Care Quality Commission

Countrywide Belmont Limited

Belmont House Care Home

Inspection report

High Street
Starbeck
Harrogate
HG2 7LW
Tel: 01423 580884
Website: belmonthouse@cwch.com

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

This inspection took place on 27 and 28 October 2015 and was unannounced.

At our last inspection on 2 June 2014 the provider was meeting the regulations that were assessed.

Belmont House offers residential, nursing and personal care for up to 106 people. The home is divided into five separate suites, spread over three floors. The Courtyard suite provides residential care for up to 30 people. The Garden and Springwater suites both provide nursing care for 14 people each. The Park suite provides residential care for up to 17 people living with dementia, while the Promenade suite provides nursing care for up to 26 people living with dementia. The service is registered for 106 people to take account of occasions where a couple may wish to share a room.

There was a registered manager in post. 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.

Summary of findings

The service had experienced difficulties in recruiting staff, particularly qualified nursing staff and there was a high use of agency staff. The registered manager told us they requested the same members of staff from the agency in order to provide some consistency in care for people. The provider had placed the recruitment of staff as a high priority.

On both days of the inspection there were adequate numbers of qualified and skilled staff working at the service. However, during our second day of inspection on one particular unit staff were not deployed effectively which placed people at risk of potential harm. There was a new unit manager and they and the registered manager acknowledged some action was required to ensure staff worked together in order to ensure people had their needs met and were not a risk of harm. **This is a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing. You can see what we have asked the provider to do at the end of the report.**

Some staff had received training with regard to the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards. However, where people lacked capacity, the restrictions that staff and the provider had put in place may amount to depriving some people of their liberty. An application under the Mental Capacity Act Deprivation of Liberty Safeguards had not been made. **This is a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing. You can see what we have asked the provider to do at the end of the report.**

People and their relatives told us they felt safe at Belmont House. Staff knew the correct procedures to follow if they considered someone was at risk of harm or abuse. They received appropriate safeguarding training and there were policies and procedures to support them in their role.

The service had systems in place for recording and analysing incidents and accidents so that action could be taken to reduce risk to people's safety. Risk assessments were completed so that risks to people could be minimised whilst still supporting people to remain independent.

Staff received on going training and management support. They received a range of training specific to the needs of people they supported.

People received their medicines at the times they needed them. The systems in place meant medicines were administered and recorded properly and this was audited regularly by the service and the dispensing pharmacist. Staff were assessed for competency prior to administering medication and this was re-assessed regularly.

People had their nutritional needs met. People were offered a varied diet and were provided with sufficient drinks and snacks. People who required special diets were catered for.

People had good access to health care services and the service was committed to working in partnership with healthcare professionals.

People told us that they were well cared for and happy with the support they received. Staff were patient, attentive and caring; they took time to listen and to respond in a way that the person they engaged with understood. They respected people's privacy and upheld their dignity when providing care and support.

People knew how to make a complaint if they were unhappy and all the people we spoke with told us that they felt that they could talk to any of the staff if they had a concern or were worried about anything.

Staff spoke positively about the registered manager. They told us she was supportive and encouraged an open and inclusive atmosphere. People living at the service, their relatives and staff were provided with opportunities to make their wishes known and to have their voice heard.

The provider completed a range of audits in order to monitor and improve service delivery. Where improvements were needed or lessons learnt, action was taken.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not consistently safe.

Staff had been trained to recognise and respond to abuse and they followed appropriate procedures.

Although overall there was sufficient staff on duty, on one of the units staff were not appropriately deployed to ensure that they were always available to meet people's needs.

Appropriate checks were completed as part of staff recruitment this helped reduce the risk of employing unsuitable people. There was enough staff to provide the support people needed.

People's medicines were managed safely and they received them as prescribed.

Requires improvement

Is the service effective?
The service was not consistently effective.

People were not appropriately supported to make decisions because

Where people lacked capacity, the restrictions that staff and the provider had put in place may amount to depriving some people of their liberty but an application under the Mental Capacity Act Deprivation of Liberty Safeguards had not been made as required.

People were provided with a choice of nutritious food. Snacks and drinks were available at any time. People's dietary likes and dislikes were known by the staff.

The home had developed good links with health care professionals which meant people had their health needs met in a timely manner.

Requires improvement

Is the service caring?
The service was caring.

People were comfortable and relaxed in the company of the staff supporting them.

