Camellia Care (Chandler's Ford) Ltd

Valley Lodge Care Home

Inspection report

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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?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

The inspection took place on 23 and 24 October 2018 and was unannounced. At our last inspection in November 2015 the service was rated as good overall. One area requiring improvement was in the reporting of incidents, which the provider has since addressed.

As a result of this inspection we have made one requirement. This is where we have identified a statutory breach of regulations. The breach in regulation requires the provider to make sure the service complies with legislation designed to protect people's rights, in this case the requirements of the Mental Capacity Act 2005.

Valley Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service provides accommodation and personal care and support to a maximum of 47 older people, including those who are living with dementia, in one adapted building. There were 31 people using the service at the time of our inspection.

The service has a registered manager. 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 were supported to have choice and control of their lives and staff supported them in the least restrictive way possible; however, the policies and systems in the service had not always supported this practice and legislation designed to protect people's rights had not been followed.

There was a friendly atmosphere in the home and staff supported people in a kind and caring way that took account of their individual needs and preferences.

There were systems and processes in place to protect people from harm. Staff were trained in how to recognise and respond to abuse and understood their responsibility to report any concerns. Risks to people were individually assessed and action taken to minimise the likelihood of harm.

There were suitable systems in place to ensure the safe storage and administration of medicines. Medicines were administered by staff who had received appropriate training.

Safe recruitment practices were followed and appropriate checks had been undertaken, which made sure only suitable staff were employed to care for people in the home. There were sufficient numbers of experienced staff to meet people's needs.

Staff received an induction and on-going training to support them to meet the needs of people using the service.

People received regular and on-going health checks and support to attend appointments. They were supported to eat and drink enough to meet their needs and to make informed choices about what they ate.

The service was responsive to people's needs and staff listened to what they said. Staff were prompt to raise issues about people's health and people were referred to health professionals when needed. People could be confident that any concerns or complaints they raised would be dealt with.

The provider and registered manager were promoting an open, empowering and inclusive culture within the service. There were a range of systems in place to assess and monitor the quality and safety of the service.

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.

Risks to people were individually assessed and action taken to minimise the likelihood of harm.

People received their medicines at the right time and in the right way to meet their needs.

People and their families felt the home was safe and staff were aware of their responsibilities to safeguard people.

There were enough staff to meet people's needs and recruiting practices ensured that all appropriate checks had been completed.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff sought verbal consent from people before providing care. However, the provider had not always followed legislation designed to protect people's rights.

People were supported to have enough to eat and drink. They had access to health professionals and other specialists if they needed them.

Staff received an induction and on-going training to support them to meet the needs of people using the service.

Is the service caring?

Good

The service was caring.

Staff developed caring and positive relationships with people and treated them with dignity and respect.

People and relatives commented about the homely atmosphere in the home.

Staff were kind and caring and knew people well.

Is the service responsive?

Good

The service was responsive.

The service was responsive to people's needs and any concerns they had.

Care plans and activities were personalised and focused on individual needs and preferences.

The service involved people and their representatives in planning and reviewing their care and had a process in place to deal with any complaints.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider and registered manager had not identified where areas of practice were not compliant with the requirements of the Mental Capacity Act 2005.

The provider and registered manager demonstrated an open and inclusive style of leadership. Staff understood their roles and responsibilities and there were clear lines of accountability within the service.

The quality of the care and treatment people experienced was monitored and action taken to promote people's safety and welfare.

Valley Lodge 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. The inspection was planned to check whether the provider was 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 a comprehensive inspection that took place on 23 and 24 October 2018 and was unannounced. The inspection was carried out by one inspector, an assistant inspector, and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the registered manager completed 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 checked other information that we held about the service and the service provider, including previous inspection reports and notifications we received from the service. A notification is information about important events which the provider is required to tell us about by law.

Although we were not able to hold a full conversation with many of the people living in the home, some were able to make comments and we were able to observe staff interacting with people. We spoke with four people and three relatives, the provider, service manager, deputy manager, senior worker and four members of the care staff. We looked at a range of records including care plans for seven people, medicines records, staff rotas, training records, and risk assessments. We also looked at information regarding the arrangements for monitoring the quality and safety of the service provided.

Following the inspection visit we received feedback from two community health and social care professionals about the service provided at Valley Lodge.

