Mayfair residential care home Limited

Mayfair Residential Care Home Ltd

Inspection report

42 Esplanade
Scarborough
North Yorkshire
YO11 2AY
Tel: 01723 360053
Website: www.mayfaircs.co.uk

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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

Overall summary

We inspected the home on the 22 October 2014, from 8.50am until 4.45pm, the visit was unannounced. Our last inspection took place in July 2013 and at that time we found the service was meeting the regulations.

Mayfair Residential Care Home Limited is registered to provide accommodation for up to 19 people who require personal care. The home does not provide nursing care. Care is provided on three floors in singly occupied rooms and these are linked by a passenger lift or short flight of stairs. There are communal areas for dining and relaxation. On street car parking is available. On the day of our inspection 17 people were living in the home.

During this visit, we spoke with ten people living at the home, one visitor, three members of staff, the registered manager and the provider.

Summary of findings

The home had a registered manager who had been registered since June 2013. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law, as does the provider.

Some people living in the home had complex needs and had difficulties with verbal communication. The staff had developed different communication methods in accordance with people's needs and preferences. This approach reduced people's levels of anxiety and stress.

People told us they felt safe in the home and had good relationships with the staff team.

The home had policies and procedures in place in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards. The manager had been trained to understand when an application should be made, and in how to submit one. This meant that processes were in place to help ensure people were safeguarded.

We found people were cared for, or supported by, sufficient numbers of suitably qualified, skilled and experienced staff. Staff had good relationships with the people living at the home and the atmosphere was happy and relaxed.

We saw that overall people were supported well and in line with their individual care needs and that staff provided the level of support required. It was clear to us that the staff knew people well and demonstrated a good level of care. However, we noted that care plans did not always fully reflect the level of support people were receiving, how needs should be met and for two people action had not been taken to address aspects of care which could impact on the persons welfare. For this reason we have asked the registered person to take steps to make sure people are protected against the risks of receiving care or treatment that is inappropriate or unsafe.

We observed interactions between staff and people living in the home and staff were kind and respectful to people when they were supporting them. Staff were aware of the values of the service and knew how to respect people's privacy and dignity.

Suitable arrangements were in place to make sure people were provided with a choice of suitable healthy food and drink ensuring their nutritional needs were met.

People were able to choose where they spent their time for example in a quiet lounge, outside or in a busier lounge area. However, some people told us they were 'bored' and that they did not always have access to activities they would like. We saw people were involved and consulted about the service including what improvements they would like to see. Staff told us people were encouraged to maintain contact with friends and family.

People we spoke with did not raise any complaints or concerns about living at the home, but knew who to speak to if they were unhappy.

There was no schedule of auditing significant areas which impacted on people's care and wellbeing such as the environment and infection control, care plans and medication. This meant that issues around safety and health were not being identified and followed up as a way to improve the service for people. For example, we found shortfalls in the recording of care, action being taken to address health related matters and no evidence that the quality or standard of cleaning in the home was being monitored. For this reason we have asked the registered person to take steps to make sure people are protected from the potential risk of harm because of the lack of an effective system to regularly assess and monitor the quality of the services provided. And to make sure people are protected from the potential risk of harm because there was no effective system in place to identify, assess and manage risks relating to the health, welfare and safety.

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 safe.

Although people told us they felt safe we found that care plans did not always fully reflect the level of support people were receiving or how needs should be met. We also found that action had not been taken to address aspects of care which could impact on two people's welfare. Specifically around weight loss, frequency of falls and blood sugar monitoring. Risk assessment documentation was generic and did not detail comprehensive risk and how support should be given to minimise that risk.

Staff knew how to recognise and respond to abuse correctly. They had a clear understanding of the procedures in place to safeguard vulnerable people from abuse. We saw people were relaxed in the company of staff.

Individual risks had been assessed and identified as part of the support and care planning process.

There were enough qualified, skilled and experienced staff to meet people's needs. We saw when people needed support or assistance from staff there was always a member of staff available to give this support.

Is the service effective?

Good

The service was effective.

We saw from the records staff had a programme of training and were trained to care and support people who used the service safely and to a good standard.

Staff we spoke with had a good understanding of the Mental Capacity Act 2005 and how to ensure the rights of people with limited mental capacity to make decisions were respected. We found the location to be meeting the requirements of the Deprivation of Liberty Safeguards.