The relationships between staff and the people they cared for were friendly and positive. Staff spoke about people in a respectful way and supported their privacy and dignity.

Staff knew people well because they understood their different needs and in the way individuals communicated.

Good

Is the service responsive?
The service was responsive.

Good

Summary of findings

People using the service had personalised care plans and their needs were regularly reviewed to make sure they received the right care and support.

Staff responded when people's needs changed, which ensured their individual needs were met. Relevant professionals were involved where needed.

The provider responded to complaints appropriately and people told us they felt confident any concerns would be addressed.

Is the service well-led?

Good

This service was well led.

There was a registered manager and people spoke positively about them and how the service was run.

Staff told us they felt able to raise concerns in the knowledge they would be addressed.

People who used the service and their relatives were encouraged to express their views about the standards of care.

Quality assurance systems were used to keep checks on standards and develop the service. This enabled the provider to monitor the quality of the service closely, and make improvements when needed.

Belmont House 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.

Prior to our inspection we reviewed the information we held about the service. This included any safeguarding alerts and outcomes, complaints, previous inspection reports and notifications that the provider had sent to Care Quality Commission (CQC). Notifications are information about important events which the service is required to tell us about by law. We had not requested 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.

This inspection took place on 27 and 28 October 2015 and was unannounced.

The inspection was carried out by two inspectors and, a Specialist Professional Advisor who specialised in providing services to people living with dementia and the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS).

We spoke with 10 people who used the service, 6 relatives, the registered manager, operations manager and 7 members of staff during the course of our visit.

We looked at 12 people's care records to see how their care was assessed and planned. We reviewed how medicines were managed and the records relating to this. We checked 3 staff recruitment files and the records kept for staff allocation, training and supervision. We looked around the premises and at records for the management of the service including quality assurance audits, action plans and health and safety records.

We contacted the local authority commissioners and Healthwatch to ask for their views and to ask if they had any concerns about the home. They are an independent body who hold key information about the local views and experiences of people receiving care. CQC has a statutory duty to work with Healthwatch to take account of their views and to consider any concerns that may have been raised with them about this service. From the feedback we received no one had any major concerns.

Requires improvement

Is the service safe?

Our findings

We spoke to people who used the service who told us they felt safe. One person said, "I feel much better now I'm here, I was becoming nervous at home on my own." A relative told us, "I have no doubt (name) is safe here, I leave here with no worries about the care." Another relative told us "The staff are lovely but I do have concerns about the numbers of agency staff used. I come in every day to make sure [name] has their meals."

Prior to the inspection we had received concerns about staffing levels at the service and the high use of agency staff being used and how this was having a negative impact on the welfare of people who lived at the service. The provider had responded proactively to these concerns and acknowledged that there had been some difficulties with the recruitment of staff; in particular qualified nursing staff. The registered manager explained that they had successfully recruited to all care staff vacancies. They were predicting all new staff would be in post by the end of November 2015. They said waking night vacancies for qualified nursing staff was still problematic and there was a high use of agency staff. The registered manager said they requested the same agency staff in order to assure some consistency in the care people received. The registered manager also explained that the service had been without a deputy manager which had placed additional responsibilities for the registered manager. There was now a new deputy manager in post to share the responsibilities for the management of the service

Staff we spoke with told us there had been staff shortages and the reliance on using agency staff had been difficult. One member of staff told us, "Things are much better now we are getting more staff. It has been quite difficult and stressful." We spoke with the registered manager about how they determined staffing levels and deployed staff. They told us each unit had a dedicated staff team which included either a nurse in charge or unit senior care assistant. Staffing levels were determined according to the needs of people living at the service and the registered manager told us they had the authority to increase staffing levels if required. One member of staff told us; "There is never a problem in increasing staffing when we need to; for example, if someone is very poorly or entering the last days of the lives."

We looked at the rotas for the previous four weeks and could see where agency staff had been used and where some shifts had not been covered. We saw that the situation had improved and there were fewer gaps in the rota for the previous two weeks. Each unit had a dedicated staff team with a unit manager and senior carers. We could see that care and nursing staff were supported by ancillary staff such as domestics, cooks and maintenance staff.

Over the two days of the inspection there were sufficient staff on duty to meet the needs of people living at the service. However, during our second day of inspection on one particular unit staff were not deployed effectively, which placed people at risk of potential harm.

