AJ & Co.(Devon) Ltd

Meadowside and St. Francis

Inspection report

5 Plymbridge Road
Plympton
Plymouth
Devon
PL7 4LE

Tel: 01752347774
Website: www.pendruccombe.co.uk

Date of inspection visit:
14 April 2016
15 April 2016
19 April 2016
03 May 2016

Date of publication:
12 July 2016

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 14,15,19 April and 3 May. The first day of the inspection was unannounced. We last inspected Meadowside and St Francis on 25 June 2014 and found no concerns.

The service provides care for older people and people with a physical disability and can provide care for up to 69 people. Meadowside and St Francis is registered to provide nursing and residential care. When we inspected, 66 people lived at the service.

A registered manager was employed to manage the service locally. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found aspects of medicine management were not always safe. We found it was not always clear whether people had been given all their medicines at the right time.

People's risk assessments and care plans did not always accurately reflect their needs or the care they required. Some care plans were detailed, but staff did not always follow the guidance in the care plans, for example regarding diabetes management. This placed people at risk. We found care records were not always updated promptly as people's needs changed. This meant there was the risk of people not receiving care according to their care plan. In addition, people's end of life care was not consistently planned and delivered to reflect their needs and preferences. People did not always have personalised end of life care plans.

The legal requirements of the Mental Capacity Act (2005) were not always followed. Assessments had not been requested by the service to ensure people were not being deprived of their liberty unlawfully. Staff were due to receive training on the Mental Capacity Act (2005) and associated Deprivation of Liberty Safeguards (DoLS) to improve their understanding of these laws which protect people's human rights. Staff however asked people for their consent as they provided care and treatment.

Audits were undertaken but these had not identified the areas we found required improvement during this inspection. People's views on the service were sought by the provider.

We found people who had more complex needs would benefit from a more individualised approach to keeping them stimulated. Group activities were enjoyed by many and included visiting animals, garden fetes, seasonal events such as horse racing and musical entertainment.

Staff were recruited safely.

People and relatives knew how to raise complaints and the service had a process for managing complaints.

We found complaints were investigated and responded to.

People told us they enjoyed the food and people had their dietary needs met. Meals were a social event and people enjoyed the company of others whilst eating in the conservatory and dining room.

Staffing levels were flexible and based upon people's needs and occupancy at the home. People and staff told us there were enough staff on duty and if there was sickness every effort was made to replace staff.

The service was clean and we saw staff followed infection control guidance.

People told us they felt safe. The service was well maintained and decorated. The staff team worked hard to create a home from home environment.

The leadership within the home was keen to provide a quality service. The registered manager was approachable and visible within the home.

We found a number of breaches of the regulations. You can see what action we told the provider to take at the back of the full version of the report.

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 always safe.

People were not always protected from the risks associated with their care needs and documentation relating to people did not always accurately reflect their needs.

People did not have all aspects of their medicines managed safely.

Staff were recruited safely to protect people.

Staff knew what action to take if they suspected abuse was taking place.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not always assessed in line with the Mental Capacity Act 2005 as required. Staff however always asked for people's consent and respected their response.

People's nutritional and hydration needs were met.

People saw a range of health and social care professionals but some told us instructions were not always followed.

People were looked after by staff trained to meet their needs however training updates were required in specialist areas of care.
People's nutritional and hydration needs were met.

Is the service caring?

Requires Improvement

The service was not always caring.

People's end of life care was not consistently planned and delivered to reflect their needs and preferences. People did not always have personalised end of life care plans.

People were looked after by staff who treated them with

kindness and respect. People and visitors spoke well of staff. Staff spoke about the people they were looking after with fondness.

People who were able, felt in control of their care.

People said staff protected their dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive. People did not always have care plans in place which reflected their current needs.

Personalised activities would benefit those unable to engage in group activities. Group activities were provided to keep people physically, mentally and socially active. People's religious needs were met.

People's concerns were listened to and the service had a complaint's policy in place.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The service's internal quality monitoring processes had not identified the issues we found during this inspection.

Systems and processes required improvement to ensure audits were identifying potential problems within the service related to medicine management, care planning and records keeping. The service required improvement to remain up to date with changes in health and social care legislation which affected staff and people's care.

People and staff felt the registered manager was approachable. The registered manager had developed a culture which was open and inclusive.

People and staff said they could suggest new ideas. People were kept up to date on developments in the service and their opinion was requested.
There were contracts in place and maintenance staff employed to ensure the equipment and building were maintained.

Meadowside and St. Francis

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.