People's nutritional needs were met. The menus we saw offered variety and choice and provided a well-balanced diet for people living in the home.

People had regular access to healthcare professionals, such as GPs, opticians, dentists and attended hospital appointments.

Is the service caring?

Good

The service was caring.

People told us they were happy with the care and support they received and their needs had been met. It was clear from our observations and from speaking with staff they had a good understanding of people's care and support needs and knew people well.

Summary of findings

Wherever possible, people were involved in making decisions about their care and staff took account of their individual needs and preferences.

We saw people's privacy and dignity was respected by staff and staff were able to give examples of how they achieved this.

Is the service responsive?

Good 

The service was responsive.

People's health, care and support needs were assessed and individual choices and preferences were discussed with people who used the service and/or a relative or advocate. We saw records confirmed people's preferences, interests, likes and dislikes and these had been recorded in their care plan. However, more detail was required to reflect the work being done by staff to support people.

Complaints were responded to appropriately and people knew who to speak to if they wanted to make a complaint.

Is the service well-led?

Requires Improvement 

The service was not well-led.

The home did not have an effective quality assurance system in place and there was no audit schedule. We found this put people at risk of potentially unsafe or inappropriate care. This meant people were not benefiting from a service that was continually looking at how it could provide better a better service for people. This contradicted the view of the staff we spoke with who told us they were keen to improve the service.

The management of the home kept up to date with current good practice and research; they spent time working alongside staff, provided learning through supervision and involved staff through regular staff discussions.

Accidents and incidents were monitored by the manager and the organisation to ensure any trends were identified.

Mayfair Residential Care Home Ltd

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 was an unannounced inspection, which was carried out in one day. We visited on 22 October 2014. This service was last inspected in July 2013 and the provider was not asked to make any improvements. The inspection team consisted of a lead and a bank inspector.

Prior to our inspection we reviewed all the information we held about the service. We considered information which had been shared with us by the local authority and looked at safeguarding alerts that had been made. Before the inspection, the provider was asked to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also spoke with the local authority and Health Watch about this service and to ask them for their views.

We used the Short Observational Framework for Inspection (SOFI) because there were four people living at the home who were living with a dementia. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We observed people in the lounge and dining areas. We also talked to people who could share their experiences, talked to visiting relatives, interviewed staff and tracked peoples care from when they were admitted and how their present needs were being met.

We looked at all areas of the home, including people's bedrooms (with their permission), the kitchen, laundry, bathrooms and communal areas.

We also spent time looking at records. This included six people's care and support records and records relating to the management of the service, for example policies and procedures, maintenance records, staff duty rosters, three staff training and supervision files and the services' training programme. We also observed some planned activities within the service, a medication round, the lunchtime experience and interactions between staff and those living at the service.

On the day we visited the service we spoke with ten people who lived at Mayfair Residential Care Home, a relative, three staff, the registered manager and the owner.

Requires Improvement

Is the service safe?

Our findings

We saw that overall people were supported well and in line with their individual care needs and that staff provided the level of support required. It was clear to us, through the observations we made and from talking to people living at the service, that the staff knew people well and demonstrated a good level of care. However, we noted that care plans did not always fully reflect the level of support people were receiving, how needs should be met and for two people action had not been taken to address aspects of care which could impact on the persons welfare. One person had lost a significant amount of weight, over a nine month period. Their weight had been recorded and staff were encouraging the person to eat. However the reduction had not been highlighted or reported to the person's doctor for possible referral to another health care professional. The same person had had several falls since May 2014 and had not been referred to another healthcare professional, for example, a falls team, to explore ways of reducing the number of falls or eliminate any health cause. It was clear that the service was recording such incidents and trying to support the person; however, they had not taken steps to involve other professionals but had tried to manage the situation 'in-house.' Staff were monitoring a condition and recording information for the district nurse for a second person, however, they had not recognised the impact associated with a rise in blood sugars or alerted the person's doctor or other health care professional. With regard to risk assessment documentation, these were generic and did not detail comprehensive risk and how support should be given to minimise that risk.

These matters were a breach of Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010.

The Mental Capacity Act 2005 (MCA) says that before care and treatment is carried out for someone it must be established whether or not they have capacity to consent to that treatment. If not, any care or treatment decisions must be made in a person's best interests. We saw that some people were unable to consent to care and treatment and had had a mental capacity assessment completed, and in some instances best interest meetings had been organised. This told us staff were working within the principles of the MCA by doing everything to empower people to make as many decisions for themselves as they could and by recording those decisions.

