing. Staff prepared, reviewed, and updated care plans for every person. The care plans were person centred and reflected people's current needs.

Staff supported people in a way that was kind, caring, and respectful. Staff also protected people's privacy, dignity, and human rights.

The service supported people to take part in a range of activities. The service had a clear policy and procedure about managing complaints. People knew how to complain and told us they would do so if necessary.

The service had a registered manager in post. There was a positive culture at the home where people felt included and consulted. People and their relatives commented positively about staff and the registered manager. Staff felt supported by the registered manager.

The service sought the views of people who used the services, their relatives, and staff to help drive improvements. The service worked effectively in partnership with health and social care professionals and commissioners.

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.

Staff completed risk assessments for every person who used the service. Risk assessments were up to date and included guidance for staff on how to reduce identified risks. However, there was no clear guidance for staff to advice when a person was assessed as being at 'medium' risk for choking, to make a Speech and Language Therapist (SALT) referral and this could place people at risk.

The service had a policy and procedure for safeguarding adults from abuse, which the registered manager and staff understood.

The service had a system to manage accidents and incidents to reduce reoccurrence.

The service had enough staff to support people. The provider carried out satisfactory background checks of staff prior to their employment.

Staff administered medicines to people safely and stored them securely.

The provider kept the premises clean and safe.

Is the service effective?

Good

The service was effective.

The service supported all staff through training, supervision and appraisals in line with the provider's policy.

Staff assessed people's nutritional needs and supported them to have a balanced diet.

People who used the service commented positively about staff and told us they were satisfied with the way they looked after them.

The registered manager and staff knew the requirements of the

Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, and acted according to this legislation.

Staff supported people to access the healthcare services they needed.

Is the service caring?

Good

The service was caring.

People who used the service and their relatives told us they were happy with the service. They said staff were kind and treated them with respect.

People were involved in making day to day decisions about the care and support they received.

Staff respected people's choices, preferences, privacy, dignity, and showed an understanding of equality and diversity.

Is the service responsive?

Good

The service was responsive.

Staff assessed people's needs and developed care plans which included details of people's views.

Care plans were regularly reviewed and up to date. Staff completed daily care records to show what support and care they provided to each person.

Staff met people's need for stimulation and social interaction.

People knew how to complain and would do so if necessary. The service had a clear policy and procedure for managing complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The service had system and process to assess and monitor the quality of the care people received. The service used learning from audits to identify areas in which the service could improve.

However, we found that the provider had not notified to the Care Quality Commission (CQC) as required, of the authorisations of

Deprivation of Liberty Safeguards (DoLS) because some people required continuous supervision by staff.

People who used the service commented positively about the registered manager and staff.

The service had a positive culture. People and staff felt the service cared about their opinions and included them in decisions about making improvements to the service.

The registered manager held meetings with staff which helped share learning and ensure that staff understood what was expected of them at all levels.

Charlton Park 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 was prompted in part by the information shared with CQC about the potential concerns indicated in relation to the arrangements for the management of choking risk assessments for people using the service. The inspection was undertaken to make sure people using the service were safe.

Before the inspection we looked at all the information we held about the service. This information included the statutory notifications that the service sent to the Care Quality Commission. A notification is information about important events that the service is required to send us by law. We also contacted health and social care professionals and the local authority safeguarding team for feedback about the service. We used this information to help inform our inspection planning.

This inspection took place on 14 and 15 March 2017 and was unannounced. This service was inspected by specialist advisor, one inspector and an expert by experience on 14 March 2017. One inspector and an expert by experience returned to the service on 15 March 2017 to complete the inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We spoke with 16 people who used the service and seven relatives, nine staff, the deputy manager, the registered manager, the regional manager, and three external health and social care professionals. Not everyone at the service could communicate their views to us so we 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 at 10 people's care records and nine staff records. We also looked at records related to the management of the service such as details about the administration of medicines, complaints, accidents and incidents, safeguarding, Deprivation of Liberty Safeguards, health and safety, and quality assurance and monitoring.

Requires Improvement

Is the service safe?

