Mrs Jane Hart

Colindale Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Colindale Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Colindale Care Home is registered to provide accommodation, care and support for up to 14 people. At the time of the inspection there were 13 people living at the home.

This unannounced comprehensive inspection took place on 15 and 16 November 2017.

There was a registered manager 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.'

People told us they were happy living at the home and felt they were well cared for. Relatives spoke positively about the way care and support was given. One relative said, "We've been very happy with the general care and have no complaints, any problems are sorted straight away…it's been very good."

At this inspection we found two breaches of the regulations.

People received their medicines as prescribed but we found weaknesses regarding the storage and management of medicines. This was a breach of the regulations.

We identified weaknesses in the provider's governance systems. The provider's existing audits and systems had not identified these weaknesses which meant these audits and systems were not fully effective. This was a breach of the regulations.

Staff were aware of what constituted abuse and the actions they should take if they suspected abuse. Relevant checks were undertaken before new staff started working at the service which ensured they were safe to work with vulnerable adults.

Staff had the right skills and training to support people appropriately. Staff spoke knowledgeably about how people liked their care and support to be given. Staff had completed or were in the process of completing The Care Certificate, which is a nationally recognised set of standards for health and social care workers.

Staff told us they felt well supported to carry out their roles and told us everyone worked very well together as a team for the benefit of the people living at Colindale Care Home.

Pre-admission assessments were completed prior to people moving into the home. People's risks were assessed and plans developed to ensure care was provided safely. Accidents and incidents were monitored

to ensure any trends were identified to enable action to be taken to safeguard people.

People were referred to health care professionals as required. If people needed additional equipment to help them mobilise or keep them safe and comfortable this was readily available.

The manager was aware of their responsibilities in regard to the Deprivation of Liberty Safeguards (DoLS). These safeguards aim to protect people living in care homes and hospitals from being inappropriately deprived of their liberty. These safeguards can only be used when there is no other way of supporting a person safely.

Staff ensured people's privacy and dignity was protected. People received personalised care from staff who were responsive to their needs and knew them well. Staff created a relaxed, friendly atmosphere in the home.

People told us they enjoyed the choice of home cooked food that was available at Colindale Care Home. Food was presented in an appetising way and people were supported sensitively to eat their meals whilst being encouraged to retain as much of their independence as possible.

People had access to a range of activities that they enjoyed taking part in. We observed individual and group activities were available for people throughout our inspection.

People told us they knew how to make a complaint and said staff listened to them and took action if they needed to raise concerns or queries.

People told us they felt the service was well led, with a clear management structure in place. Relatives told us they were made to feel welcome at any time and were always kept informed of any changes to their relative's health and care needs.

There were some systems in place to drive the improvement of the safety and quality of the service. The manager was in the process of implementing further quality assurance systems.

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 generally safe but improvements were needed in relation to the management and storage of medicines.

Staff were safely recruited and there were enough staff on duty to provide safe care and support for people

Staff demonstrated an understanding of the signs of abuse and neglect. They were aware of what action to take if they suspected abuse was taking place.

Is the service effective?

Good

The service was effective. Staff worked in accordance with the Mental Capacity Act 2005.

Staff received on-going support from senior staff who had the appropriate knowledge and skills.

Induction and supervision processes were in place to enable staff to receive feedback on their performance and identify further training needs.

People had access to a range of healthcare professionals as appropriate.

Is the service caring?

Good

The service was caring. Care was provided with kindness and compassion by staff who treated people with respect and dignity.

Staff were aware of people's preferences and took an interest in people and their families in order to provide person centred care.

People and relatives told us that staff were kind, caring and compassionate.

Is the service responsive?

Good

The service was responsive. People had personalised care and support plans which took account of their likes, dislikes and

preferences.

Staff were responsive to people's changing needs.

People's views were sought. They felt they could raise a concern if required and were confident that these would be addressed promptly.

Is the service well-led?

Requires Improvement

People and staff felt the service was well led, however breaches of the regulations were identified during the inspection that had not been identified by the management team.