The inspection took place on 14,15,19 April and 3 May 2016 and the first day was unannounced. .

The inspection team was made up of two inspectors for adult social care, a pharmacist inspector, a specialist nurse advisor 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 care service).

Prior to the inspection we reviewed the records held on the service. This included the Provider Information Return (PIR) which is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed previous inspection reports and notifications. Notifications are specific events registered people have to tell us about by law.

During the inspection we spoke with 24 people and 7 relatives. We reviewed 8 records in detail and spoke with people and staff caring for them where we could. This was to ensure they were receiving their care as planned. We observed how staff interacted with people. We also spoke with 8 staff and reviewed 10 personnel records and the training records for all staff. We were supported on the inspection by the registered manager.

Other records we reviewed included the records held within the service to show the registered manager reviewed the quality of the service. This included a range of audits, questionnaires to people who live at the service, minutes of meetings, newsletters and policies and practices.

Prior to the inspection we spoke to the local authority quality team and during the inspection we spoke with a social worker, a physiotherapist and a district nurse.

Requires Improvement

Is the service safe?

Our findings

People's medicines were not always managed safely. Medicines requiring extra security were stored safely, however regular checks of these medicines to ensure they were all accounted for, were not being recorded. We checked the number of some of these medicines in stock at the inspection and they were found to be correct.

People could look after all of their own medicines, and two people were doing this at the time of the inspection. There was a policy and paperwork available to record whether this had been assessed as safe for them. We saw that this was completed for one person but the other person had no recorded risk assessment to show that staff had assessed if this was suitable and safe for this person.

Medicines record charts were generally well completed; however one person had a gap in their medicine chart for the morning of the inspection. Another person had a dose of medicine signed as being given at lunchtime on the same day but the doses were still in the pack. This means it was not possible to be sure if these people had been given their medication in the way prescribed for them.

We checked the records of three people who were prescribed medicine that required regular blood checks and changes in dose as a result of these checks. One person had clear written prescription instructions which had been faxed from the GP surgery. One person had faxes of previous dosages but no written confirmation of the current dose. The third person had entries in their daily care records where doses had been phoned through from the GP and no follow up in writing had been obtained. This is not safe practice as nurses giving these doses had no way to clearly check what dose had been prescribed.

External items, such as creams, were applied by care staff. Directions for staff as to where and how skin creams should be applied were not always clear. On St Francis unit there were no systems in place for staff to record accurately which products were being applied. This meant it was not possible to be sure whether people were having these products applied correctly in the way prescribed for them.

There was an audit trail of medicines received into the home and those sent for destruction. This helped to show how medicines were managed and handled in the home. Audits were completed to help check that medicines were managed correctly; however not all of the issues we saw had been picked up or acted upon by staff. We were told that staff had all received updated training on medicines handling recently, however there had been no competency checks to make sure they had the skills to give medicines safely. We were told that a system for checking competencies of staff to make sure they could give medicines safely was about to be introduced and we saw the forms that were planned to be used.

We observed medicines being administered to people at lunchtime, and saw that they were given by a safe method. People were asked if they needed any medicines that were prescribed to be taken 'when required', for example pain killers. Policies and procedures were available for staff. There was a homely remedies policy in place, and suitable supplies available, which meant staff could respond to minor symptoms for people without delay. Information on medicines was available for staff and residents.

Risk assessments and care plans were in place to support people to live safely at the service. However we found these were not always reflective of people's identified needs. For example one skin care assessment said the person's skin was intact, but the person's daily notes said they had sore, open skin on parts of their body. This meant the risk assessment did not reflect their condition or provide up to date guidance to staff on how to mitigate the risks to them.

Another person had recently had complex bowel surgery and was receiving Total Parenteral Nutrition(TPN) with little oral intake. However they did not have a complete nutritional assessment in place or a care plan for managing their increased nutritional needs since surgery. A specialist team visited twice a day to set up and disconnect the TPN but there was no care plan or guidance in place for staff on what to do if there were an emergency in between their visits. This feed was accessed through the central arterial system so the risk could be life threatening if the port was compromised.

A further person was on end of life care. They had been at the home for a week but had no care plans or risk assessments in place to advise staff how to meet their needs. This meant their potential risks of falls, skin damage or weight loss were not known to staff.