We carried out a SOFI observation on the Promenade suite (for people requiring nursing dementia care.) We sat in the lounge area and saw 7 people sat in this room; 4 people were sat in wheelchairs. There were no staff present in the room. There was a Glen Miller film on the TV. One person was humming along and tapping their foot. One person who appeared very unsteady on their feet was negotiating themselves around the room holding onto furniture and the walls. They attempted to manoeuvre between a piece of furniture and someone sat in wheelchair, but there was insufficient room and their leg very nearly became entangled in the wheelchair footplates. A person who lived at the service assisted them; held their arm and walked with them out of the room saying, "Let's find a member of staff there must be one somewhere." There were 2 other people were sat in wheelchairs, one with no brakes on. This person had the footplates on their wheelchair in the up position with their feet on the floor. They kept attempting to push themselves to standing but every time they did this the wheelchair moved. Another person sat in their wheelchair with their footplates in the up position. They managed to stand up but were unable to walk because the footplates were preventing them. At this point we stopped the SOFI and went to alert staff to the imminent risk to people.

We observed lunchtime on this unit and saw staff were very kind and patient with people, however, there were too many people who required assistance for the numbers of staff available. This meant people were not attended to in manner which promoted their well-being. We discussed both observations with the registered manager. The registered manager acknowledged our observations and reported that they had had discussions with the new unit

manager, when they took on the role about the need for team development and action to ensure staff worked together in order to ensure people had their needs met and were not at risk of harm.

This is a breach of Regulation 18 (Staffing) The Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

We looked at the recruitment records for three staff and found they had all completed an application form, which included details of former employment with dates. This meant the provider was able to follow up any gaps in employment. All of them had attended an interview and two references and Disclosure and Barring Service (DBS) (previously criminal records bureau) checks had been obtained prior to the member of staff starting work. This process helped reduce the risk of unsuitable staff being employed.

The service had policies and procedures with regard to safeguarding adults and whistleblowing. Information the CQC had received demonstrated the registered manager was committed to working in partnership with the local authority safeguarding teams. The service had made and responded to safeguarding alerts appropriately. Staff we spoke with confirmed they had received training about safeguarding adults and were able to describe the different types of abuse. Staff knew about situations where people's safety may be at risk and were also aware of the reporting process for any accidents or incidents that occurred.

Staff also talked to us about whistleblowing policies and procedures. (Whistle blowing is when staff tells someone in authority about their concerns about care). One member of staff said they had looked at this during their induction and felt any poor practice reported would be listened to and acted upon.

We found that risk assessments, where appropriate, were in place, as identified through the assessment and care planning process, which meant that risks had been identified/minimised to keep people safe. Risk assessments were proportionate and included information for staff on how to reduce identified risks, whilst avoiding undue restriction. For example, individual risk assessments included measures to minimise the risk of falls whilst encouraging people to walk independently. Assessments also considered the likelihood of pressure ulcers developing or to ensure people were eating and drinking. This meant that risks could be identified and action taken to keep people safe. Standard supporting tools such as the Waterlow Pressure UIcer Risk Assessment and Malnutrition Universal Screening Tool (MUST) were routinely used in the completion of individual risk assessments to ensure people's nutritional and pressure sore risks were minimised.

Accidents and incidents were analysed for trends and patterns; for example if someone started to fall more frequently. In the event of a person falling additional checks were put in place to monitor for any ongoing effects.

There were risk assessments in place relating to the safety of the environment and equipment used in the home such as hoisting equipment and the vertical passenger lift. We saw records confirming equipment was serviced and maintained regularly. The service had in place emergency contingency plans in the event of power failure or adverse weather for example. There was a fire risk assessment in place for the service and personal emergency evacuation plans (PEEPs) for individuals.

We walked around the building and saw grab and handrails to support people and chairs located so people could move around independently but with places to stop and rest. Communal areas and corridors although homely, were free from trip hazards.

The home was clean. We saw staff had access to personal protective equipment such as aprons and gloves. We observed staff using good hand washing practice. There were systems in place to monitor and audit the cleanliness and infection control measures in place.

We spoke with the unit managers responsible for handling medicines on the day of our visit about the safe management of medicines, including creams and nutritional supplements within the home. Medicines were locked away securely to ensure that they were not misused. Daily temperature checks were carried out in all medicine storage areas to ensure the medicines did not spoil or become unfit for use. Stock was managed effectively to prevent over stocking, whilst at the same time protecting people from the risk of running out of their medicines. Medication records were clear, complete and accurate and

Requires improvement

Is the service safe?

it was easy to determine that people had been given their medicines correctly by checking the current stock against those records. On occasions where medicines had not been given, staff had clearly recorded the reason why.

