Four Seasons 2000 Limited

Copper Beeches

Inspection report

5 Sylewood Close
Borstal
Rochester
Kent
ME1 3LL

Tel: 01634817858
Website: www.fshc.co.uk

Date of inspection visit:
09 August 2016
10 August 2016

Date of publication:
31 October 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection was carried out on 9 and 10 August 2016 and was unannounced.

Copper Beeches is a care home providing accommodation, personal care and nursing care for up to 36 older people who may be living with complex dementia. At the time of this inspection there were 34 people living at the service. Accommodation was provided over two floors. A lift was available to take people between floors.

A registered manager was not employed at the service. 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. However, the provider had appointed a manager who intended to apply to register with the Care Quality Commission.

The available resources and levels of commitment to activities and mental stimulation did not support best practice in ensuring people lived well with dementia and reduced social isolation.

The provider and manager ensured that they had planned for foreseeable emergencies, so that should emergencies happen, people's care needs would continue to be met. Equipment in the service had been tested and well maintained, but this did not always include equipment people provided for themselves.

We have made a recommendation about this.

There were policies in place for the safe administration of medicines. Nursing staff were aware of these policies and had been trained to administer medicines safely. However, there were issues with cleanliness and infection control in some areas of the clinical rooms.

Staff received training that related to the needs of the people they were caring for and nurses were supported to develop their professional skills maintaining their registration with the Nursing and Midwifery Council (NMC). The manager had not ensured that a consistent system was in place for staff supervisions and appraisals.

Nursing staff assessed people's needs and planned people's care. They worked closely with other staff to ensure the assessed care was delivered. General and individual risks were assessed, recorded and reviewed. Infection risks were assessed and control protocols were in place and understood by staff to ensure that infections were contained if they occurred. End of life care was delivered by consent and mutually agreed with people and their families.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care services. Restrictions imposed on people were only considered after their ability to

make individual decisions had been assessed as required under the Mental Capacity Act (2005) Code of Practice. The manager understood when an application should be made. Decisions people made about their care or medical treatment were dealt with lawfully and fully recorded.

The manager had ensured that they employed enough nursing and care staff to meet people's assessed needs. A robust agency back up system was in place. The provider had a system in place to assess people's needs and to work out the required staffing levels. Nursing staff had the skills and experience to lead care staff and to meet people's needs effectively and the manager provided nurses with clinical training and development.

Recruitment policies were in place. Safe recruitment practices had been followed before staff started working at the service. This included checking nurse's professional registration.

People were supported to eat and drink enough to maintain their health and wellbeing. They had access to good quality foods and staff ensured people had access to food, snacks and drinks during the day and at night.

We observed safe care. Staff had received training about protecting people from abuse and showed a good understanding of what their roles and responsibilities were in preventing abuse. Nursing staff understood their professional responsibility to safeguard people. The manager responded quickly to safeguarding concerns and learnt from these to prevent them happening again.

Incidents and accidents were recorded and checked by the manager to see what steps could be taken to prevent these happening again. The risk was assessed and the steps to be taken to minimise them were understood by staff.

People had access to qualified nursing staff who monitored their general health, for example by testing people's blood pressure. Also, people had regular access to their GP to ensure their health and wellbeing was supported by prompt referrals and access to medical care if they became unwell.

We observed staff that were welcoming and friendly. People and their relatives described staff that were friendly and compassionate. Staff delivered care and support calmly and confidently. People were encouraged to get involved in how their care was planned and delivered. Staff upheld people's right to choose who was involved in their care and people's right to do things for themselves was respected.

If people complained, they were listened to and the manager made changes or suggested solutions that people were happy with.

The manager of the service, nurses and other senior managers were experienced and provided good leadership. They ensured that they followed their action plans to improve the quality of the service. This was reflected in the changes they had already made within the service.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this 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?

Good

The service was safe.

The premises and equipment provided by the service were maintained to protected people from harm, but some equipment people owned themselves needed to be included.