There was a system of audits in place but these were not consistently effective in highlighting shortfalls in the delivery and quality of care.

Staff felt well supported by the management team. Staff felt comfortable to raise concerns if needed and felt confident they would be listened to and any concerns acted upon.

Observations and feedback from people and staff showed us the service had a supportive, honest, open culture.

Colindale Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This comprehensive inspection took place on 15 and 16 November 2017 and was unannounced. One CQC inspector conducted the inspection.

Before the inspection we reviewed the information we held about the service. This included information about incidents the provider had notified us of. We also asked the local authority who commission the service for their views on the care and service given by the home. We requested written feedback from a selection of health professionals and GPs who visited the home on a regular basis.

The provider had completed a Provider Information Return (PIR) inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they planned to make. We used the information in the PIR to plan and undertake the inspection.

During the inspection we met and spoke with all of the people living at Colindale Care Home. We spoke with the owners, the registered manager, the administration manager, four members of care staff, and four relatives.

We observed how people were supported and looked at three people's care, treatment and support records in depth. We reviewed the medication administration records and medicine systems. We also looked at records relating to the management of the service including staffing rota's, three staff recruitment and training records, premises maintenance records, accident and incident information, policies and audits and staff and resident meeting minutes. Following the inspection we asked the registered manager to forward premises maintenance certificates and audits that were still waiting to be received from independent companies who had completed the work. We received this information as agreed.

We used the Short Observational Framework for Inspection (SOFI). This is a way of observing care to help us

understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

We asked people if they felt safe living at Colindale Care Home. People replied, "Oh yes" and "Of course, nothing to worry about here." A relative told us, "I never have to worry, she is cared for very well."

People received their medicines as prescribed but medicine storage and medicine management systems were not always safe. Medicines were stored in a medicine cupboard in the communal lounge. There was not a system in place or equipment available for recording the daily temperature of the medicine cupboard. This meant staff would not know if temperatures were outside of recommended guidelines which could pose a risk some medicines would be compromised. Staff were not able to tell us the safe range of temperatures for the storage of medicines.

Medicines that were required to be stored in cool temperatures were kept secured in a container within the homes communal fridge. The daily temperatures of the fridge were not recorded and there was no guidance for staff stating what the safe maximum and minimum temperature should be.

We reviewed people's medication administration records (MARs). Where the MARs had been handwritten, two staff had not signed to authorise the handwritten entries. This meant there was not a system in place to check handwritten MARs were correctly completed. This could pose a risk people may not receive their medicines as prescribed.

Some people, under a 'best interests decision' of the Mental Capacity Act 2005 (MCA) needed to have their medicine administered covertly disguised in their food or drink. For these medicines there was not an authority from the pharmacist to confirm the medicines would be effective if they were crushed or given covertly in food or drink. We discussed this with staff, who were not aware that it was good practice to seek advice from a pharmacist when crushing medicines. This was to ensure that the medicine was suitable to be crushed, and to check whether there were any foods or drinks that the crushed medicine should not be given with.

These shortfalls in the proper and safe management of medicines were a breach of regulation 12 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The stock of medicines recorded in the medicine stock book accurately reflected the stock of medicines held at the home. This showed medicines were accounted for accurately.

Staff who administered medicines to people had completed training in medication administration and received annual medicine administration competency checks. People's MARs showed medicines had been signed for when given. There was a photograph at the front of each person's records to assist staff in correctly identifying people and people's allergies were clearly recorded. Occasionally there were some minor gaps in the recording of people's MARs. Staff said they normally wrote on the back of the MARs when gaps occurred but this had not been done for the records we saw. This is an area for improvement. The registered manager said she would discuss these findings with the staff involved. Generally, MARs showed

staff had initialled each dose of medicine that was due.