We saw controlled drugs were stored in a suitable locked cabinet and we checked stock against the controlled drugs register. The stock tallied with the record. We noted that where people were prescribed PRN (as required) medicines, information was recorded about the circumstances under which the medicine could be administered.

Staff were not permitted to administer medicines until they had completed medication training. The training included a written exam and observation of competency which meant people could be assured they received the medicines they were prescribed safely.

Regular audits were carried out to determine how well the service managed medicines. We saw evidence that where concerns or discrepancies had been highlighted, the senior staff and registered manager had taken appropriate action straightaway in order to address those concerns and further improve the way medicines were managed within the home.

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. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

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

We saw in people's care plans that MCA assessments had been undertaken of people's capacity to make particular decisions. These were decision specific for example "consent to care and share information, consent to having a photograph taken". However, although there were approximately 45 beds specifically for people living with dementia the registered manager had only completed one DOLs application. By virtual of the fact that there were 42 people living at the service with dementia due to their personal safety they were not free to leave the home and were therefore subject to constant supervision. Their capacity to consent to live within the service should therefore have been assessed. The registered manager showed us guidance they had been issued with from the local authority and we saw this guidance was out of date and did not relate to current guidance following the supreme court ruling. This ruling is known as Cheshire West which clarified the notion of deprivation of liberty for people living in a care home setting. The provider had not made an application for DoLS authorisations even though people's liberty may have been restricted.

This is a breach of Regulation 11 (Need for consent) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw records of when people had made advanced decisions on receiving care and treatment. The care files held 'Do not attempt cardio-pulmonary resuscitation' decisions for people and we saw that the correct form had been used and was fully completed recording the person's name, an assessment of capacity, communication with relatives and the names and positions held of the health and social care professionals completing the form.

We discussed with the registered manager the training arrangements for staff. They told us newly appointed staff completed a comprehensive induction which included face to face and e- learning covering health and safety training such as moving and handling, first aid and safeguarding adults. Staff also completed a period of working alongside more experienced staff before they worked unsupervised. The registered manager showed us a training matrix which recorded the training staff had completed and a system which alerted them when staff were due for updates. Staff confirmed that they had completed appropriate training courses for lifting and handling, fire precautions and dementia training and this was relevant to their role.

We observed the lunchtime experience on three of the units and saw that people were given time to enjoy their meal and it was a social and relaxed occasion. There was a choice available to people and people told us that staff asked them what they would like to eat. Those people who needed it were given discrete assistance with eating their meal and we saw people using adapted cutlery and plate guards in order that they could be independent when eating their meals.

On the second day of our inspection we observed the lunchtime experience on Promenade, (for people with nursing and dementia care needs.) Due to the number of people requiring support and the numbers of staff people did not receive a good dining experience. For example we observed one person's face light up when their meal was placed in front of them; a member of staff started to assist them with their meals but had to leave them to attend to someone else. The person then fell asleep at the table. When the member of staff returned the food was no longer hot and the person became disinterested in the meal. We did note that despite the pressure staff were under they were very kind and patient in their assistance of people. We spoke with the registered manager about our observations and they told us they had had some discussion with the new unit manager about a having two sittings for meals in order that there were sufficient staff to support people but as yet this had not been implemented.

Requires improvement

Is the service effective?

Whilst we were at the home we noted that people had access to juice and water and that people were offered tea and coffee at regular intervals and we heard staff encouraging people to drink sufficient fluids.

During this inspection the care records we looked at included those of people who had nutritional risks associated with their health and well-being. We saw people had a nutritional risk assessment completed. Care plans included how often people needed to be weighed, whether food or fluid charts needed to be completed and any recommendations from the speech and language assessment where this had been completed. We saw plans had been reviewed regularly and amended as required; for instance one person had changed from needing a soft diet to a blended diet and food supplements. However we did see two people's records where no action had been taken despite a record of weight loss. This meant their nutritional needs may not have been met.

Staff reported good working relationships with local health professionals. We spoke to a visiting district nurse who said referrals from the service were appropriate and staff followed district nurse advice and completed appropriate records such as food and fluid, continence and re positioning records which helps to ensure that people received appropriate treatment. They also commented on how well the home worked with the local GP surgery and district nurses in providing end of life care.

People's care plans included information about people's access to chiropody, hearing specialists and opticians. During the inspection the community dentist visited following a referral from the service for someone who was experiencing some dental discomfort.