Our findings

People who used the service and their relatives told us they felt safe and that staff and the registered manager treated them well. One person told us, "Yes, I feel very safe. It is nice here." Another person said, "This place is very good. The staff are very nice and friendly." One relative commented, "I don't have any concerns. I don't feel my loved one is vulnerable." People appeared comfortable with staff and those who could, approached them when they needed something. We saw staff supported people to adjust their sitting positions and encouraged movement in a safe manner in the communal area.

Staff completed risk assessments for every person who used the service. These covered areas including manual handling, falls, eating and drinking, and skin integrity. We reviewed 10 people's risk assessments and all were up to date with detailed guidance for staff on how to reduce identified risks. For example, where people had been identified as being at high risk from choking, a risk management plan had been put in place which identified the type of food and the level of support people needed to reduce the level of risk. We observed during the lunch time that people were getting the correct diet when needed. We also noted that staff sought advice from the Speech and Language Team (SALT) where a person had been identified as having swallowing difficulties. In another example, we saw staff regularly repositioned people where their skin integrity had been identified as an area of risk because of their immobility. This was confirmed when we reviewed completed daily monitoring charts. There was a concern about one person who was assessed as being at 'moderate risk of choking' and their own food being brought in by their family members. The registered manager told us that currently, there was no person living at the home with their own food being brought in by their families. They further said should there be a situation; the service would follow the food management guidelines in line with the provider's policy about food safety management.

However, there was no clear guidance for staff when a person was assessed as being at 'medium' risk for choking, to make a Speech and Language Therapist (SALT) referral and this could place people at risk. For example, the provider's policy stated, 'consideration' should be given to referral to when a person was being assessed at medium risk of choking. A registered nurse told us, when a person was assessed as being at 'low risk for choking', they did not do a SALT referral but the GP was consulted; for a person being assessed as at 'high risk of choking', and they immediately made a SALT referral. However, for a person identified as being at 'medium risk of choking', the nurse said staff 'considered' making a referral on the basis of identified risks. Nevertheless, there was no clarity about what issues needed to be taken in to account to prompt a SALT referral, and this could place people at potential risk of choking. The service had not taken sufficient steps to mitigate risks and provide staff with clear guidance.

This issue was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014).

We drew our concerns to the attention of the registered manager who told us when a person was identified as at being of 'medium risk of choking, if a SALT referral was not made, an explanation would be clearly documented in the care records to explain why no SALT referral was required at this stage and this would be discussed in staff meetings.

The service had a policy and procedure for safeguarding adults from abuse. The registered manager and staff understood the types of abuse, and the signs to look for. Staff knew what to do if they suspected abuse had occurred. This included reporting their concerns to the registered manager, the local authority safeguarding team, and the Care Quality Commission (CQC). One member of staff told us, "If I come across any safeguarding incident, I report to the manager or if necessary to a social worker and local authority safeguarding team." Staff we spoke with told us, and records confirmed that they had completed safeguarding training. They were aware of the provider's whistle-blowing procedure and said they would use it if they needed to. One member of staff told us, "I'm aware about the whistle-blowing policy and procedures. If anyone is mistreated, I shall follow it."

The provider maintained records of safeguarding alerts and monitored their progress to enable learning from the outcomes when known. The registered manager sought external professional's support and implemented service improvement plans to make sure people's needs were met safely. For example, safety measures had been reviewed for a person and appropriate alarm equipment was put in place to alert staff if the person was trying to leave the premises. The service worked in cooperation with the local authority and the police where necessary in relation to safeguarding concerns, and notified the CQC of any allegations received in line with the requirements of the regulations. At the time of this inspection there were two safeguarding concerns being investigated by another authority. We cannot report on the outcome of these investigations at this stage but will continue to monitor the progress. In the interim, the provider had carried out a review of all the people with the risk of choking and staff followed the choking risk management plans, to ensure that people's needs were met safely. However, we found some improvements required to this.