People had their allergies recorded and basic guidance on the use of 'PRN' as required medicines was recorded. The majority of people were able to tell staff if they needed pain relief. If people were unable to verbalise their pain levels, staff used an independent pain management tool to advise them if people needed additional pain relief. If people were prescribed transdermal pain patches, staff told us they placed each patch on an alternate position on the body to avoid the risk of the patch irritating the skin. A transdermal patch is a medicated adhesive patch that is placed on the skin to deliver a specific dose of medicine through the skin and into the bloodstream. Staff told us they would be implementing the use of body maps to record where the transdermal patches were placed on the body. This would ensure alternate sites on the body were used for each patch and reduce the risk of skin irritation.

There was a system of colour coded body maps in use to ensure people's prescribed creams would be applied correctly. The body map clearly guided staff on where to apply the prescribed creams. Creams were generally signed and dated by staff when they were opened.

During the inspection the registered manager told us they were going to approach independent pharmacies to see if they would visit the home and complete a medicine audit. This was completed in the immediate days following our inspection.

Staff had access to personal protective equipment such as gloves and aprons. We saw anti-bacterial hand gels were readily available for all people to use throughout the premises. The registered manager showed us they were in the process of re furnishing and redecorating the premises.

We found areas where improvements were needed in the provider's infection control processes. Some bedrooms had furniture and wall coverings that were damaged and could pose an infection control risk. Some commodes had areas of rust on their frames and some hand basin vanity units had water damage to their surfaces and had started to crack and flake. We discussed these findings with the registered manager who told us in addition to their refurbishment programme they would be reviewing their infection control processes. They said they would shortly be implementing a new infection control audit system which would ensure all areas of infection control would be checked and reviewed on a regular basis.

One person had denture cleaning tablets on display in their room. These can pose a risk to people's health if they are accidentally swallowed. We brought this to the attention of a member of staff who immediately placed them out of sight in a cupboard. They told us the cleaning tablets were normally stored out of sight. We recommend the service adheres to current guidelines regarding the safe storage of denture cleaning tablets in services that accommodate people living with dementia.

We visited the laundry and saw all laundry was placed on a hot/boil wash to ensure bacteria would be killed and the risk of cross contamination reduced.

Staff spoke knowledgably about the different types of abuse that people may be subjected to. They knew the procedure for reporting allegations of potential abuse and who to contact for advice and guidance. Training records confirmed staff had completed their safeguarding adults training courses and received refresher training when required.

There was a system in place to ensure people's risks were continually assessed and plans were in place to reduce these risks. The registered manager showed us the recent improvements and changes they had made in the compilation of people's risk assessments, care plans and care and support records. Each

person had an effective one page summary completed for them. This gave staff an easy 'at a glance' record of all information that was important to care and support people safely.

Care plans and risk assessments had been updated to reflect people's changing health needs. We reviewed, in depth, the care and support records of three people. This was so we could evaluate how people's care needs were assessed and care was planned and delivered.

People had their needs assessed for areas of risk such as mobility, malnutrition, moving and handling and pressure area care. Records showed if people's health was deteriorating the person was referred to a health care professional such as the district nursing team, occupational therapist or GP.

There were systems in place to ensure the safety of the premises, including regular servicing of equipment. There were up to date service certificates for the majority of the premises equipment and services. Up to date certificates were available for electric portable appliance testing, gas safety, fire alarms, fire extinguishers, call bell alarms and safety certificates for the lift and lifting equipment such as hoists. The provider completed a flush of the water system and monitored the water temperatures on a regular basis.

The registered manager confirmed the premises had not had a recent Legionella test conducted. This is an area for improvement. Legionella is a water borne bacteria that can be harmful to people's health. They confirmed they would arrange for a Legionella test to be completed as soon as possible following the inspection.

The provider had made arrangements to deal with emergencies. People had a personal emergency evacuation plan completed for them which gave staff guidance on how they would need supporting in the event of an emergency.

Accidents and incidents were documented and reviewed each month by the registered manager. Summaries of analysis, outcome and risks identified were completed so that any trends would be highlighted and preventative action could be taken.