People experienced a service that made them feel safe. Staff knew what they should do to identify and raise safeguarding concerns.

Risks were assessed and recorded. Medicines were managed and administered safely. Incidents and accidents were recorded and monitored.

There were sufficient staff to meet people's needs. The provider used safe recruitment procedures.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received an induction and training but were not well supported to carry out their roles.

People's rights were protected by staff who were guided by The Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Staff understood their responsibility to help people maintain their health and wellbeing. Nurses routinely monitored people's general health.

Is the service caring?

Good

The service was caring.

People had forged good relationships with staff so that they were comfortable and felt well treated. People were treated as individuals and able to make choices about their care.

People had been involved in planning their care and their views were taken into account.

People were treated with dignity and respect.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Information about people was updated often and with their involvement. Activities were not consistent with published guidance for people living with dementia.

People were provided with care when they needed it based on assessments and the development of a care plan about them.

People were encouraged to raise any issues they were unhappy about.

Is the service well-led?

Good

The service was well led.

The manager was qualified with the appropriate skills and experience to lead staff in the service and drive through improvements to people's care.

There were clear structures in place to monitor and review the risks.

The provider and manager promoted person centred values within the service. The provider asked for feedback about the quality of the service.

Copper Beeches

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 took place on 9 and 10 August 2016 and was unannounced. The inspection team consisted of an inspector and a nurse specialist.

Before the inspection we looked at previous inspection reports and notifications about important events that had taken place at the service, which the provider is required to tell us by law. The provider completed a Provider Information Return (PIR). The PIR 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 used short observational inspection techniques to observe how care was provided to people who were unable to tell us about their experiences. We spoke with one person and three relatives about their experience of the service. We spoke with eight staff including the current manager, the newly appointed manager, the providers regional manager, two nurses and three care workers. We asked four health and social care professionals for their views about the service.

We spent time looking at records, policies and procedures, complaint and incident and accident monitoring systems. We looked at five people's care files, four staff record files, the staff training programme, the staff rota and medicine records. At the end of the inspection we asked for more information to be sent to us. The manager sent us further information about staff training, maintenance checks and how they monitor agency staff.

Good

Is the service safe?

Our findings

People living with dementia were unable to verbally tell us about their experiences of the care at Copper Beeches. However, we observed people smiling when staff spoke to them, we observed that people were relaxed and comfortable with staff when care was delivered. One person said, "Safe as houses. I am safer here than anywhere, the staff are darlings".

Relatives told us that they felt that their family members were safe. They described a service that was also supportive to them. One said, "The staff are good." Another said, "My mum is safe here and I don't have any cause for concern in this area".

At our inspection on 16 and 21 July 2015, we identified a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Sufficient numbers of staff were not deployed to cover both emergency and the routine work of the service.

At this inspection we found the daytime care staffing levels had increased. Although there had been high levels of staff turnover, the manager had been constantly recruiting to vacant post. The rota showed that in addition to the manager, there was a deputy manager who was also the nursing clinical lead. There were seven staff available to deliver care plus a qualified nurse and a clinical health care assistant between 8 am and 8 pm. At night there were four care staff managed by an additional qualified nurse. The rota showed that time was given between shifts for staff to hand over. Staffing levels were consistent and any staff or nurse absences were covered by approved agency or internal bank staff. Cleaning, maintenance, cooking and organising activities were carried out by other staff so that staff employed in delivering care were always available to people.

There were enough staff to ensure the care people received was safe and they were protected from foreseeable risks. Our observation and discussion with staff showed that staffing deployment was based on an analysis of the levels of care people needed. We observed staff prioritising answering nurse call bell alarms and people confirmed to us they did not have to wait long for staff to assist them. People's dependency levels were reviewed at least monthly. There were enough staff available to walk with people using their walking frames if they were at risks of falls. We observed staff were vigilant and we saw staff reminding people about using walking frames. Staff told us and records confirmed that staff had training in moving and handling and the use hoists to move people.