Not keeping accurate and contemporaneous notes including care plans and risk assessments is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Another person with complex health needs had unstable diabetes. They had a care plan written by a specialist diabetes nurse and instructions from the person's doctor on what to do if the person's blood sugar went too high. We found between 7 March and 21 March there were 15 occasions when the person's blood sugar had been too high and specialist guidance had not been followed. This placed the person at risk of ketosis (Ketosis is a metabolic state in which most of the body's energy supply comes from ketone bodies in the blood) and can be serious in a person with diabetes.

Care and treatment was not always provided in a safe way. People's risks were not always assessed and guidance regarding people's care was not always followed. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were recruited safely. The necessary checks were carried out to ensure staff were safe to work with vulnerable people.

People told us they felt safe living at Meadowside and St Francis. People felt comfortable speaking with staff and told us staff would address any concerns they had about their safety. Visitors also felt it was a safe place for their family member to live.

People were looked after by staff who understood how to identify abuse and what action to take if they had any concerns. Staff said they would listen to people or notice if people's physical presentation or emotions changed that might be a sign something was wrong. Staff would pass on concerns to the registered manager. All staff felt action would be taken in respect of their concerns. Staff said they would take their concerns to external agencies, such as CQC, if they felt concerns were not being addressed.

There were sufficient staff to meet people's needs safely. The registered manager had systems which were flexible to ensure staffing levels were safe and in line with people's needs. People told us there were enough staff. Staff told us there were enough staff for them to meet people's needs safely.

All prospective staff completed an application and interview. In this process, prospective staff's attitude and

values were assessed alongside any previous experience. New staff underwent a probationary period to ensure they continued to be suitable to carry out their role.

People's needs were considered and met in the event of an emergency situation such as a fire. Staff at the home had participated in fire training and regular fire drills took place.

Regular health and safety checks had been undertaken and equipment was regularly serviced, ensuring this equipment was safe and fit for purpose. Most routine maintenance was carried out by the maintenance man. Staff confirmed faulty items were reported and repaired promptly.

Staff followed good infection control practices. We observed hand washing facilities were available for staff around the service. Staff were provided with gloves and aprons. Staff explained the importance of good infection control practices and how they applied this in their work. Audits were in place. Housekeeping meeting minutes indicated there were clear policies and practices; and the registered manager ensured appropriate contracts were in place to remove clinical and domestic waste.

Requires Improvement

Is the service effective?

Our findings

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA) and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager understood their responsibilities under the MCA and had attended training. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When 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. Records did not always demonstrate MCA assessments were taking place as required.

People who may be deprived of their liberty had not been assessed properly, which meant their human rights may not be protected. 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). Not all people who may be subject to Deprivation of Liberty Safeguards applications (DoLS) had been assessed. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. Many people living at the home were under constant supervision and control and not free to leave.

The legislative framework of the Mental Capacity Act (MCA) 2005 and associated Deprivation of Liberty Safeguards (DoLS) were not always being followed. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us staff always asked for their consent before commencing any care tasks. We observed staff ask for people's consent and give them time to respond at their own pace. This included administering medicines and personal care. Staff offered to come back later if the person did not want the care at that time. Staff told us people's care was discussed with a range of professionals and the family where appropriate to ensure decisions were made in the people's best interest. Staff were given clear guidance in the care plans on when they were acting in people's best interest.

Staff told us they felt trained to carry out their role effectively. The registered manager had systems in place to ensure all staff were trained in the areas identified by the provider as mandatory subjects. This included first aid; fire safety; manual handling; safeguarding vulnerable adults; infection control and food safety. Staff were trained in additional areas to meet the specific needs of people living at the service for example skin care and continence. However, the competency checks and training in specialist areas of care such as tracheostomy care and PEG feeding had lapsed. A tracheostomy is an opening created at the front of the neck so a tube can be inserted into the windpipe (trachea) to help a person breathe. Percutaneous endoscopic gastrostomy (PEG) is an endoscopic medical procedure in which a tube (PEG tube) is passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate).

Staff were supported to gain qualifications in health and social care, for example some staff had recently

completed the new nursing assistant course. Staff had regular supervision, appraisals and checks of their competency, to ensure they continued to be effective in their role. Additional supervision was offered for any staff that required it and any staff performance concerns were reviewed by the registered manager.

New staff underwent an induction when they started to work at the service. New staff shadowed other experienced staff. The service was aware of the Care Certificate. The Care Certificate has been introduced to train all staff new to care to a nationally agreed level.