The service had a system to manage accidents and incidents to reduce the risk of them happening again. Staff completed accidents and incidents records. These included details of the action staff took to respond and minimise future risks, and who they notified, such as a relative or healthcare professional. The registered manager reviewed each incident and monitored them, taking action to manage risks where needed. For example, when a person had a fall when walking down the corridor and lost balance, the GPs help was sought and a referral to the falls team was made and the person was put on observation by staff every 30 minutes to ensure their safety. In another case, when a person who was nursed on a low bed with a crush mattress next to their bed, was found on the crush mattress during hourly checks by the night staff. The service arranged a best interests meeting with the family and GP and decided to put bedrails for their safety and the need for bed rails was reviewed monthly. Actions to reduce future risks as well as how to manage accidents and incidents were also discussed in staff meetings.

The service had enough staff to support people safely in a timely manner. One person told us, "When I'm in my room, if I need to, I use a bell-push. Someone [staff] come to see and ask what you want, I feel safe." Another person said, "When I use the buzzer, they [staff] are very quick, they come in about a minute." The registered manager monitored call bell response times to ensure calls were answered promptly. We saw staff responding to people's needs in a timely manner. The registered manager carried out a dependency assessment to identify staffing levels required to meet the needs of people using the service. The dependency assessment was kept under regular review to determine if the service needed to change staffing levels to meet people's needs. The staff rota showed that staffing levels were consistently maintained to meet the assessed needs of the people and that staffing levels increased in line with changes in people's needs where required.

The service carried out comprehensive background checks of staff before they started work. These checks included details about applicants' qualifications and experience, their employment history and reasons for any gaps in employment, references, a criminal records check, health declaration, proof of identification, and registration of qualified nurses with their professional bodies. This meant people only received care

from staff who were suitable for their roles.

Staff kept the premises clean and safe. The provider had procedures in place in relation to infection control and cleanliness of the home and these were followed by staff. Staff were clear about the infection control procedure in place at the home and explained how they cleaned each bedroom and communal areas to maintain cleanliness standards. Staff and external agencies, where necessary, carried out safety checks for environmental and equipment hazards such as hoists, and safety of gas appliances.

The service had arrangements to deal with emergencies. The service carried out regular fire drills and records we saw confirmed this. Staff completed personal emergency evacuation plans (PEEP) for every person who used the service. These included contact numbers for emergency services and provided advice for staff on what to do in a range of possible emergency situations. Staff received first aid and fire awareness training so that they could support people safely in an emergency.

Staff supported people to take their medicines safely. One person told us, "I have medication when I need it, the staff are pretty obliging." Another person said, "Medicine. Yes, it comes on time." The provider trained and assessed the competency of staff responsible for the administration of people's medicines. We saw a registered nurse administered medicine to people safely. For example one person, who was having their medicines administered covertly, we found in their best interests the service had sought advice from the healthcare professionals and agreed on how to administer medicine covertly. People's Medicines Administration Records (MAR) were up to date and accurate. They showed that people had received their medicines as prescribed and remaining medicine stocks were reflective of the information recorded. Medicines were stored securely including controlled drugs. Staff monitored fridge and room temperature to ensure that medicines were stored within the safe temperature range. A registered nurse conducted weekly medicine management audits and shared any learning outcomes with staff to ensure people received their medicine safely.

Good

Is the service effective?

Our findings

People were supported by staff who had the skills and knowledge to meet their needs. One person told us, "Yes, they [staff] work very hard and they do look after me very well." Another person said, "I have help with cutting up my food." We saw staff assisted people who required with cutting up food and made sure their dietary needs were attended to.

Staff completed training relevant to their roles and responsibilities. One member of staff told us, "All my training is up to date, and they are very helpful in improving my skills." Staff told us they completed comprehensive induction training developed by the provider, when they started work. A senior member of staff told us, "At the time of the induction, I tell all the new staff, you look at residents as your mother, father, grandmother or grandfather you care, you have to care." They further said, "All the staff we have now are dedicated, they care for people, they look after them well." The registered manager told us all staff completed mandatory training identified by the provider. The training covered areas from food hygiene, infection control, equality and diversity, health and safety, to moving and handling, management of medicines, catheter care, the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and English language communication lessons for those who required it. Staff told us the training programmes enabled them to deliver the care and support people needed. The service provided refresher training to staff and training records we saw confirmed this.