The provider's recruitment policy was followed by the manager. This protected people from new staff being employed who may not be suitable to work with people who needed safeguarding. All applicants for jobs had been checked against the disclosure and barring service (DBS) records. This would highlight any issues there may be about new staff having previous criminal convictions or if they were barred from working with people who needed safeguarding. Before employment, all applicants for posts at this service were asked to explain in full any gaps in their employment history. This was fully recorded and double checked by the manager. New staff could not be offered positions unless they had provided proof of identity, written references, and confirmation of previous training and qualifications. Nurses were registered to practice with

the Nursing and Midwifery Council (NMC) and their ability to practice in the UK was recorded.

Equipment was serviced and staff were trained how to use it. The premises environment was maintained to protect people's safety and to meet their needs. There were adaptations within the premises like ramps to reduce the risk of people falling or tripping. When staff needed to use equipment like a hoist to safely move people from bed to chair, this had been individually risk assessed. We saw comprehensive records that confirmed both portable and fixed equipment was serviced and maintained. However, we noted that where people had provided their own equipment via a third party, for example concentrate oxygen, the procedures for prompt servicing and repair of the equipment were not clear.

We have recommended that the manager ensures that information about using, servicing and repairing all equipment in the service is in place.

People received their medicines safely from staff who had received specialist training in this area. Medicines were correctly ordered, booked in to and stored in the service by staff and this was done in line with the service procedures and policy. For example, nurses and trained staff administered medicines as prescribed by other health and social care professionals. This ensured the medicines were available to administer safely to people as prescribed and required. Medicines were stored safely and securely in temperature controlled rooms within lockable storage containers. However, we noted that a medicine trolley and some liquid medicines bottles were not clean, for example where liquid had run down the bottle it had not been wiped off. Also, areas around the window in the clinical room had not been cleaned and that medicine cups were left to drip dry rather than wiped dry. We discussed this with the staff and the manager. These issues were addressed during the inspection and the cleaning of the medicines trolley and the window area was added to the cleaning schedule.

The provider's policy on the administration of medicines followed published guidance and best practice and had been reviewed annually. Competences of staff administering medicines were checked by the manager against the medicines policy to ensure good practices were maintained. Staff confirmed that they had training in the administration of medicines and on-going competency training. Care staff trained to administer medicines were supported to do this safely by qualified nursing staff. We observed a nurse checking a person's blood sugar levels before administering insulin and encouraging and assisting the person to eat well. Nurses knew how to respond when a person did not wish to take their medicine. It would be offered again according to guidance from the GP. Staff understood how to keep people safe when administering medicines.

The provider had policies and guidance in place about protecting people from the risk of service failure due to foreseeable emergencies, like flood or fire. Contingency plans were detailed and professionally written to ensure people's care would continue in emergency situations. Each person had an emergency evacuation plan (PEEP).

People were protected from potential abuse by staff trained in how to safeguard adults. The provider had an up to date policy about protecting people from abuse. Staff told us how they followed the providers safeguarding policy and their training. They understood how abuse could occur and what they needed to do if they suspected or saw abuse was taking place. Staff explained to us their understanding of keeping people safe.

The manager had ensured that risks had been assessed and safe working practices were followed by staff. Risk assessments considered the levels of risk and severity, which was in line with recognised best practice. People had been assessed to see if they were at any risk from falls or not eating and drinking enough.

People were protected from preventable harm and could call for help if needed. There was a computerised risk reporting system that analysed incidents, such as falls, which enabled the manager to check for patterns of risk. Where necessary, the local authority safeguarding team had been notified. There had been ten recordable incidents or accidents since our last inspection. These incidents and accidents had been investigated and checked by the manager to make sure that responses were effective and to see if any changes could be made to prevent incidents happening again.

Requires Improvement

Is the service effective?