The home was last inspected on 23 November 2015 when the service was rated good overall and no breach of the regulations was identified.

Good

Is the service safe?

Our findings

People who were able to speak with us said they felt safe at Valley Lodge. A person showed us their call bell. Asked if they used it they nodded and asked if they had to wait long for a response they said "No, not long really". A visiting relative said "She hasn't lived here very long but yes, she's safe and yes we are very pleased with the way she's looked after". Another visitor told us "Yes, we are very pleased with the care here".

Since the last inspection, the service had notified Hampshire County Council and CQC of potential safeguarding and other incidents when appropriate. There had been a relatively high level of injury notifications and the provider had met with the local safeguarding authority to discuss unwitnessed falls. As a result of this meeting and advice from the safeguarding authority, the provider had taken action. For example, they had implemented daily short meetings of staff on duty in the mornings, in order to make sure any changes in people's needs or important tasks were communicated among staff. A social care professional said "How impressed I have been by their response to the concerns we have raised recently and their commitment to acting on our advice and completing identified actions in a timely manner".

Staff understood how to keep people safe and their responsibilities for reporting accidents, incidents or concerns. They were aware of the policy and procedures for protecting people from abuse or avoidable harm. Staff understood the possible signs that could indicate abuse and were confident that any issues they reported would be responded to appropriately by the provider and registered manager. There was also a policy protecting staff if they needed to report concerns to other agencies in the event of the provider and registered manager not taking appropriate action.

Staff respected and promoted people's independence, while remaining aware of their safety. Risks to people's health and wellbeing had been assessed and actions had been taken to minimise any risks identified, such as the risks of people falling or becoming malnourished. This information was recorded in each person's care records and updated regularly with any changes to the level of risk or changes to health. A system of monitoring people who had falls was used to identify any patterns occurring, and referrals to external health professionals were made when appropriate.

During the inspection, the provider told us the service was looking at adopting the falls huddle procedure following a recommendation from Hampshire County Council. This is a debriefing following a fall to see if any preventative actions might have been possible. Following the inspection the registered manager, who had been on leave at the time of our visit, confirmed that they had contacted the Clinical Commissioning Group (CCG) to implement this approach, which is based on current best practice.

A range of systems and processes were in place to identify and manage environmental risks. These included maintenance checks of the home and equipment and regular health and safety audits. There was a current fire risk assessment and records were kept of regular checks and tests of the fire alarm, emergency lighting and fire safety equipment. Each person had a personal emergency evacuation plan, which included important information about the care and support each person required in the event they needed to evacuate the premises. A business continuity plan was in place and set out the arrangements for ensuring

the service was maintained in light of foreseeable emergencies.

People were protected by a clean home environment. We saw baths, showers, toilets, corridors and public areas were clean. Beds and bedding appeared clean, fresh and in good condition. Furniture looked new and of a good standard; there were no tears or stains noted on sofas, chairs or cushions. Staff were aware of infection control procedures and used protective clothing when carrying out cleaning and personal care tasks. A member of the domestic staff worked methodically all day across the home.

Since the last inspection staffing levels had increased to support an increase in the number of people accommodated and to reflect the larger building. Staff rotas showed there were six care staff on duty in the mornings and five staff on duty each afternoon. A senior member of staff and/or the registered manager was also present in the home. Nights were covered by four staff. The service also employed laundry, cleaning, and kitchen staff and an activity coordinator.

The provider and registered manager kept staff numbers under review. A dependency tool was used to evaluate staffing requirements based on people's changing needs and levels were adjusted accordingly. The provider was in the process of recruiting new staff and had capped the occupancy level at 38 people while this took place. Agency staff were being deployed in the interim.

Staff confirmed they thought there were enough staff on duty and were able to respond to people quickly. We observed this in practice when staff heard call bells going and attended to people in their rooms promptly. A social care professional told us, "Comparatively speaking with other local homes their staffing ratio's are actually quite high. They have a settled staff team I believe and the quality of care delivery is always mentioned positively when we review residents".

The service followed robust recruitment and selection processes to make sure staff were safe and suitable to work with people. We looked at the files for four staff including staff recruited since the last inspection. The staff files included evidence that pre-employment checks had been carried out, including employment histories, written references, satisfactory disclosure and barring service clearance (DBS), and evidence of the applicants' identity.