We looked around the service and found it to be generally clean and smelt fresh. Some areas of the home were looking worn and showing signs of wear and tear, particularly in bathrooms and toilets and some communal areas. The provider had a two year plan, 2014 – 2016, of redecoration and refurbishment and this included some of the areas highlighted. We saw that one large window, in a second floor bedroom, did not have a window restrictor fitted. Which meant that someone could climb over the low window ledge and fall or jump from it. The provider took immediate action to make sure this area was made safe on the day of our visit.

There was an infection control policy and procedure; however, this had not been reviewed since 2004, meaning it did not fully meet the current regulations and guidance. Despite this we found staff were familiar with good practice and there were posters and hygiene arrangements in place in the kitchen, toilets and bathrooms. There were contracts in place for domestic and clinical waste disposal. We spoke with the manager about the formal cleaning schedules and if there were audits undertaken. The manager told us the staff worked as a team and understood what was needed to make sure the home was kept clean.

When we inspected this service in July 2013 we found the provider had made suitable arrangements to make sure people were protected against the risk of abuse and staff knew how to respond to any allegations or complaints.

When we spoke with staff, during the course of this inspection, about protecting people from harm and potential abuse they told us that they would report any concerns that they had about someone's welfare or safety to the manager, a senior member of staff or the owner without hesitation. Staff were able to describe the action they would take and what their expectations were if they reported anything to the senior staff. One person who used the service told us, "I feel safe because I trust the staff looking after me." People were safe because staff and people who used the service knew what to do when they had a concern.

At our previous visit in July 2013, we had found there were enough qualified, skilled and experienced staff to meet people's needs. We found the same at this inspection. Staff we spoke with told us they thought there were enough staff on duty to keep people safe at all times. We saw on the rosters, and staff confirmed to us, that there were at least two care assistants (including senior care assistants) on

Requires Improvement

Is the service safe?

duty from 7.30am until 9pm, seven days a week. Staff alternated their shifts working either 7.30am – 2pm or 2pm - 9pm. Staff told us they reported to work early, to make sure they had at least 15 minutes to hand over at each shift change. The service also employed a housekeeper, a cook, a kitchen assistant and a handyman. Therefore care assistants could devote their time to caring and supporting people living at the service. The home also provided two waking staff during the night. There was a robust system in place for the recruitment and selection of staff.

The ancillary staff worked predominantly Monday to Friday, but suitable arrangements were in place to make sure food provision, laundry and cleaning was not compromised during the weekend by existing staff covering additional roles and hours. The service was also actively seeking to recruit a part time cook to fill a vacancy, therefore relieving the need for staff to work additional hours to provide cover.

The manager worked alongside care staff during her shift, which was usually 7am until 2pm, Monday to Friday. She also worked an occasional weekend shift, if there was a shortfall in hours due to staff holidays or other absences. The owner, who was not shown on the roster, told us she was a regular visitor to the service, often calling in on a daily basis, and would work in the afternoon completing office tasks and supporting staff. Everyone we spoke with told us the owner was very visible and that they all knew her and more importantly she 'knew us.' The provider also explained how the needs analysis and risk assessment process was used to determine staffing numbers.

We saw the majority of people who lived at the service were relatively independent and needed prompting and support from staff rather than full 'hands on' care. A small number of people had care needs which meant they required observation and greater support from staff, which we saw was available throughout our visit.

Every person we spoke with said they had not experienced any problems 'getting staff to help' or assist. One person told us, "The staff check we are alright all the time, they are around if we need them." Another person told us, "I like all the staff; they do a difficult job, well."

One member of staff told us, "There are enough staff. The clients are quite independent and can do a lot for themselves." It was clear from talking to staff that they took their work seriously and managed to cover each other's absences effectively, so as not to have to use agency staff.

"We like to give continuity of care to our clients, so we work it out between us" one member of staff told us. When we spoke with the manager about the staffing arrangements she told us they maintained staffing levels throughout the week, and additional shifts were arranged to cover events such as hospital appointments or activities. When we checked the staff rosters we could see staffing levels were consistent with what we had been told. This meant that people were safeguarded because they were supported by a suitable number of staff which reflected the dependency levels of the people living in the service at the time of our visit. The manager agreed that this would be kept under review as peoples dependency levels varied over time.