Our findings

People living with dementia were unable to verbally tell us about their experiences of the care at Copper Beeches. A relative said, "My husband had hurt his arm and needed assistance. A nurse was there, no problem." And, "When my relative came into the home he had a bad pressure ulcer, the staff turned him every two hours and he has no pressure ulcers now."

A persons GP commented, "When I saw the person they looked very well, I had not seen them looking so well for some time."

At our inspection on 16 and 21 July 2015, we found that people were not being weighed as frequently as indicated in their care plans. At this inspection we found the situation had improved.

Staff we spoke with could not describe a culture where regular supervision and colleague support was effective. Staff told us they felt 'Thrown in at the deep end' when they started as other staff did not have time to spend mentoring them. Staff did not know about the purpose and value of supervision. Some staff could not remember whether there was an agenda and whether notes were taken at their last supervision. One member of staff said, "I think that I had supervision about five months ago". Another member of staff said, "We are told that we have to attend supervision before such and such date, but nobody tells you how to fit it in our already busy day. Give me the time and I will attend."

The supervision and annual appraisal tracker showed that supervisions were not happening every eight weeks as stated in the provider's policy. Between January 2016 and July 2016 there should have been 141 supervisions. However, only 55 had been recorded. In 2015 the records showed that only 92 supervisions had been recorded. During this period some staff had received two supervisions and others none. Between January 2016 and July 2016 the records indicated there should have been 19 annual appraisals, but only four had been recorded. This meant that people were not experiencing care that was provided by staff who were well supported and properly supervised. We discussed this with the manager. They told us that the newly appointed deputy manager would be responsible for the effective mentoring and induction of staff.

The examples above showed that staff were not receiving appropriate support, supervision and appraisal to carry out the duties they were employed to perform. This was a breach of Regulation 18 (1) (2) (a) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were provided with food and drink that enabled them to maintain a healthy diet and stay hydrated. People had their nutritional needs assessed and were provided with a diet which met their needs and preferences. Nutrition assessment tools were completed every month for each person and actions were taken to support people to stay healthy if they were considered to be at risk. For example, in cases were the person's body mass index (BMI) had dropped, the catering team was informed and they provided fortified food for the person. The care plans detailed to support people's wellbeing and enable staff to record progress.

We observed six people in the downstairs dining room. People were smiling and chatting to each other and one person was singing. This created an up-beat atmosphere which people engaged with, making the lunch service enjoyable.

People could access snacks and hot and cold drinks at any time and tea trolley rounds took place during the day. Staff told us that people could access drinks and snacks at night and foods like sandwiches were left for people to access. People were weighed regularly and when necessary what people ate and drank was recorded so that their health could be monitored by staff. We saw records of this taking place. Care plans detailed people's food preferences. People's dietary requirements were understood by the staff preparing and serving the food and the staff assisting people in the dining rooms or in their bedrooms. People's preferences were met by staff who gave individual attention to people who needed it.

People's physical health and mental wellbeing was protected by staff who were qualified and trained to meet these needs. Nurses informed us that they had received appropriate training to carry out their roles. This included statutory mandatory training, infection prevention and control, First aid and moving and handling people. The first aid training had provided them with information on how to manage/support people who may be bleeding or choking. A nurse gave us information about the revalidation process with the nursing and midwifery council (NMC) showing a good understanding of the purpose and process.

Training provided staff with the knowledge and skills to understand people's needs and deliver safe care. Staff told us that the training was well planned and provided them with the skills to do their jobs well. Training records confirmed staff had attended training courses or were booked onto training after these had been identified as part of staff training and development. This gave staff the opportunity to develop their skills and keep up to date with people's needs through regular meetings with managers.

Training was planned and specialised to enable staff to meet the needs of the people they supported and cared for. Staff received training in end of life care, wound care and gained knowledge of other conditions people may have such as diabetes and dementia. New staff inductions followed nationally recognised standards in social care. For example, the new care certificate. The training and induction provided to staff ensured that they were able to deliver care and support to people appropriately.