Medicines were safely and appropriately stored, including controlled drugs (CDs). CDs are regulated under the Misuse of Drugs Act and require additional safeguards to be in place. Access to the medicines room and the administration of medicines was by trained staff only.
Medicines were checked regularly so that any potential administration errors would be identified quickly and action taken. Up to date records were kept of the receipt and administration of medicines and there was a clear procedure for dealing with any unused medicines.

There were detailed individual support plans in relation to people's medicines, including any associated risks. Guidelines were in place for when prescribed 'as required' (PRN) medicines should be given and staff demonstrated their knowledge of these. Body maps were used to ensure that staff knew where to apply people's prescribed creams and lotions. Where people were able to administer these independently, they had lockable drawers or cabinets in which to store them.

Requires Improvement

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.

At the previous inspection we found that some mental capacity assessments needed to be clearer to show how staff had assessed people's mental capacity to make specific decisions.

Closed-circuit television (CCTV) was installed in the communal lounges and hallways and the provider informed us this was to ensure any unwitnessed falls or incidents could be monitored and documented accurately. Within the home there were people who lacked the mental capacity to make an informed decision, or give consent, to the use of CCTV in the place where they lived.

There was evidence that a consent form had been signed by a relative with appropriate power of attorney (POA) in relation to CCTV being used at another location owned by the provider. These records were not available in relation to people using the service at Valley Lodge. The service manager acknowledged that they were unable to confirm that mental capacity assessments and best interests decisions relating to consent to the use of CCTV at Valley Lodge had taken place. This was also confirmed by the registered manager after the inspection visit.

There was evidence that a policy regarding CCTV and surveillance was in place at another location owned by the provider, but this was not held in the policies folder for Valley Lodge. The service manager printed and added the policy to the home folder during the inspection. The policy stated that CCTV is in use but did not refer to the MCA or people's consent. The statement of purpose for the home did not include information relating to the use of CCTV. There was signage in the home relating to CCTV being in operation.

The provider had not acted in accordance with the requirements of the MCA and associated code of practice. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection visit the registered manager sent us an updated photography permission form that was to be attached to all care plans and included the use of CCTV in communal areas.

We saw records showing that mental capacity assessments and best interests decisions relating to people's general health and care had taken place. Staff received training in the Mental Capacity Act (MCA) 2005 and we observed them giving people choices, for example, they respected people's wishes and preferences at mealtimes and in the activities they wanted to do.

Some staff were able to demonstrate better understanding of the MCA than others, although we observed

all staff promoted people's choice and independence. One member of staff said "Sometimes people don't have capacity so can't make decisions. If they can't then decisions are made but only in their best interests". They told us about a person they supported who had capacity, so was just being encouraged to wear incontinence pads at night due to occasional incontinence. The member of staff said "We have a really good relationship so sometimes she will wear them, other times she doesn't".

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority to protect the person from harm. The provider and registered manager understood Deprivation of Liberty Safeguards (DoLS) and staff received training to support their understanding. Applications to deprive people of their liberty had been made to the local authority responsible for making these decisions.

Records showed staff completed a range of essential training that included safeguarding, health and safety, fire safety, infection control, basic life support, moving and handling, food hygiene and nutrition awareness. The records indicated refresher training for some staff was overdue.

A health care professional told us that three training sessions had been organised in relation to infection control and pressure ulcer care, however staff from the home had not attended. They said "I find it difficult to engage with the home consistently, but the residents I have seen appear well cared for". They added, "Communication could be better".

The health care professional said "They do contact me regarding concerns that they have, as with GP's or falls, however they do not follow up the recommendations that I offer, I have to chase them continually, but the work is not completed. For example, I have introduced the falls huddle to the home on a few occasions. Each time I have asked them to complete the huddle after a fall and I would go in and review it with them, or to complete one retrospectively and I would review it with them. This has not occurred, and I am having to chase for a response".

Following the inspection visit and a conversation with the registered manager about the training, they sent us an email stating that infection control training was undertaken by staff on either 08/05/2018 or 25/09/2018; and those that had not attended the training would get a training booklet to complete.