The manager told us being a small home they knew on a day to day basis how many staff they would need on each shift to maintain people's safety. They told us staff cover was provided from within the current team and they did not use agency staff to cover for staff absences. This meant people were cared for in a consistent way by staff who knew them well. Staff rotas confirmed the required number of staff were present on the day of our visit. There were two members of staff employed for night shifts to support people. People and staff told us there were sufficient numbers of staff to support people safely. We asked one person if they had ever needed to call for support in the night. They told us, "Sometimes I have done, but I normally don't have to wait long, it's ok." During our visit staff did not appear rushed and people and their relatives told us they received help and support when they needed it.

Recruitment practices were safe and the relevant checks had been completed before staff worked unsupervised at the home. These checks included the use of application forms, an interview, reference checks and criminal record checks. This made sure that people were protected as far as possible from staff who were known to be unsuitable.

Good

Is the service effective?

Our findings

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. The registered manager showed us the recent work that had been carried out around the completion of best interests decisions for people. This would aim to ensure staff followed the principles of The Mental Capacity Act 2005 when providing care and support to people.

Mental capacity assessments and best interest decisions were in place for people in relation to specific decisions. Where possible these decisions had been made in consultation with people's relatives, representatives and health professionals. There was a system in place to check if people had a Lasting Power of Attorney arrangement for health and welfare and/or finance. This meant people would have appointed people to help them make decisions or support them with decisions made on their behalf.

Where people were living with dementia and had been assessed as not having the capacity to make decisions about their personal care, a 'best interests decision' had been completed for them. These covered a range of areas, including having their medicines administered covertly disguised in their food and drink. One member of staff had completed all the best interests decisions for people and they were knowledgeable about following the principles of the Mental Capacity Act 2005.

The manager was aware of their responsibilities in regard to the Deprivation of Liberty Safeguards (DoLS). These safeguards aim to protect people living in care homes and hospitals from being inappropriately deprived of their liberty. These safeguards can only be used when there is no other way of supporting a person safely. The responsibility for applying to authorise a deprivation of liberty rested with the registered manager.

All of the people living at Colindale Care Home either had a DoLS in place or were in the process of having a DoLS applied for with the local authority. All DoLS were standard authorisations and did not have any specific conditions placed on them. Most of the DoLS had expired, we discussed this with the registered manager who said the local authority were aware and were managing the situation. Following the inspection the registered manager stated they had reviewed all of the DoLS with the local authority and confirmed a system was in place with the local authority to manage and review their DoLS.

Each person was assessed before they started living at Colindale Care home. This was to ensure the service was able to meet their health and support needs and provide them with person centred care in line with current guidance. Admission assessments identified people's health needs and led to the completion of a detailed care plan that gave staff guidance on how people preferred their care and support to be given.

People had a range of health risk assessments completed about them which included, skin integrity, nutrition and mobility. These were reviewed each month to ensure people received appropriate care to

maintain or improve their health and promote a good quality of life.

Call bells were within easy reach and available for all people that had the mental capacity to use them. We observed people were able to use a call bell when they were in their bedrooms and in all the communal areas. We chatted to one person about their call bell. They told us, "Oh I know all about that… I press it if I need someone, it's ok."

If people liked to mobilise on their own and were assessed as being at a high risk of falls, they had alarm pressure mats in place to alert staff when they were moving around. This ensured staff were alerted to when the person was mobilising and could be with them in time to help prevent the risk of them falling. Staff explained they had recently introduced an alarm mat for one person which had directly led to a reduction in the amount of falls the person had experienced. All falls and incidents were reviewed each month and analysed in a pictorial format so that preventative action could be put in place to prevent re-occurrence.

People received care and support from staff who had the appropriate training and skills to complete their job effectively. We reviewed the training schedule which showed staff received regular training in all the core subjects such as, nutrition and hydration, dementia awareness, safeguarding, medication, moving and handling and fire safety. Additional training such as end of life care, falls prevention and safe swallow (difficulty or discomfort in swallowing) was also offered.