People's health was protected by proper health assessments and the involvement of health and social care professionals. People had routine access to their GP, and people had access to occupational therapist and other specialist services. We observed staff encouraged people to walk with their frames and noted that in doing this staff were following people's recorded care plan. Care plans covered risk in relation to older people and the condition of their skin referred to as tissue viability. The care plans could be cross referenced with risk assessments on file that covered the same area. Waterlow assessments had been completed. (Waterlow assessments are used in care and nursing settings to estimate and prevent risk to people, including from the development of pressure ulcers.) Staff understood how to effectively implement people's assessed needs to protect their health and wellbeing.

Staff understood that people needed to consent to their care. One said, "When I give care, I always ask them for their permission and tell them what I am about to do. Sometimes if they are confused or angry I leave them for a while and come back. I always get them to do as much as they can by themselves. Sometimes I find it quite helpful to talk about their likes and dislikes."

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 services 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. Care plans for people who lacked capacity, showed that decisions had been made in their best interests. The manager understood when an application should be made and how to submit them. Care plan records demonstrated DoLS applications had been made to the local authority supervisory body in line with agreed processes. This ensured that people were not unlawfully restricted.

Good

Is the service caring?

Our findings

People living with dementia were unable to verbally tell us about their experiences of the care at Copper Beeches. We observed friendly and compassionate care in the service. All of the people and relatives we spoke to told us that the staff were caring. They told us staff were, 'Very nice, very kind, that staff listen to them and that staff never refused anything people asked for.' One person said, "Staff work very hard." Relatives said, "The staff are very caring."

A health and social care professional commented. 'The staff are very young and show a calm demeanour towards those in their care. In the main staff remain remarkably cheerful and kind to the residents.'

Staff operated a key worker and named nurse system. This enabled people to build relationships and trust with familiar staff. People and their relatives knew the names of staff and the manager.

Staff built good relationships with the people they cared for. Staff promoted a non-discriminatory atmosphere and a belief that all people were valued. Throughout the inspection staff were busy and on the move, always attending to the people. Staff were helping people with their personal care, checking on people, keeping them comfortable and repositioning them if they were cared for in bed. Although there was a lot to do staff were calm and relaxed, they did not rush the people when assisting them during meal times or when delivering care. Staff took time to explain the care to the people. We observed staff respecting people's dignity by softly speaking to people so others could not easily hear, staff were getting on their knees in order to get close and maintain eye contact with people sometimes repeating the same instructions again and on more than one occasion multi-tasking. Staff encouraged independence by getting people to do as much for themselves as possible together with maintaining people's privacy and dignity at all times.

Staff were always accessible to the people. All of the staff we spoke with displayed a caring attitude and told us that they enjoyed helping and working with people. Staff said, "I get a lot of satisfaction from doing the job with a smile. When you give someone care with a smile you get a smile back and this is more that money can buy." And, "I love working with people."

Care plans described people's communication needs on a day to day basis. The care plans included a good level of information so that it would be clear to staff reading them how best to communicate with the people they were caring for. Relatives spoke positively about being able to access the person centred care plans for their loved ones. One relative said, "I can keep an eye on what my husband has eaten and the checks staff have been making on him."

People's rights were protected. People told us that staff respected their privacy. Records showed that independent advocacy support was provided for people who lacked the capacity to make certain decisions. Staff we spoke with described the steps they took to preserve people's privacy and dignity in the service. People were able to state whether they preferred to be cared for by male or female staff and this was recorded in their care plans and respected by staff. People were able to personalise their rooms as they

wished.

People's rights to consent to their care was respected by staff. People had choices in relation to their care. Care plans covered people's preferences about personal care and personal hygiene needs. The care plans made reference to promoting independence and helping to maintain people's current levels of self-care skills in this area. People or their representative had signed to agree their consent to the care being provided whenever possible. Staff confirmed they sought people's consent before they provided care for people. This meant that staff understood how to maintain people's individuality and respect choice.