Most people had their nutritional and hydration needs met in a person centred way. One person with sensory needs, who we met at lunch, was eating their food with their fingers as it had not been cut up to help them eat it. Their relative informed us staff often forgot to cut up their food. Another person was cross that they had been given a meal they had told staff they did not want. Staff offered this person a different meal. Most people and relatives we spoke with were very happy with the meals provided commenting "I like it when they bring me a drink because they know exactly how I like my tea, it's perfect"; "All the staff seem to know how to look after me, they are wonderful"; "You always get a choice at mealtime and if there is something I don't fancy, the chef has told me just to mention it and he'll make me something else"; "They make the best cup of coffee in the world and there's a variety of meals" A relative told us "The staff bring bananas and biscuits up to my relative's room if he doesn't fancy eating much."

Staff looked for creative ways to ensure people had enough to eat and drink. People's likes and dislikes were sought from them or staff learned them by experience. People's special dietary needs were catered for. People could contribute ideas to the menu. People had access to fluid and snacks when required. People who could not help themselves were supported by staff to have regular food and fluid intake. Any concerns were acted on immediately. For example, people who were losing weight, or were observed by staff to struggle to eat certain foods, were referred for assessments with their consent. Guidance given was then followed to support the individual person.

Feedback from professionals was mixed and one physiotherapist we spoke with was concerned people were not always supported by staff with their recovery or rehabilitation needs. One person we spoke with who had mobility needs and instructions in place from the physiotherapist, confirmed they had not been supported with their exercises and their care records did not evidence attempts had been made to assist the person with these prescribed exercises. The purpose of these exercises was to help the person maintain their strength for surgery and to enable them to return home. We also saw other health professional advice was not always followed as directed, for example diabetes management. Staff told us they did help people with their exercises and gave multiple examples of people who had recovered well in their care, but people's documentation did not always reflect this.

People said they could see their GP and other healthcare staff as required for example people who lived on the residential unit often saw district nurses. People and staff added that this was always achieved without any delay. Records detailed people saw their GP, specialist nurses, opticians and dentists as necessary. People also had regular medicine and health assessments with their GP. Any advice from professionals was clearly documented and linked to their care plan to ensure continuity of care and treatment.

People's individual needs were met by adaptation, design and decoration of the service. The service was decorated to a high standard with colours used which provided both a peaceful and calm atmosphere for people living with dementia and helped to reduce their anxiety. Displays provided stimulation for people. The garden area was well maintained, accessible and designed in a way so that it could be used safely by people, with minimal support by staff.

Requires Improvement

Is the service caring?

Our findings

Meadowside and St Francis cared for people at the end of their life. We looked at three people's end of life care in detail. We found end of life care was not always planned well for people; and people's end of life wishes were not always, well known and recorded. This meant staff may not know what to do or what decisions to make regarding people's end of life care. Care plans which detailed how people wanted to be cared for at the end of their life were basic and not individualised. Some people had no pain assessment tool in place and staff were not always responsive to signs which might indicate people were uncomfortable. For example one person's care notes recorded that in the three days prior to their death they appeared agitated and had been squeezing the arms of staff. This possible agitation or discomfort was not reported to the palliative care team or the person's doctor. We looked at the pain management of another person. Their pain relieving patch, which should have been changed every three days to manage the pain caused by their cancer, had not been changed on time as prescribed. This may have caused unnecessary suffering. Another person's care records said they had no problems with their sleeping and they had slept all night for the previous six days but the person and staff said they were having trouble sleeping at night. The person told us "I take a long while to get to sleep and the staff are not gentle, they storm in and turn the lights on at night"; "Here, everything is a job; I know I just have to get used to it." Night sedation was being arranged for them during the inspection to aid their disturbed nights.

Care and treatment was not always appropriate to meet people's needs and reflect their preferences. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was an End of Life champion at the home and an event was being held in May 2016 to have an open discussion about end of life care. Staff on the nursing side of the service were due to attend additional training in end of life care. Staff worked closely with the local hospice. Staff told us they felt they did provide compassionate end of life care. They recalled people they had supported at the end of their life describing how they had made people look smart for their families to say their goodbyes, bought them flowers for their rooms and supported grieving relatives. They told us families were always welcome to stay and chairs, tea and biscuits would be brought to people's rooms for them so relatives and friends were as comfortable as possible.

People told us they did not know what their care plan was or what was in it. Staff told us they got to know people and this information contributed to people's care plans. Staff and relatives told us they felt involved in care planning but this was not always recorded. Some people told us they would like to see their care plan. The registered manager was in the process of updating the care planning system and we were informed the new system would be more person-centred.