We saw dates for further and refresher training were scheduled over the coming months, including MCA / DoLS, dementia awareness and person-centred care planning. A member of staff told us they had also received training in diabetes, equality and diversity, end of life, and confirmed "We have a Mental Capacity Act refresher coming up soon". New staff undertook a period of induction and shadowing experienced staff before they were assessed as competent to work on their own. The induction incorporated the Care Certificate, where appropriate, which is a nationally recognised set of induction standards for health and social care staff.

Staff told us they felt well supported. A member of staff told us "We get supervisions every three months and can speak to (registered manager) whenever we need to".

The home environment was well maintained and in good decorative order. The design of the home had dementia friendly elements such as blue painted doors to bathrooms and toilets, which were in contrast to other painted doors. There were dementia friendly signs on these doors. Contrasting wall colours had also been used in a corridor to help people to find their way around the home. Photo boxes were placed outside people's rooms and staff were in the process of putting a photograph of the person whose room it was in the

boxes. The layout of the home enabled those people who were able to walk, to move around the home and gardens as they wished. Sensor lighting had been installed in corridors and there was a flat walkway around the home, which was illuminated after dark so people could walk outside safely.

People were effectively supported to eat and drink enough to meet their needs. Their support plans included nutritional assessments and details of their dietary requirements and support needs. A risk assessment tool was used to help identify anyone who might be at risk of malnutrition and specific care plans were put in place to minimise the risk, if required. In the kitchen was a communications board that was used to record any changes in people's food preferences and requirements, such as for a person on a diabetic diet. There were no other special diets required and the majority of people were able to eat independently.

During the morning one of the activity co-ordinators was visiting people in their rooms and discussing the lunch menu. A person told us "I always have the same thing for breakfast, I like to have a sandwich and yoghurt." And asked if they liked the food served here they said "Yes, we have nice lunches and suppers". We asked several other people if they liked the food served at Valley Lodge, they nodded or said yes. One person told us "I like to stay here in my room and I have my meals here, I prefer my own company".

At lunchtime the atmosphere in the dining room was calm and relaxed. The tables were neatly laid with cutlery and condiments on the table. People could choose where they sat and were offered serviettes or clothes covers and cold drinks of their choice. The meals were presented attractively and looked appetising. Two people in the dining room required assistance to eat their meal. Two staff sat with these people and assisted them slowly, making eye contact with people and not rushing them. One person did not want the fish pie or hunters chicken. The cook produced fish fingers and potato croquettes and when shown this plate the person smiled and nodded.

Staff tried several times to encourage a person attending on day care to sit and eat lunch. The person refused at first and continued to walk around the home and gardens. Then they saw the dessert, rhubarb crumble and custard. The person stopped and then agreed to sit at a quiet table and ate a two course meal.

Around the home there were containers of cold fruit squash kept in cooled glass containers. The containers were labelled with a use by date. Water was also available on request. While walking round the home we observed people being encouraged to drink and saw drinks on people's tables in their rooms, within easy reach. Hot drinks and biscuits were served between 10.30 and 11 am in the lounges and to people who were in their rooms. This process was repeated in the afternoon. Care staff demonstrated an awareness of people's preferences by alerting an agency care worker as to whether some people liked sugar in their tea or coffee. Also, some people preferred and chose cold drinks.

Staff carried out an assessment of people's care and support needs before they moved in. This included information about their medical history, their care needs and their personal history, beliefs and interests. This helped to ensure that appropriate decisions were made about whether the service would be able to meet the person's needs. People were offered a trial period of four weeks at the service to further ensure it would suit their needs.

Where necessary a range of healthcare professionals had been involved in planning and monitoring people's health and wellbeing to help ensure this was delivered effectively. People had regular visits from their GP and from other healthcare professionals such as community nurses and mental health professionals. There was a treatment room in the home where visiting health professionals could speak to and assess people's needs in private. There was evidence that relatives were kept informed of the outcome

of GP or hospital appointments.

Good

Is the service caring?

Our findings

People and their visitors were positive in their comments about the care people received and throughout our inspection, we saw examples of a caring and person centred culture. A person told us "All the staff are very nice". A visitor said "We are very pleased with the care here. It's a lovely place" and "I've not come across any member of staff that doesn't know Mum and what she likes". Another visitor said "People with dementia are cared for very well here".

Staff were welcoming and helpful and there was a relaxed and pleasant atmosphere in the home. Staff spoke to and treated people in a respectful, inclusive and kind manner. Staff gave people time to communicate their wishes, views and choices and spoke in a way people could understand, such as keeping questions and answers short and to the point.