At the time of our visit none of the people living at the service needed assistance with moving and handling using slings or hoists. Three people had their own wheelchair to use, if they needed it when outside the home, otherwise people were fully mobile and could use the stairs or passenger lift provided. When we looked at the electrical wiring checks we saw that recommended remedial work had been completed and that the provider had an up to date certificate on site.

There was a fire risk assessment taking place on the day of our visit, we did not see the documentation as the contractor had not finished it before we gave the provider feedback. We were told this would include personal evacuation plans for everyone in the service.

We were told by staff that fire safety training had been delivered in early October 2013; this was confirmed by the records we looked at. Staff had also been present during a fire drill and fire alarms were routinely checked weekly. Fire fighting equipment had also been serviced within the last twelve months which meant that all safety precautions were in place in the event of a fire. Staff were able to tell us what they would do in the event of an emergency, for example if there was a fire or an accident.

We inspected how medicines were managed. We looked at how the service received, stored, administered, recorded and disposed of medicines. We also looked at how controlled drugs were managed. We joined a member of staff carrying out a medicine round to observe practice. The service had a medicines policy and procedure; however, this had not been reviewed since 2004, meaning it did not fully meet the current regulations and guidance. Despite this we found that overall medicines management was well organised and people received their medication

Requires Improvement

Is the service safe?

at the right time and in accordance with the prescribers directions. We asked staff about how they managed medicines to be administered 'when required.' Staff were very clear about having specific instructions from the prescriber and showed us evidence of when they had asked for clarity to make sure medication was given appropriately.

There had been no medication errors at the service over the last twelve months which related to people not receiving medication in a timely manner, returns of medication and roles and responsibilities of staff. This showed that the service was managing medication appropriately.

The records which confirmed the administration of medication or application of creams and other topical preparations were completed at the time medication was given by the member of staff carrying out the task. When we checked a random sample of medicines for nine people alongside the records, we found these matched the expected stock being held. People we spoke with told us they received their medication at a convenient time and did not have any problems getting their medication if it was for pain or discomfort.

None of the people living at the service at the time of our visit were given their medication 'covertly'. This is when medicines are given in food or drink to people unable to give their consent or refuse treatment. Staff told us they would contact the person's doctor and work with the pharmacist if this need arose.

The medication trolley was kept locked and was fastened securely to a wall when not in use. The provider did not have a separate medication fridge, but had followed the pharmacists advice about making sure medication was kept separate and away from other items. Records were kept of the fridge temperature being used to store medication, which had to be kept cool and maintained at less than 5 degree centigrade. This meant that medication was being stored as instructed by the manufacturer and safe to use.

Controlled drugs, which are medicines which may be liable to misuse, were being stored appropriately. We checked the records of their use and found that the required documentation was being kept, that two staff were signing when the drugs were being used and that the stock matched the expected amount.

Good

Is the service effective?

Our findings

Mayfair Residential Care Home is an adapted house and due to the lack of lift access in some areas people are generally fully mobile on admission. Despite this, people's needs were able to be met by the layout of the building.

Communal rooms were on the ground and basement floors and were used extensively by people at the service. Attempts had been made to make the environment feel homely and some of the bedrooms we were given permission to see were found to be decorated and individualised by the person using them, clearly reflecting their own tastes and preferences. No-one had a key to their own room, which according to the manager was a choice by them. However, we could not see how this could be achieved, should someone wish to lock their own room, without a new door/lock being provided.

There was some signage to help direct people with a sensory or cognitive impairment to communal areas, bathrooms and toilets. The provider explained to us that they would provide additional signage should that be required as people's needs changed, therefore adapting the environment to suit everyone. Furniture and floorcoverings were appropriate to people's needs.

People requiring assistance with meals and drinks were given appropriate support during their meal times and when having snacks. We observed the dining experience and found that overall the experience was relaxing and calm for everyone. Everyone we spoke with told us they thought the food was of a good standard and that they enjoyed their meals. Three people had specific seating arrangements, of these two people were positioned away from the larger group in the dining area. We found that one person, had chosen this arrangement and they confirmed this to us during our visit. However, the other person was unable to confirm this would be their choice and there was nothing in their individual care records to say why this seating arrangement had been selected or if it was in the person's best interests. When we asked staff about this they told us it was because of the persons individual needs, however, they were unable to say why the person was facing the wall. We asked the provider and manager to review the arrangement.