People told us they felt cared for and we observed positive interactions between people and staff. People and staff told us Meadowside and St Francis was a "homely", family run service. People and visitors we spoke with commented "In a nutshell, they can't do enough for me"; "They changed my bed because the other one was too high"; "It's like being in a hotel. I asked to be moved from upstairs to downstairs and it was no problem"; "The staff are lovely and you can have a bit of banter with them"; "The staff are 100 %.

Anything I need, I get" and "I had a nose bleed so I used my call bell and they came flying up to my room" "I think the younger staff are lovely" and "I think it's great here, the staff are lovely". One staff member commented, "We care for people as we would do our parents." The atmosphere in the service was calm and people were observed to be happy in the company of staff. We observed the staff supported people throughout our time at the service with kindness, respect and in the person's own time. Plentiful thank you cards described the kindness of staff. All the staff talked about the people they were looking after with passion and caring. Staff described a strong ethos of care led by the registered manager.

Staff spoke to people gently where they were less able and unable to verbally communicate their needs. Staff told us about people's individual ways of communicating for example one person used their eyes.However we found people's records and care plans did not include these personal details to ensure staff all supported them in a consistent way.

Staff spoke of people with fondness and told us how they encouraged people to remain independent and where possible regain independence so they were able to return home. They recalled how they had helped teach people how to use their mobility frames, encouraged people to wash where they could and encouraged people to hold their own cutlery where possible.

Visitors were seen coming and going throughout our time at the service. They were always greeted warmly by staff and by name. They were then updated on their family member's condition where appropriate. Visitors confirmed they were always welcomed and given refreshments regardless of the time of day.

People told us staff protected their dignity at all times. For example, staff were discreet when delivering personal care and curtains were always drawn and doors shut. We observed offers of care in public areas were offered quietly and sensitively. The registered manager attended the local Dignity in Care Forum and demonstrated they were actively involved in improving how people were cared for in their local area and their service.

Requires Improvement

Is the service responsive?

Our findings

Most people had care plans in place which were personalised and reflected their current needs however, this was not always the case and some were not personalised to people's specific needs. For example one person's activity plan said to encourage the person to join in with the activities on offer. However, this person was at the end of their life and their admission notes said they were not ready to mix and preferred to stay in their own room. Not all people were familiar with their care plans and some people told us they would like to see their care records. Care plans gave guidance for staff on how to manage aspects of people's health but we found these instructions were not always followed; for example one person's care plan had guidance for staff on how to manage the person's elimination but this had not been followed. This person also had a history of epilepsy but there was no guidance in place for staff in the event they had a seizure. People's care records did not always reflect the care given for example when tracheostomy tube changes had been made, one person's care plan advised their oxygen should be running at 3 litres a minute but it was running at 2.5 litres a minute. Staff advised the prescription had been changed but the care plan did not reflect the changes. This person's care plan also advised they had a convene in place but they actually had an indwelling urinary catheter. We spoke to the registered manager and these people's care plans were updated during the inspection. This meant that in future there would be clear guidance in place for staff regarding people's care. We were advised the new care planning process would support people's care to be more individualised.

People were provided with a range of opportunities to remain cognitively, physically and socially stimulated. Visitors told us "I always read the newsletter to see what is going on at the home" and "I know my relative enjoys the bingo and going out into the garden."

There were two designated activities co-ordinator employed to provide a programme of events at the home aimed at supporting people to remain active. Planned activities were provided regularly by staff and by entertainment coming into the home. People were given a list of the activities in advance in a monthly newsletter. People had taken part in seasonal events such as a sweep stake for the Grand National and some had enjoyed making bird boxes for the garden. There were also regular trips out and about. People told us they could join in or not as they wished. The registered manager told us people were supported with their shopping and if required escorted to family events such as weddings. People also enjoyed minibus outings and group activities such as crafts.

However, some people who were unwell and chose to stay in their room, told us they did not see the activities co coordinator. The registered manager advised one to one time was available for people so they intended to investigate this issue further. Another person told us they were unable to engage in some of the activities because they were unable to hold the cards and dominoes, "The activities are not adapted and I can't use my hands functionally." We also found one person who was cognitively impaired and unable to move from their bed, had little visual stimulation on their walls. The registered manager took action and improved this person's room immediately.

People's concerns and complaints were acknowledged and investigated. People said they knew how to

raise a complaint and felt comfortable speaking to the registered manager and other staff. The service had a complaints policy in place. This was made available to people and relatives on enquiring about the service. Staff had systems in place to help ensure people's concerns could be picked up and resolved quickly. All concerns and complaints were investigated. We reviewed three complaints and spoke to relatives who had made complaints during the inspection process.