Records showed that staff were supported in their roles through regular supervision and a yearly appraisal. One member of staff told us, "I get supervisions once every two months and they are helpful." Staff told us that areas covered in supervision included their wellbeing and sickness absence, roles and responsibilities, and training and development plans. They said they felt supported and were able to approach their line manager, or the registered manager, at any time for support.

Staff asked for people's consent to their care. Records clearly evidenced people's choices and preferences about their care provision. Staff we spoke with understood the importance of gaining people's consent before they supported them. For example, prior to offering support with giving people a shower or wash.

The Mental Capacity Act 2005 (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 they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. 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 and hospitals 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. The registered manager knew the conditions under which an authorisation may be required to deprive a person of their liberty in the best interests under DoLS. Records showed that appropriate applications had been made, and authorisations

granted by the relevant 'Supervisory Body' to ensure people's freedoms were not unduly restricted.

Records showed that people's mental capacity had been assessed relating to specific decisions about the support they received where staff suspected they may not have capacity to make the decision for themselves. Assessments had been completed in accordance with the requirements of the MCA. Where people had been assessed as lacking capacity we saw that the relevant decision had been made in their best interests, with the involvement of staff, relatives and/or healthcare professionals, where appropriate. For example about their specific healthcare needs in relation to having bed rails and staff administering medicines covertly for those who needed.

Staff assessed people's nutritional needs and supported them to have a balanced diet. People told us they had enough to eat and drink. One person who used the service told us, "The food is good here, you normally get two choices." A relative said, "They [staff] help with food at mealtimes, my [loved one] is always the last one in the dining room, they [staff] don't rush her." Another relative commented, "My [loved one] has a good appetite, she has put on weight, so I know this is the right place for her. She was very thin and poorly before coming here."

Staff recorded people's dietary needs in their care plan and shared the information with kitchen staff to ensure people received the right kind of diet in line with their preferences and needs. We saw that a range of dietary needs were met by the service. For example, the service catered for people who needed soft diets, thickened fluids and fortified diets, and a healthy balanced diet for people with a particular health condition. The service protected people from the risk of malnutrition and dehydration. One member of staff told us, "We refer people to a dietician only when the person crosses the benchmark based on the Multi Universal Nutrition Screening Tool (MUST) score, until then we seek advice from the GP and manage with fortified food and homemade milk shakes, and regularly monitor people's food and fluid intake, and check their weight as required." Records we saw showed that where risks were identified, staff completed food and fluid charts to monitor people's intake and took further action if required. We noted that staff sought advice from the dietician where a person had been identified as losing weight.

We carried out observations at lunch time. We saw positive staff interactions with people. The dining room atmosphere was relaxed and not rushed. There were enough staff to assist people and we saw them provide appropriate support to people who needed help to eat and drink. Staff made meaningful conversation with people, and helped those who ate slowly, encouraging them to finish their meals.

Staff supported people to access healthcare services. We saw the contact details of external healthcare professionals, such as specialist departments in the hospital, GP, dentist, district nurses, and podiatrist in every person's care record. Staff completed health action plans for everyone who used the service and monitored their healthcare appointments. The staff attended healthcare appointments with people to support them where needed. An external healthcare professional told us the registered manager and her team did a good job with the care they provided to people who used the service and that they were happy with the service.

Good

Is the service caring?

Our findings

People told us they were happy with the service and that staff were kind and treated them with respect. One person told us, "Staff are lovely, all of them. They all care about us" Another person said, "Staff are kind and very respectful and caring." A relative commented, "If they [staff] were not looking after my loved one well, I wouldn't even know because my loved one has a health condition and can't tell me. The fact that they [staff] always call me about every incident, even though I would be none the wiser, shows how much they care."

We observed that staff had good communication skills and were kind, caring and compassionate. Staff talked gently to people in a dignified manner. They encouraged and supported people who required assistance with snacks. They knew each person well and pro-actively engaged with them, using touch as a form of reassurance, for example by holding people's hands and maintaining eye contact, which was positively received.

Staff involved people and their relatives where appropriate in the assessment, planning and review of their care. The registered manager told us they had involved relatives where appropriate in the care reviews and care planning process. Care records we saw confirmed this.