We looked at whether the service was applying the Deprivation of Liberty safeguards (DoLS) appropriately. These safeguards protect the rights of people using services by ensuring that if there are restrictions on their freedom and liberty these are assessed by professionals who are trained to assess whether the restriction is needed. The manager told us there was one person living in the home who needed an authorisation in place and they were in the process of obtaining this. We saw evidence of authorisations and a review date had been agreed. We found the manager was meeting the requirements of the Deprivation of Liberty Safeguards.

We saw that the staff team had worked together for over five years and there had been one new starter recently. We looked at the new member of staff file and saw that they had received induction training and worked with more experienced staff when they first started working at the service.

We saw that there was a training programme in place for all staff and that training was being provided by a company specialising in training for health care professionals. Staff told us that their training needs were being met and that training was being provided regularly. A senior member of staff had the responsibility of keeping a 'track' of training delivery and we could see from the records that all the mandatory training had been delivered and those courses due for renewal had been arranged. For example, First Aid and Safeguarding training was due to be refreshed.

People who used the service told us they thought their health needs were fully met. One person told us, "When I need the doctor they contact them and they come and see me here." Another person told us, "The care here is excellent, it can't be easy for staff but they do a good job." We saw that specialists had been consulted over people's care and welfare which included other health professionals, doctors and consultants linked to the local hospital. People also had records which provided information for staff on past and present medical conditions and included all healthcare appointments. This meant staff could readily identify any areas of concern and take timely action.

The provider and manager had good working relationships with their local doctor's practices and particularly the community psychiatric nurses. One person at the service was in need of emotional support and the staff demonstrated a good understanding of this and had sought the advice of a local team to make sure they were providing appropriate care.

Good

Is the service caring?

Our findings

Some people who had complex needs were unable to tell us about their experiences in the home. So we spent time observing the interactions between the staff and the people they cared for. Our use of the Short Observational Framework for Inspections (SOFI) tool found people responded in a positive way to staff in their gestures and facial expressions. We saw staff approached people with respect and support was offered in a sensitive way. We saw people were relaxed and at ease in the company of the staff who cared for them.

We observed staff speaking clearly when communicating with people and care was taken not to overload the person with too much information. This helped staff to build positive relationships with the people they were supporting. Staff were able to give us many examples of how people communicated their needs and feelings. All the staff we spoke with told us of their commitment to provide a good standard of care and that they took a personal pride in their work.

People we spoke with said they were happy with the care provided and were very positive about their relationships with staff. They also told us they felt listened to. One person told us, "Staff listen, they know what I need." Another person told us, "I am treated like a person." Other comments included, "I am well looked after and well cared for" and a visitor told us, "I have seen staff coping with difficult people and they look after them well." Another person told us, "Staff pop into my room to see what I need. I am happy with the care, and the way I am treated."

People we spoke with told us they were well cared for by a staff team who had the skills and correct attitudes to look after them properly. Comments included, "I like it here, I like a bit of fun and we do have fun!" And, "They are very good here, we don't want for anything; they bring you things you want." People told us that their rights and dignity were respected and that they had been involved in making decisions where there were may be a risk. One person told us, "They [staff] always ask my permission before they do anything for me. I make my own decisions with help sometimes."

We observed interaction between staff and people living in the home. People were relaxed with staff and confident to approach them throughout our visit. We saw staff interacted positively with people, showing them respect, kindness and patience. There was a relaxed atmosphere in the home. People could choose where to sit and spend their recreational time.

We looked at six people's care plans. Overall people's needs were assessed and care and support was planned in line with their individual needs in mind. However, some of the detail was missing, which staff clearly knew about people. This individual information was shared at each shift change and no one we spoke with raised an issue about their overall care needs not being met. However, not all the work being done to support people was recorded and therefore positive steps being taken to address care needs of people were not reflected in the records. None of the records we reviewed included Do Not Attempt Cardio Pulmonary Resuscitation Forms.

The staff we spoke with told us the care plans were easy to use and follow and that they had recently reviewed some of the care plans to bring them up to date. Staff demonstrated an in-depth knowledge and understanding of people's care, support needs and routines and could describe care needs provided for each person. Staff told us they felt able to make comments or raise concerns about people's care. The manager acknowledged that the information held could be more detailed but stressed that the staff, many of them longstanding, knew the people living at the service and she was confident that people's needs were fully met.