Relatives we spoke with during the inspection said they were involved with the care planning process. One relative told us, "The home keeps me well informed about my relative if I can't make it in to see them."

People's needs were assessed when coming to live at the service. People, those who mattered to them and professionals were involved in identifying their needs. New people were encouraged to visit the service to ensure it was the right place for them. The registered manager advised they were careful to ensure they had the right staff with the right training to meet people's needs before they accepted them into the service. They also sought as much information as possible about people's needs to ensure any initial care plan was able to respond to their needs.

People were supported to maintain their faith and cultural identity. A communion service was held at the home for those unable to attend their local church. Faith leaders came to the service but people could also maintain their links with their chosen church or faith group. Staff discussed people's faith and cultural needs with them and every effort was made to ensure this was met.

Requires Improvement

Is the service well-led?

Our findings

Policies and procedures were in place, discussed and accessible to staff. However, we found some policies required updating. We found there were multiple policies relating to the same aspect of care, which could cause confusion.

The service had a number of audits in place to ensure the quality of the service. This included an infection control audit, audit of medicines, care plan audit and audit of falls. These were completed at regular intervals. However, these audits had not identified problems with medicines or record keeping. Staff undertaking these audits told us there wasn't always time to do them.

The systems and processes in place were not sufficiently robust to ensure competency checks had been undertaken when due, and care planning was person centred and reflected people's needs. The service had not developed systems and processes to embed changes from recent legislation to ensure people's human rights were protected and the necessary steps taken to ensure people were not deprived of their liberty unlawfully.

People and visitors spoke positively about the registered manager and felt comfortable approaching them. They felt any issues would be heard and acted on. People were involved in contributing ideas on how the service could be run. People and their families were asked to complete questionnaires but were also asked their opinion informally. People commented that their ideas were sought and put into action.

Staff confirmed they were able to raise concerns and any concerns raised were dealt with immediately. Staff had a good understanding of their roles and responsibilities and said they were well supported by the registered manager. Staff told us the registered manager worked alongside them. Staff said there was good communication within the staff team and they all worked well together. An "employee of the month" scheme was run within the service to encourage staff to maintain high quality care.

The registered manager took an active role within the running of the home and had good knowledge of the people and the staff. There were clear lines of responsibility and accountability within the management structure of the company. The registered manager demonstrated they knew the details of the care provided to people, which showed they had regular contact with the people who used the service and with the staff.

The registered manager had systems in place to ensure the building and equipment was safely maintained. The utilities were checked regularly to ensure they were safe. Essential checks such as that for legionnaires and of fire safety equipment took place.

The registered manager knew how to notify the Care Quality Commission (CQC) of any significant events which occurred in line with their legal obligations. The registered manager kept relevant agencies informed of incidents and significant events as they occurred. This demonstrated openness and transparency and they sought additional support, if needed to help reduce the likelihood of recurrence.

The registered manager promoted the ethos of honesty, learned from mistakes and admitted when things had gone wrong. This reflected the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment.

There was a whistleblowing procedure in place and staff understood their responsibilities to raise concerns about poor conduct. Staff told us they felt confident concerns raised with the registered manager would be addressed appropriately.

The registered manager held management meetings to discuss the day to day management of the service with the senior staff fromresidential and nursing unit, kitchen staff and housekeeping staff. These allowed staff from all areas to contribute their ideas and to look at aspects of the service which could be improved. The service had plans for improvement which included all people having a "hospital passport" to aid transitions to hospital and the development of a new electronic care planning system.

The registered manager participated in local networks and groups to maintain their knowledge and was part of a group representing care home managers across the city to ensure people received care as close to home as possible.

The management team listened positively to our inspection feedback and was proactive in making changes when we identified areas for improvement as part of our inspection.

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 9 HSCA RA Regulations 2014 Person-centred care Person-Centred Care Regulation 9 (1) (2) (3) (a) (b) Care and treatment was not always appropriate to meet people's needs and reflect their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Need for consent Regulation 11 11 (1) (2) (3) The legislative framework of the Mental Capacity Act (MCA) 2005 and associated Deprivation of Liberty Safeguards (DoLS) were not always being followed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Safe Care and Treatment Regulation 12 (1) (2) (a) (b) (g) Care and treatment was not always provided in a safe way. People's risks were not always

assessed and guidance regarding people's care was not always followed.
Medicines were not always managed in a safe way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Good Governance Regulation 17 (1) (2)(c) Records of people's care were not always accurate, complete and contemporaneous.