People and their relatives confirmed staff were friendly, polite and upheld people's dignity. We observed staff knocked on people's doors and greeted them by name. People received personal care in the privacy of their bedrooms; their clothes looked clean and in good condition and their skin, hair and nails appeared clean. Care and support plans were written in a respectful way that promoted people's dignity and independence.

Staff knew people well and communicated in a caring and effective way with them. In the main lounge one person had lost her hair slides. A member of staff who was with her said "I've got plenty at home, I'll bring some in for you". One person who called out frequently during the day and appeared agitated at times was sat with a member of staff who spoke gently to her. The member of staff said "You're safe, don't worry, just relax, you're fine". which calmed the person for a while.

A kitchen assistant served drinks to people in the morning, he demonstrated an awareness of people's preferences but still asked them first to choose. If people were sat on chairs and sofas he knelt next to them, spoke to people by name and spent a little time talking to everyone. The people living there responded to him, some by smiling and those who could talk spoke to him.

During the day two new people were admitted to the home. We met with one person and spoke briefly to their visitor. The visitor said "He's been here before to give me a break but now has come in to stay. We know the home and I know he likes it here".

A member of staff told us about how they built relationships with people they supported. They said "I had two weeks of shadowing and just talked to them, got to know them slowly, asking how they are. If (person) is having a bad day, I'll ask her what's wrong. You need to understand good and bad days. I recognise when she's having a bad day and know what to do to help". They told us "(Person's) speech can sometimes be difficult to understand, so it's important to take the time to understand her".

The same member of staff told us there was a person who was French, who could sometimes feel lonely because of this; "I always try and say 'bonjour amour', she appreciates feeling cared about". They said "I

always come in about half an hour early, so I can spend a bit of time chatting to residents before I start". Another member of staff said "You learn to pick up on what they like and don't like. (Person) will definitely tell you if she doesn't like something". Staff we spoke with told us they were happy working at the home. A care worker said staff "All genuinely get on very well, which is good for residents".

Good

Is the service responsive?

Our findings

People confirmed staff were responsive to their needs and any concerns they may have. They told us they were comfortable in approaching staff and saying if they were unhappy about anything. People's relatives told us they had been involved in care planning. A health care professional told us, "Whenever I have been in the home, residents look well cared for and staff have been attentive and responsive to people's needs".

A personalised approach to responding to people's needs was evident in the service. Following a pre-admission assessment, which included gathering information from the person and, where appropriate, from their relatives and any professionals involved in their care, an individual care plan was developed. This plan described the person's needs in a range of areas such as personal care, eating and drinking, mobility, medicines management and mental health.

Staff told us about their key worker responsibilities. They had monthly meetings with the person, or as and when the person wanted them, and also spoke with the person's relative to get their views. They updated care plans as and when changes happened. They also had responsibilities when on shift for giving personal care and checking the person's daily care records to ensure they were all being completed. Due to a health issue a person had spent time in hospital and was currently having hourly night checks instead of two hourly.

Staff handover meetings were held daily and helped to ensure staff had accurate and up to date information about people's needs. Where necessary, external health and social care professionals were referred to as part of the response to people's changing needs.

Staff were consistent in the way they responded to people's individual needs. Throughout the inspection we observed that people were offered choices, such as where they would like to sit, what they wanted to eat, and whether or not they wanted to join in with activities.

The service employed two members of staff as activity coordinators. There was an activities notice board and a calendar showing what was planned for every day of the week and for the month. Activities included: beach ball, trips out, games, arts and crafts, cake decorating, crosswords, word searches, films, bead threading, visits to a café, horse racing and chair exercises. Photographs of past activities showed some of the current people who lived there enjoying a trip to Marwell Zoo and the summer garden party where animals visited. There was also a list of church services to be held monthly in the home for the year.

The planned activity for the morning was icing biscuits. Four people sat in the dining room at a table wearing plastic aprons and disposable gloves. The cook had made over 30 biscuits cut into Halloween or Christmas shapes and also bags of icing, some coloured with bright food colouring. The two activity co-ordinators encouraged people to ice the biscuits themselves and add their choice of sprinkles. There was a very relaxed atmosphere during this activity, the people taking part demonstrated their enjoyment by smiling and laughing and admiring their own work. One of the activity co-ordinators then left to start some music and movement exercises in the main lounge.