Staff told us they enjoyed the training which was delivered in a variety of ways, either electronically, individually or in small groups by an independent training provider. One member of staff said, "The training has been really good, I've learnt a lot and it all makes so much sense." Another member of staff said, "It's really important to keep up to date with the training…methods change all the time and we have constant update training so we know we are doing everything right".

Recently recruited staff were in the process of completing the Care Certificate which is a nationally recognised induction training programme. The Care Certificate is designed to help ensure care staff that are new to working in the care service have initial training that gives them an understanding of good working practice within the care sector. We spoke with staff about their induction process. Staff told us they had felt well supported throughout the process and had always been with a more experienced member of staff when they started their employment. Staff spent time 'Shadowing' more experienced staff for as long as they needed before they were assessed as being competent to care and support people independently.

There was a system of staff supervision, review and appraisal in place. Records showed staff received regular supervision sessions with their line manager. These were conducted in a positive way and gave staff the opportunity to put forward additional training requests. Staff said they found their supervision sessions useful and helpful. One member of staff said, "Everyone here has been so friendly and helpful. I can ask for help at any time, with any one, it's been really good".

We observed a lunchtime during our inspection. Six people took their dinner in the dining room and they were all able to eat independently. When one person required some assistance with their meal, this was given in a sensitive way by staff. People were given choice regarding their meal time experience. People chose where they wished to sit. Some sat with people they knew, others preferred to sit at a table on their own.

Staff spoke knowledgeably about what food and drink people liked and how they preferred their food to be presented. For example some people needed their food cut into small bite size pieces or mashed to a 'soft' consistency so they could eat their food independently in a safe way. Staff took time to explain what was on

the menu and people were offered a choice of cold or hot drinks and fruit juices. All meals were home cooked and staff knew what people liked to eat.

We observed people were given choice, one person did not want the chilli con carne that was on the menu and had their choice of faggots instead. Another person enjoyed a glass of milk with their meal and this was ready for them when they sat down. One person requested an omelette and this was made for them. When people had finished their meal, staff asked if they wanted any more. One person said, "Oh no, I really enjoyed that, I couldn't eat anymore". Another person said, "That was good, they certainly have good food… that was very good". Another person was asked if they would like a yoghurt or apple pie and cream but they declined both saying "No thanks I've had enough". People enjoyed their meal time experience and one person was singing softly to themselves while others chatted to each other.

Plain white or cream crockery was used throughout the home. People living with dementia and or sight loss would have benefitted from eating and drinking from brightly contrasting coloured crockery. This is because research has shown that food and drinks are easier to see and people subsequently eat and drink more. We recommend the provider adheres to current guidelines regarding appropriate coloured crockery for people living with dementia.

Some people required their food and fluid to be monitored to ensure they were eating and drinking enough to prevent the risk of malnutrition or dehydration. There was a system in place for staff to record the amount of food and fluid people ate during the day. The system included target fluid amounts for people, which meant staff could see how much people needed to eat and drink to remain healthy. Staff knew people well and told us how one person liked to eat little and often. They ensured this person was not overwhelmed with food and this meant they ate well. If they had too much food on their plate they would not eat it.

People had their weight checked and recorded regularly and any major fluctuations were referred to a health professional or dietician. A selection of cakes, biscuits and fruit were available throughout the day and we observed staff offering people hot or cold drinks and a variety of fruit juices. Relatives and people spoke appreciatively about the food, they told us, "It's good, no complaints" and "There's plenty of it, very nice".

There were systems in place to monitor people's on-going health needs. Records showed people were referred to external services such as the mental health team and physiotherapists when changes in their health occurred. Regular visits were made to people by a variety of healthcare professionals such as GP's, district nurses, chiropodists and opticians. All the relatives we spoke with told us they had full confidence in the staff that their relative was given the best care and support for their on going healthcare needs.

There was a health passport system in place to ensure people had consistent care when transferring between services, for example when people were admitted to hospital. The system included important personal information for each person, such as, a summary of their medicines, a Do Not Attempt Resuscitation (DNAR) if required, things that are important to the person such as their likes and dislikes, things that cause them distress and anxiety and things that bring them calm and pleasure.