Staff completed end of life care plans where this was necessary to ensure people's wishes were met. An external healthcare professional told us that the registered manager and clinical team are good and they do a good assessment of people's needs. They sought timely support from the GP, palliative care team and the hospice as appropriate. Records we saw confirmed this. Staff completed Do Not Attempt Cardiopulmonary Resuscitation (DNAR) forms with the engagement of the person concerned, their relative where necessary, and by their general practitioner.

Staff respected people's choices and preferences. For example, where people preferred to spend time in their own rooms, or in the lounge, we observed this happened. We saw that staff regularly checked on people's wellbeing and comfort. One member of staff told us, "One person doesn't like water or juice, but only tea, so I give them tea." We saw staff ensured people's personal belongings were within their reach. Staff could tell us people had preferred forms of address and how some people requested staff use their preferred first name. These names were recorded in their care plans and used by staff. Relatives told us they were free to visit at any time and that all were made welcome.

Staff respected people's privacy and dignity. One person told us, "Yes, they [staff] respect my dignity." Another person said, "They [staff] always close the door before they get me undressed." One relative commented, "They [staff] are kind, tactful and respect dignity of my loved one." We saw staff knocked and waited for a response before entering people's rooms, and they kept people's information confidential. We noticed people's bedroom doors were closed when staff delivered personal care. People were well presented and we saw how staff helped people to adjust clothing to maintain their dignity. Records showed staff received training in maintaining people's privacy and dignity.

Staff encouraged people to maintain their independence. One person told us, "They [staff] lend a hand

where needed when I'm dressing, but some of us are quite able anyway." One member of staff said, "If a person is able to walk short distances, I encourage them including eating by themselves." Staff prompted people where necessary to wash, dress and undress, eat and drink, and brush their teeth.

Staff showed an understanding of equality and diversity. Staff completed care records for every person who used the service, which included details about their ethnicity, preferred faith, culture and spiritual needs. The registered manager told us that the service was non-discriminatory and that staff would always seek to support people with any needs they had with regards to their disability, race, religion, sexual orientation or gender. Staff we spoke with confirmed that people were supported with their spiritual needs where requested. For example, staff encouraged visitors from the local church to come and interact with people in their individual rooms for people who were interested.

Good

Is the service responsive?

Our findings

People received care and support that met their needs. One person told us, "Staff are very obliging, whatever we ask, they do it quickly." We saw staff responding to people's needs in a timely manner. For example, when one person had difficulty drinking tea by themselves staff attended to them immediately. We also saw staff responded to people by adjusting their sitting positions, encouraging movement, and regularly checking on their wellbeing and comfort.

Staff supported people to follow their interests and take part in activities. One person told us, "sometimes we have games, one day this week we had bingo, on Tuesday they have a hairdresser here, and I'm going to have a perm." A member of staff told us that they ask residents what they would like to do and built programmes to suit them. Activities on offer included Church services, musical events, pampering sessions, quizzes, arts and crafts sessions and external entertainers. We noted that these activities had a positive effect on people's wellbeing. For example, we observed people enjoying music on one day of our inspection. They responded positively to the performance, with some people clapping along to the music.

Staff carried out a pre-admission assessment of each person to see if the service was suitable to meet their needs. Where appropriate, staff involved relatives in this assessment and they used this information as a basis for developing personalised care plans to meet each person's individual needs.

Care plans contained information about people's personal life and social history likes and dislikes their interests and hobbies, their health and social care needs, allergies, family and friends, and contact details of health and social care professionals. One relative commented, "Yes, I'm aware of the care plan and the care plan is in my loved one's room and we can access it and we can comment if required." Care plans also included the level of support people needed and what they could manage to do by themselves. Senior staff updated care plans when people's needs changed and we noted that plans included clear guidance for staff on the level of support each person required. For example, for people who required it, staff monitored their food and fluid intake and weight. All of the care plans we reviewed were up to date and reflective of people's current needs.

Staff completed daily care records to show what support and care they provided to each person. They also maintained a record which listed the specific tasks for the day such as who required a weight check, fluid and food intake monitoring, hourly checks, repositioning of people in the bed and skin care management. Staff discussed the changes to people's needs during the daily shift handover meeting and staff team meeting, to ensure continuity of care. The service used a communication log to record key events such as changes to health and healthcare appointments for people, to ensure their needs were met in a timely manner.