After lunch four people sat in the Retro Lounge. They sat in pairs and listened to classical music that was playing softly in the background. In the main lounge the afternoon started quietly with people relaxing in small groups after their lunch. Care staff sat in the lounge completing care records. The two large televisions were tuned to a channel showing old films and TV programmes and several people were watching a film. After the film, a number of other activities took place, including a beach ball game and chair exercises to music with people encouraged to dance or sing along. One of the care staff went to people and offered to refresh their nail polish. This allowed for one to one engagement. The lounge was large enough to absorb the different activities at once without being overwhelming. Having several members of staff in the room added to the pleasant atmosphere and they were able to spend time with people. There was a happy and relaxed atmosphere in the two lounges and people were free to join in if they wanted to.

No one told us they had any complaints. A visitor said "I would say to the staff if there was a problem but there hasn't been". There was a procedure in place which explained how complaints would be answered and what people could do if they remained dissatisfied. This was also available in large print or audio if people needed this. A record had been kept of any complaints or concerns received and responses from the provider detailing actions taken.

There was evidence that people had been supported by staff to have a comfortable and dignified death. When people reached the end of their life, staff worked closely with the GP and community nursing team to meet their needs. Do not attempt cardio-pulmonary resuscitation (DNACPR) decisions were recorded where appropriate.

Requires Improvement

Is the service well-led?

Our findings

This inspection has found a breach of one of the legal requirements. This has meant that the rating for the well led key question cannot be rated better than requires improvement.

Since the last inspection there had been a change of registered manager. The previous registered manager left the service in September 2017. The deputy manager had been managing the service since then and was registered in April 2018. They had identified a number of improvements that could be made and had a service development action plan, which was being updated. The action plan had not identified where areas of practice were not compliant with the requirements of the Mental Capacity Act 2005.

There was no evidence of recent resident, relatives and staff quality assurance surveys available at the time of the inspection. This would help to gather information about people's views about the service and to find out whether they had any suggestions for improvements. Visitors we spoke with knew the name of the registered manager and spoke positively about how the home was managed. One visitor told us "My relative has been here over two years so we can see its run well". Asked if there was anything the service could do better, they said "No, they do plenty of activities here and people are looked after well".

Current actions being taken to improve the service included updating care plans using a new electronic system, for which staff had received training in using. People's relatives had been asked to help complete some aspects of care plans, such as end of life care requirements, spirituality, and social histories. This information would assist in the development of more person-centred care plans to guide staff in meeting people's diverse needs.

New staff roles were being developed and work routines had been changed, to allow staff to spend more quality time with people as well as completing their tasks for the shift and reviewing care plans. The registered manager worked shifts with the care staff one weekend a month, as this helped them to understand people's current needs and what care staff were experiencing on shift. Staff told us they felt supported by the registered manager. A member of staff said they had requested to do an NVQ (National Vocational Qualification) in care and the registered manager had supported this and it was being funded by the provider.

Staff meetings took place and staff said they felt the provider and registered manager listened to them and were open to suggestions for developing and improving the service. A member of staff told us "You can always go to them" and, "They will address any issues". They described the provider as "Friendly and fair". Another member of staff said, "If we want something and have a good reason for it, he (the provider) does it". They also told us the registered manager "Always makes time for me if I need it".

There were clear lines of accountability within the service with each shift having a clearly designated member of staff in charge. Individual members of staff had delegated areas of responsibility, such as medicines.

There were quality assurance policies, procedures and checks in place. Staff responsiveness to call bells was monitored to ensure when people pressed their call bell staff answered in a timely way. During the inspection a member of staff demonstrated by activating a sensor mat in a person's bedroom. Another member of staff answered the call within the two minute timescale, which was in line with the person's support plan. There were also regular fire safety and other environmental checks in place, such as health and safety checks, routine environmental risk assessments, gas and electrical installation and equipment tests, regular servicing of the lift, and ongoing refurbishment of bedrooms. Regular audits took place to ensure staff were following procedures and that records were up to date.

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 11 HSCA RA Regulations 2014 Need for consent The provider had not acted in accordance with the requirements of the MCA and associated code of practice, in relation to obtaining people's consent to the use of CCTV in the home.