People and their relatives had been asked about their views and experiences of using the service. The provider's quality policy included gaining written feedback from people about the service and from relatives and health and social care professionals. There were good levels of satisfaction from people who had experienced the service, either as a resident or relative. This enabled people to stay involved with developments and events within the service and give them the opportunity to influence decisions the provider had made about changes in the service.

Information about people was kept securely in the office and in locked cabinets with access restricted to senior staff. When staff completed paperwork they kept this confidential.

Requires Improvement

Is the service responsive?

Our findings

People living with dementia were unable to verbally tell us about their experiences of the care at Copper Beeches. We observed the responsiveness of staff and people's reactions to care being delivered. We saw that staff met people's needs when requested or in line with their care plans.

Relatives told us they could complain if they needed to. One said, "The staff are very approachable, if I needed to complain I am sure they would listen."

People had opportunities to take part in activities and mental stimulation, but it was not clear these were consistently delivered. There was a mixed picture in relation to the level of activities available. On the day of the inspection we did not observe any activities taking place. There were records in people's files of both group and one-to-one activities taking place. We did see, at times, care staff sitting with people and chatting. However, when we spoke to staff the majority told us that they did not get enough time to stay with people for long. There was an activities planner on display for people from the week before our inspection. We noted that there was one activities coordinator who worked Monday to Friday. When we arrived for the inspection we were informed that the activities person was on leave. However, later in the day the activities co-ordinator was seen in the service updating the activities planners and daily displays of day, date and weather. The activities co-ordinator did not work weekends nor were they covered on days off. There were six people cared for in bed and it was not clear how much time was spent with them on activities to reduce social isolation. The levels of resources being put into activities had been reduced. At our last inspection there were two full time activities co-ordinators. We saw from the manager's business development plan that they intended to reduce activities by 50%. There was no evidence showing activities took place outside the service.

The examples above showed that people were not consistently able to access activities that would meet their needs. This was a breach of Regulation 9 (1) (a) (b) (3) (b) (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care was kept under review and changes were made to improve their experiences of the service. Staff had a good understanding of offering choice to people. Staff told us that people have a lot of choice, one said, "We ask people what and where they want to eat and they can have snacks at any time. They can choose what time they want to get up and what time they want their personal care, they can choose the type of clothes they want to wear." We observed staff presenting two plates of food to a person and asking him which one he preferred at lunchtime. Staff told us people could change their minds about decisions they had made and this was respected.

People received care from staff who were aware of their needs, their individual likes and dislikes and their life stories, interests and preferences. People's needs had been fully assessed and care plans had been developed. Before people moved into the service an assessment of their needs had been completed to confirm that the nursing or residential service was suited to the person's needs. Risk identified in each area had an associated care plan which listed interventions to be implemented to address reduce the risks.

We saw records of referrals to GPs and other external professionals seeking advice from them when required. There were some people who received additional support from the community mental health teams.

People's health and wellbeing was protected by care planning. The care plans were well written. They focused on areas of care people needed, for example if their skin integrity needed monitoring to prevent pressure areas from developing. The care plans showed that people's diet, weight, blood sugar was regularly monitored and recorded. People also had support from District nurses via GPs when requested. Separate personalised information about people's life histories was available or being put into place in people's bedroom files, telling others who people were and about their lives and loves. Knowing about people's histories, hobbies and former life before they needed care could assist staff to help people to live fulfilled lives, especially if they were living with memory loss, dementia or chronic illness.

The manager and staff responded appropriately to maintain people's health and wellbeing. Dependency assessments had an emphasis on weight and body mass indicators. Nurses had implemented weight management plans based on advice from a dietician and emergency health care plans had been completed in response to people's illnesses. We cross checked this against the care plans and found they were kept under review. This had resulted in the people maintaining their health through good hydration and nutrition and minimised the risk of infection. After people had been unwell, the progress to recovery was monitored by nursing staff and if necessary further advice had been sought from their GP. This ensured that people's health was protected.