Some people living at Colindale Care Home were able to move independently around the home. We observed they mobilised safely around the home during our inspection and spent time chatting to staff and people in all areas of the home. People that needed support and assistance were supported by staff who were kind and patient. For people with restricted mobility there was a lift that took them to the second floor. Bathrooms and toilets had grab rails in place to assist people in maintaining their independence. People and relatives told us they could choose where they liked to spend their time and had the choice of sitting in

the main lounge, the dining room, the quiet room, their bedroom or in nice weather, outside in the garden.

Most bedrooms were personalised with people's own furniture, bed linen, pictures, ornaments and photographs. The registered manager told us the home was undergoing a schedule of refurbishment and redecoration. They said this was a gradual process and showed us some bedrooms that had been refurnished and redecorated. They told us the aim was to do all communal areas and all remaining bedrooms. They also said the kitchen would be refitted and updated with stainless steel work surfaces to adhere to current HSE guidelines.

Good

Is the service caring?

Our findings

People and relatives told us they found all the staff to be kind, caring and friendly. People told us, "The staff are great, very kind indeed". A relative told us, "The care and staff here are amazing, they get on so well with [relative] and know exactly how to care for them". Another relative told us, "The staff always phone me to let me know what's happening. I'm made to feel very welcome, everyone is very approachable. I've no concerns at all, I'm very happy with everything."

Throughout our inspection we observed people were treated with dignity and respect by staff. There was a relaxed, friendly atmosphere in the home. People were offered choices about what they would like to do, where they would like to sit and what food and drink they would like. Staff knocked on people's bedroom doors before entering them and called people by their preferred name. Personal care was carried out in people's bedrooms to ensure their privacy was maintained. People's care records were kept securely in a lockable room and no personal information was on display.

Staff interacted with people in a friendly and unrushed manner and were able to explain how people preferred their care to be given. People sought staff out to chat and spend time with, staff genuinely cared for people which showed in the positive way they interacted and spoke with them. Staff spoke fondly and knowledgeably about the people they cared for explaining how people liked to spend their day and what their likes and dislikes were.

Staff reassured people and if people got anxious or agitated they spent time talking with them and engaging them in different activities until they became calm.

Staff told us they were given enough time to support people in the way they preferred. We observed staff spending time with people on a one to one basis taking time to chat and reassure them. Relatives told us staff were always available to discuss any questions or queries they may have. They told us, "I can ask any one, they are all friendly and always have time for you."

Staff explained how one person preferred to communicate in a non verbal way. They showed us the specific actions the person made when they wanted to communicate and how they interpreted their body language to ensure they were comfortable and had enough food and drink. Another person who was living with dementia, liked to actively walk around the home. Staff interacted positively with them, chatting to them and involving them in their daily tasks. The person enjoyed the time they spent with the staff and remained calm and settled. We spent time with this person who told us they really liked their time with the staff as it cheered them up and made them feel good.

People or their relatives were involved in planning their care and lifestyle in the home. Records showed people's views and preferences for care had been sought and were respected. People's life histories, their important relationships, hobbies and previous life experiences were documented in their care plans. The records included detail about how people preferred to spend their day, their night time needs and what social activities and hobbies they enjoyed. This information was useful for staff to get to know the person

well and provide activities they enjoyed.

Relatives told us they felt communication in the home was effective. They told us, "They are really good with letting me know if anything has happened. They are quick to pick up the phone, it's really reassuring.

Good

Is the service responsive?

Our findings

People received personalised care and support based on their individual preferences, likes and dislikes. The registered manager told us they had recently changed the format of people's care and support plans and we reviewed a selection of these. Care records and summaries reflected people's physical, mental, emotional and social needs and were divided into areas which included; mental health, medicines, mobility, bathing, communication, nutrition and spiritual needs. The assessments showed people and their relatives had been included and involved in the process wherever possible.