People and their relatives told us they knew how to complain and would do so if necessary. One person told us, "Well, you can really talk to them about any concerns." One relative said, "If I have a concern, staff will stop and listen. The manager and the deputy are very pleasant." The service had a clear policy and procedure about managing complaints. We saw information was displayed in the communal areas about

how to make a complaint and what action the service would take to address any concerns received. The registered manager had maintained a complaints log, which showed that they had investigated any complaints when concerns had been raised, and responded to them in a timely manner. These were about care issues. For example, staff had not involved relatives when changes were made to their loved one's care plan. The registered manager told us they discussed with relatives and had not received any complaints after these concerns had been raised and the records we saw confirmed this.

Requires Improvement

Is the service well-led?

Our findings

The service had system and process to assess and monitor the quality of the care people received. This included audits covering areas such as the administration of medicine, health and safety, accidents and incidents, house maintenance, care plans, risk assessments, infection control, and complaints monitoring by the registered manager. We noted that improvements had been made in response to audit findings. These included care plans and risk assessments being brought up to date, and medicines were managed safely.

Although the manager understood most of their responsibilities as a registered manager, they failed to notify to the Care Quality Commission (CQC) as required, of the authorisations of Deprivation of Liberty Safeguards (DoLS) because some people required continuous supervision by staff. When asked, the registered manager told us this has been an oversight, and in future they would notify CQC in a timely manner. As a result of the inspection feedback, the registered manager confirmed that in future they would ensure to complete notifications to the CQC.

This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

People and their relatives commented positively about staff and the registered manager. The atmosphere in the home was calm and friendly, and we saw meaningful interactions between staff, people and their relatives. One person told us, "I think the home is well managed." One relative said, "We had family meetings, the manager is very engaging, able to approach, they knew all the residents here and their relatives." A visiting healthcare professional commented, "The service has been good, because of the manager and the staff in the last two years."

We saw the registered manager interacted with staff in a positive and supportive manner. Staff described the leadership of the service positively. One member of staff told us, "The manager supported me when I was not sure about something for example, when there was confusion in relation to some information from the family about their loved one's appointment with a healthcare specialist, the manager sorted it out quickly." Another member of staff said, "When I was not able to arrange replacement staff due to short notice of a regular member of staff absence, the manager joined the floor to support us." A third member of staff said, "The manager's door is always open, willing to listen, and is strict and fair."

The service had a positive culture, where people and staff felt the provider cared about their opinions and included them in decisions. We saw a staff feedback survey from 2016 and found that most of the responses were good. For example, staff felt proud to work at the care home, had clear expectations of their roles and responsibilities and were encouraged to learn from other colleagues. The registered manager told us that staff retention had improved which ensured continuity of care to meet people's needs. The registered manager held regular staff meetings, where staff shared learning and good practice so they understood what was expected of them at all levels. Records of the meetings included discussions of any changes in people's needs and guidance to staff about the day to day management of the service, coordination with health and social care professionals, and any changes or developments within the service.

The service worked effectively in partnership with health and social care professionals, commissioners, members of safeguarding team at the local authority, community mental health team, GP, hospice, speech and language therapist, and the hospital. Care records we saw confirmed this. Health and social care professionals told us that the standards and quality of care delivered by the service to people was good and that they were happy with the management and staff at the service.

The registered manager encouraged and empowered people to be involved in service improvements through feedback surveys and residents' and relatives meetings. We found that most of the responses were positive. The areas covered in feedback surveys included quality of the care provided, food and menu choices, content and quality of activities, and the quality of staff interactions with people and their relatives. The registered manager told us that any suggestions from the feedback survey were discussed in the residents and relatives meeting and improvements were carried out. For example, about the range of activities people would like to do, redecoration of the premises, food and menu choices. Residents and relatives meeting records we saw confirmed this.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider failed to notify the Care Quality Commission (CQC) as required, of the authorisations of Deprivation of Liberty Safeguards (DoLS).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There was no clear guidance for staff when a person was assessed as being at 'medium' risk for choking, to make a Speech and Language Therapist (SALT) referral.