People experienced a service that enabled them to openly raise concerns or make suggestions about changes they would like. This increased their involvement in the running of the service. There was a policy about dealing with complaints that the staff and the manager followed. Information about how to make complaints was displayed in the service for people to see. There had been four formal complaints recorded so far in 2016. The manager had responded to the complaints in writing. A relative told us that they had complained to the manager about the food and the issue had been resolved to their satisfaction. Complaints were monitored higher up in the organisation to assist the manager to resolve issues.

Good

Is the service well-led?

Our findings

The provider had appointed a new manager who was in charge of the day-to-day running of the service. The new manager was experienced in managing this type of service and had held registration in two other similar services. The outgoing manager was still in post and was supporting the new manager during their induction. The management team were supported to manage the service by the provider's regional manager who visited the service regularly.

People's relatives and staff acknowledged that there had been improvements in the service under the current manager and recognised there was still more to do. For example, they were worried about staffing levels. However, our discussions with the new manager demonstrated that they understood the challenges faced by the service and they had the experience to ensure that improvements continued.

The manager carried out regular audits of health and safety risks within the service and of the quality of the service provided. There was a five star food hygiene rating displayed from the last food hygiene inspection. The manager told us that the provider listened to, considered and acted on requests made for additional resources.

General risk assessments affecting everybody in the service were recorded and monitored by the manager. Service quality audits were planned in advance and recorded. The frequency of audits was based on the levels of risk. For example, daily management walk around audits had taken place to check for any immediate risk such as trip hazards or blocked exits. The audits covered every aspect of the service.

The manager checked that risk assessments, care plans and other systems in the service were reviewed and up to date. All of the areas of risk in the service were covered; staff told us they practiced fire evacuations. Each audit had an action plan. We could see that issues identified on audits were shared with staff and it had been recorded how and when they would make the improvements.

Staff told us they felt supported by their manager. There were various meetings arranged for nursing and care staff. These included daily shift hand over meetings. These meeting were recorded and shared. Information about how staff could blow the whistle was understood by staff. Staff told us about their responsibilities to share concerns with outside agencies when necessary. Staff also confirmed that they attended team meetings and handover meetings. Staff felt that they could speak up at meetings and that the manager listened to them. This meant that staff were involved in how the service was run.

There were a range of policies and procedures governing how the service needed to be run. They were kept up to date with new developments in social care. The policies protected staff who wanted to raise concerns about practice within the service.

Maintenance staff ensured that repairs were carried out quickly and safely and these were signed off as completed. Other environmental matters were monitored to protect people's health and wellbeing. These included legionella risk assessments and water temperatures checks, ensuring that people were protected

from water borne illnesses. The maintenance team kept records of checks they made to ensure the safety of people's bedframes, other equipment and that people's mattresses were suitable. This ensured that people were protected from environmental risks and faulty equipment.

The manager produced development plans showing what improvements they intended to make over the coming year. These plans included improvements to the premises. For example, we saw that parts of the service had been refurbished, which included the downstairs dining room being made more homely with a fire place and an area of reminiscence for people. The provider had also approved the expenditure for a fruit garden to be developed in the outside spaces.

The manager was proactive in keeping people safe. They discussed safeguarding issues with the local authority safeguarding team. The manager understood their responsibilities around meeting their legal obligations. For example, by sending notifications to CQC about events within the service. This ensured that people could raise issues about their safety and the right actions would be taken.

The provider's regional manager was often on site. They had assisted the manager to develop the service systems and they were kept informed of issues that related to people's health and welfare and they checked to make sure that these issues were being addressed.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care The design of activities provided for service users did not ensure their needs and preferences were met. Regulation 9 (1) (a) (b) (3) (b) (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not receiving appropriate support, supervision and appraisal to carry out the duties they were employed to perform. This was a breach of Regulation 18 (1) (2) (a) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.