The provider used recognised risk assessment tools to assess the risk of malnutrition, poor mobility and skin breakdown. People's assessed needs were then recorded in their care plans that provided staff with guidance on how the person liked to receive their individualised care and support. Examples included, 'Explain what is happening and why, talk calmly and reassure, use correct handling to ensure any discomfort is minimised' and 'I like to be as independent as possible. Please dry and style my hair for me. I do like it to look nice'.

Some people had been diagnosed with diabetes and we discussed with staff how these people were given appropriate care and support to maintain their health. Staff had received specialised training in supporting people diagnosed with diabetes. Staff spoke knowledgeably about how people may present if they were to become either hypo or hyperglycaemic and what action to take if they suspected people were at risk of a hypoglycaemic episode.

Care plans were reviewed each month or more frequently if people's care needs changed. Where care plans stated people needed specialist equipment such as pressure relieving cushions and mattresses, we saw these were in place and set at the correct setting for the person's weight. People were weighed regularly depending on their health needs and records showed they were referred to their GP or dietician when required. Body maps were in place to record any bruising or injuries sustained by a person.

People were encouraged to take part in a varied range of activities provided by the home. Activities covered group sessions as well as individual hobbies and interests that people liked. People were supported to maintain their preferred faith and visits were made to the home from a variety of religious groups. People who preferred to spend time on their own were given one to one support by staff, which included, water colour painting, hand massage, reading and reminiscence sessions. This meant people were protected from the risk of social isolation and were encouraged to take part in activities that enriched their lives and promoted their well being.

We spoke to people and relatives about what activities were on offer that they were able to take part in. One person told us, "I love singing, did you see me this morning with the singer? I love singing and sing as much as I can. I used to teach people to sing…I loved it." Another person told us, "I liked the singer today, it was great." Relatives told us they were happy with the level of activities offered and told us about the different independent entertainers that visited the home. These included, various animal, bird and reptile acts, singers and visits from local art museums that conducted talks and brought in relevant memorabilia for

people to reminisce about and discuss. The home also provided daily activities such as, quizzes, sewing and arts and crafts sessions.

The registered manager told us staff accompanied people out into the community. These visits included attendance at religious events as well as for health appointments such as hospital appointments. The registered manager said over the Easter period they had arranged for some active hatching chicken eggs to be kept at the home. People had enjoyed watching the chickens hatch and progress each day.

Staff were knowledgeable about people's needs and provided the support they required. People's individual communication needs were identified in their care plan and clear guidance was given for staff on ensuring their communication needs were met. Staff used a nationally recognised system for people who were not able to verbalise when they were in pain. The system used pictures for people to indicate if they needed additional pain relief. For those people that were unable to use this tool, staff knew people well and explained how individual people presented when they were in pain.

For people who did not have capacity to use the call bells, staff made regular visits to them to ensure they were comfortable. The majority of people were able to spend their day in the communal areas which enabled staff to check they had everything they needed. For people that were not able to verbalise their health needs, staff were able to explain how these people used their body language to communicate to staff.

There was a system in place for receiving, investigating and resolving complaints. People and relatives told us they knew how to make a complaint and felt any concerns they raised would be listened to and resolved to their satisfaction. There were no on going complaints at the time of the inspection. There was guidance on display in the communal areas of the home, informing people how and who to make a complaint to if required. Some of the information required updating; we discussed this with the registered manager who ensured the information was updated straight away.

The provider had received three complaints in the previous twelve months. Records were not always consistently completed. Records showed the complaints had been acknowledged with the parties involved but not all of them showed if a conclusion had been agreed. We discussed this with the registered manager who told us all complaints had been fully resolved. We recommend the provider ensures a full audit trail is followed in accordance with the provider's complaint policy.

Records showed compliment and thank you correspondence was received from people and relatives. Comments included, 'I am so grateful for the care you have provided…It is a huge relief to know that [person] is now safe and appropriately cared for'.