On the whole, people were supported in maintaining their independence and community involvement. On the day of our inspection we saw people spending time in communal lounge areas of the home, leaving the home to have a walk, attend a hospital appointment or in their bedroom. We saw staff asked people what they wanted to drink and eat mid-morning. We also saw staff walking slowly with people, at their own pace and chatting with them about recent events on the news.

People were given appropriate information and support regarding their care or support. There was documented evidence in the care plans we looked at the person and/or their relative had contributed to the development of their care and supports needs. The manager together with the person living in the service and/or their relative held care review discussions.

Everyone we spoke with told us their dignity and privacy was respected. They said staff closed doors and drew

Good

Is the service caring?

curtains when attending to their personal care needs. We saw staff knocked on people's doors before entering their bedrooms. Visitors told us they were made to feel welcome at the service and that they thought their relative was well looked after. People using the service told us that staff supported their independence and worked in a way that was unrestrictive and promoted freedom of choice.

During our inspection we spoke with members of staff who were able to explain and give examples of how they would maintain people's dignity, privacy and independence. One member of staff we spoke with said, "I would be happy for my mum to live here. You can't say better than that."

Good

Is the service responsive?

Our findings

People's care and support needs had been assessed before they moved into the home. We saw records confirmed people's preferences, interests, likes and dislikes and these had been recorded in their care plan. However, more detail was required to reflect the work being done by staff to support people. People and their families were involved in discussions about their care and the associated risk factors. Individual choices and decisions were documented in the care plans and reviewed on a regular basis. People's needs were periodically assessed and reviewed, more frequently where needs were changing and at least six monthly in all other examples we saw.

People we spoke with told us they were involved in care planning and reviews. One person told us, "I think they did talk to me when I first came, found out about me and what I liked and needed. I don't remember it too clearly but I'm sure that they did it." Another person told us, "I have never had to complain about anything but I could talk to the manager if I was worried." A visitor told us how they had been involved in the initial stages of admission helping to complete a care plan. However, they went on to say their relative could express themselves and they felt confident if the support wasn't right they would be able to say so. They also said they could make decisions about their own care, how they were looked after, that staff knew them well and their needs.

However, five people commented that they were sometimes 'bored' and that not enough was done to keep people stimulated and occupied. One person told us, "If I didn't go out myself I don't know how I would manage." Six people told us they could go out, feed the birds and have a walk. However there was a general feeling that more could be done to occupy their day. The provider allows for a member of staff to stay behind after their shift for two hours, twice a week to focus on activities. There was also a structured activity programme, including such things as aromatherapy, chair exercises and musical entertainment. However, from the comments we received it appears that this could be improved upon.

There was evidence that the equipment in assisted bathrooms had been inspected and serviced by an external contractor. The manager told us that the assisted bathrooms were used regularly and that people were also making a choice to use the showers provided.

We spoke with people about how they passed the day and whether there was enough to do. One person told us, "It can be a bit boring, there's not much to do if you can't go out yourself." The manager and staff we spoke with told us about a member of staff who was allocated an extra two hours per day which was used to focus on activities in the home. We shared people's overall feedback, about there being little to do, with the provider and manager without identifying who had commented. They were keen to address this and agreed to speak with people about it and find out what they would like to do more of as the arrangements in place were clearly not satisfying everyone's needs.

The manager told us people were given support to make a comment or complaint where they needed assistance. They said people's complaints were fully investigated and resolved where possible to their satisfaction. Staff we spoke with knew how to respond to complaints and understood the complaints procedure. We looked at the complaints records; however there had not been a formal complaint in the last twelve months. The manager told us there had been minor complaints 'grumbles and niggles' and these had been dealt with at the time and quickly resolved. We saw there was a complaints procedure for staff to follow should a concern be raised. However, this had not been reviewed since 2004 and still referred to predecessor organisations before CQC was set up. People we spoke with and visitors said they felt able to raise any concerns or complaints with staff and were confident they would be acted on appropriately. One person told us, "I'd just tell them if I wasn't happy, they would sort it out straight away I am sure of it."

People were supported to maintain relationships with their family. On visitor told us they were kept up to date on their family member's progress by telephone, they were made welcome in the home when they visited and that they had an opportunity to talk to staff if they needed to pass on information or ask for clarity.