The provider had attained the Gold Standards Framework award. The National Gold Standards Framework (GSF) is a nationally recognised training programme for people providing end of life care to ensure better lives for people and recognised standards of care. People had Advance Care Plans completed for them, these outlined their choices and wishes for the end of their life. Records showed relatives and representatives were consulted and supported with compassion and kindness when their relative reached the end of their life. We saw cards and correspondence from relatives that showed their appreciation for the kind care and support that was given to both them and their relative when the person was reaching the end of their life.

Requires Improvement

Is the service well-led?

Our findings

Although people and relatives told us they felt the service was well led, we identified some areas where improvements were needed. There was a system of audits in place to monitor the quality of service provided to ensure people's care needs were met. These audits included, medication, care plans, accidents and incidents, falls and infection control. However, during our inspection we identified breaches in regulation for management of medicine. The provider's existing audits and systems had not identified these weaknesses which meant these audits were not fully effective.

These shortfalls in good governance were a breach of regulation 17 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they felt well supported in their role, they said the management team were approachable and available for help and guidance when they needed extra support. Staff and relatives spoke of the open and honest culture within the home and felt the whole staff team worked well together to create a friendly, homely atmosphere. The registered manager felt proud of their staff team and told us they all worked so well together to ensure people received the best care. Staff told us, "Being a smallish home, we are all like a big family, we all help each other. We all know everyone so well. It's lovely…just like a big family."

Staff demonstrated an understanding about equality, diversity and human rights. One member of staff told us, "It's all about the people who live here, we always look after their best interests, we're here for them and to help them do what they want to do." The registered manager told us there was a plan in place to review and update all of the service's policies which would include equality and diversity. Staff felt they were treated fairly by the management team and supported well to do their job to the best of their ability. One member of staff said, "I've learnt so much, everything is explained really well, I really enjoy it, I don't think there is anything they need to improve on, everyone receives really good care here."

People and staff described the culture of the home as, "Friendly, supportive, homely and open". Staff told us communication within the home was good and they could approach anyone for help and advice. There was a communication handover book that all staff read and completed. Handovers were completed at the start and end of each shift and staff were knowledgeable about people's changing health needs. This ensured staff were kept up to date with changes to people's care and support.

The registered manager told us they had not held a recent relatives or resident meeting. They said as a small home they were able to speak with most relatives regularly. All of the relatives we spoke with told us they felt they were kept well informed about the health of their relative. They told us they felt involved and consulted with the on going care and support given to their relative and said they found the management team and staff approachable, friendly and supportive. A service satisfaction questionnaire had not been sent out since the last CQC inspection. The registered manager told us this would be sent out in the near future.

The previous CQC report and rating was displayed in the communal area of the home as required by the

regulations. Records were stored securely and computers were password protected to ensure people's privacy and confidentiality were respected.

Regular staff meetings were held with topics discussed and actions recorded for staff to view if they had been unable to attend the meeting. Staff told us they found the meetings useful and informative. Staff told us they always felt listened to by the management team and said they would have no hesitation in raising any concerns or ideas they may have. Staff were aware of the provider's whistleblowing policy, and felt comfortable to use it should they be required to.

The provider had a range of policies covering topics, such as; staff recruitment, safeguarding adults, disciplinary and grievance and mental capacity. The registered manager told us there was a plan in place to review and update all of the services policies.

The registered manager understood their responsibilities to provide notifications to the Care Quality Commission (CQC) regarding significant events such as; serious injuries and deaths. The registered manager told us they kept updated about changes in practice via email correspondence sent out by the local authority and the Care Quality Commission. They said they had positive relationships with the local healthcare professionals such as GP's, district nursing teams, occupational therapists and the mental health team. The registered manager acknowledged they would investigate further local forums and workshops that they could attend which would support them in their role and provide opportunities for on going learning and guidance.

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 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always safely managed and stored.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance We identified shortfalls in the provider's governance systems. The provider's existing audits and systems had not identified these weaknesses which meant these audits and systems were not fully effective.