Relatives were encouraged and supported to make their views known about the care provided by the service. The home had invited people living in the home and relatives to complete a customer satisfaction questionnaire in August 2014. Out of 24 sent, they had had a 50% response rate. All 12 responses had answered questions about the service

Good

Is the service responsive?

and scored between 'strongly agree' and 'agree' with the statements in it. Therefore all giving positive feedback and the comments were complimentary about the service and the staff.

The manager told us formal residents meetings were not held on a regular basis as people shared their views openly on an on going basis. We could see this throughout our visit and being a relatively small service it was clear that people were consulted about the running of service on a day to day basis.

Requires Improvement

Is the service well-led?

Our findings

We asked to look at audits carried out by the home and found that there was little or no auditing and monitoring taking place. There was no schedule of auditing and significant areas which impacted on people's care and wellbeing such as the environment and infection control, care plans and medication. This meant that issues around safety and health were not being identified and followed up as a way to improve the service for people. For example, we found shortfalls in the recording of care, action being taken to address health related matters and no evidence that the quality or standard of cleaning in the home was being monitored.

We asked the provider about their management oversight of the service. She told us she visited the home regularly and would pick up on issues then. We noted that the visiting pharmacist had carried out an audit of the medication system and that the manager had put their recommendations in place; however this audit had been reliant on an external party and not as a result of the procedures in the home.

This lack of an effective system to assess and monitor the quality of the service provided created risks that shortfalls would not be identified and resolved in a timely way, by either the manager or provider. Notwithstanding this, we saw that the manager and provider were keen to develop and improve the service. The manager made sure she kept up to date with current practice and research. For example, they were fully aware of the fundamental standards and how this affected their service. The manager had researched recent publications and shared good practice with other managers in the area.

These matters were a breach of Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010.

At the time of our inspection the service had a manager who had been registered with the Care Quality Commission since June 2013.

The service had notified the Care Quality Commission, as required by law, about seven accidents and incidents since their last inspection. The manager showed us how they monitored this information to make sure they could learn from them or identify any improvements they might make.

We noted that the manager analysed and recorded accidents and incidents to make sure action could be taken to prevent recurrence, identify trends and patterns.

We saw both the manager and provider were regularly in the communal areas of the home. They acknowledged people living in the home and were clearly known to them. People either responded to them verbally or with smiles.

We spoke with the provider and manager about staff. They told us, "We have a good team here; we are lucky, staff stay and help us run it as a family business." Staff told us they met regularly with the manager to discuss practice issues and that as a team there was a handover at each shift change, making sure current issues were discussed. Formal staff meetings were arranged twice a year, which they all agreed was enough, as being a relatively small home they saw each other regularly. Staff were keen to point out to us that should they need a meeting with the provider or manager they only needed to ask.

Staff we spoke with told us they were aware of their roles and responsibilities and that they felt very well supported by the provider, the manager and each other. Observations of interactions between the registered manager, provider and staff showed they were inclusive and positive. All staff spoke of strong commitment to providing a good quality service for people living in the home. They told us the registered manager was approachable, supportive, they felt listened to and they were confident about challenging and reporting poor practice, which they felt would be taken seriously. One member of staff told us, "I really love my job, I enjoy coming to work." Another member of staff said, "The perfect home hasn't been built yet, but this is as close as you can get."

Staff received supervision and an annual appraisal of their work which ensured they could express any views about the service in a private and formal manner. Staff were aware of the whistle blowing procedures should they wish to raise any concerns about the organisation. There was a culture of openness in the home, to enable staff to question practice and suggest new ideas.

Staff meetings were not held frequently, the last meeting had been in September 2014 and prior to that March 2014. However, staff told us they did not have to wait for meetings to pass on important messages or information. The handover, which was at least twice a day, was when the manager and senior on duty passed on important

Requires Improvement

Is the service well-led?

messages. Staff also received written confirmation if there was a new way of working or information which impacted on their roles. There was clearly an 'open door' ethos and people living in the home and their relatives were welcome to contact them at any time.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services People were not protected against the risks of receiving care or treatment that is inappropriate or unsafe. Timely action had not always been taken where people had lost weight, fell frequently or had other health related issues which could impact on their overall health and wellbeing. Regulation 9 (1)(a) and 9(1)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers People were not protected from the potential risk of harm because there was no effective system in place to regularly assess and monitor the quality of the services provided. Regulation 10(1)(a) People were not protected from the potential risk of harm because there was no effective system in place to identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity. Regulation 10(1)(b)