When we looked around the service and saw distinct contrasts between the areas where nursing care was provided and the areas where people living with dementia lived. We could see that consideration had been given to research associated with supportive environments for people living with dementia. For example we saw in the communal areas the walls were plain which provided a contrast to the coloured furniture. There were pictures on the walls from the 50's and 60's which seemed relevant to the age of people. Rummage boxes were available for reminiscence which all had a different theme. For example seasons, nature, textiles and childhood memories. There were scrapbooks for people to look at featuring events from different decades and the royal family. There was a board telling people what day, date and season it was and what the weather was like outside. The registered manager explained the provider was due to implement an accreditation scheme based on the work of Professor Dawn Brooker called LIFE (Living In Fulfilling Environments.) The registered manager said she felt the accreditation process would further enhance staff skills and enhance the lives of people living with dementia at the service.

Good

Is the service caring?

Our findings

People we spoke with were complimentary about the care they received and told us that staff offered kindness to people. One person said, “The staff are lovely, they look after you well.” And another person said, “Staff are very patient, I spend most of my time in my room but they pop in to see if I’m ok.” Everyone said that they were treated with dignity and respect and we observed this during our visit. One person said, “I need help with a bath but I don’t want a male carer to do it and they respect that.”

We spent time in the communal areas in all the units of the home. We observed staff treat people sensitively and engaged people in conversation which was meaningful and relevant to them. For example we heard staff referring to people’s interest and family members. We saw that staff approached people in a kind and respectful way and people looked well cared for and appeared at ease with staff.

We observed that people were asked what they wanted to do and staff listened and asked whether they were comfortable or needed anything. In addition, we observed staff explaining what they were doing, for example in relation to giving people their medicines. When staff carried out tasks for people they bent down as they talked to them, so they were at eye level. We saw that when staff assisted people they met their needs in a sensitive and patient manner.

One person required assistance using a hoist. We observe staff give verbal and physical reassurance; talking to them about what was about to happen in a patient and reassuring manner. We saw people were offered blankets or were assisted to ensure their clothing protected their dignity. During lunch people were offered protective clothing before being assisted with their meal and we saw staff knocked on bedroom doors and waited for a response before they entered.

The care plans we looked at provided sufficient information about people's wishes and preferences, so that they were cared for in the way they had chosen. For example, one person had recorded clear instructions which had been agreed by the person which promoted their continued independence.

Staff were seen to be patient, kind and polite with people who used the service and their relatives. Staff clearly demonstrated that they knew people well, their life histories and their likes and dislikes and were able to describe people’s care preferences and routines. People looked well cared for with attention given to people’s personal appearances and we saw people’s bedrooms were personalised with their own furniture and possessions or family photographs.

People’s confidential information was kept private and secure and their records were stored appropriately. Staff knew the importance of maintaining confidentiality and had received training on the principles of privacy and dignity and person centred care.

Staff told us they had received training with regard to providing end of life care. We looked at two people’s end of life care plans and they included information about the relevant people who were involved in decisions about this person’s end of life choices and details about anticipation of any emergency health problems. Also included were areas of importance to people, for example one person had stated that although they did not wear make-up they always wanted to wear a little lipstick and they enjoyed a hand massage and human touch. This meant that health and emotional care information was available to inform staff of the person’s wishes at this important time, to ensure that their final wishes could be met. We saw recorded in a thank you card sent by a relative, “Thank you for the tender care you gave my mother in her last days.”

Good

Is the service responsive?

Our findings

The registered manager explained that they completed pre admission assessments of people's needs. They said they would involve other people in the process such as relatives and professionals, to ensure as much information was gathered as possible in order to determine whether they would be able to meet those needs. They went on to tell us that prior to admission wherever possible the person would have an opportunity to visit the home this provided an opportunity for the person to decide if they wanted to live there and for everyone to meet each other.

The registered manager explained that people's care records were all stored on an electronic system which was accessed by staff via a unique password and user name. The date, time and author of the record was automatically saved and cannot be amended. The registered manager said this ensured the most accurate record and although there had been some resistance to moving away from a paper hand written record this system had proved to be more effective in terms of a readable record which could not be amended. The programme also generated prompts for staff to take specific action, for example where an accident had been recorded the computer programme would prompt a review or completion of a corresponding risk assessment.

We reviewed 12 people's electronic records and found them comprehensive and easy to follow. Care plans covered areas such as personal care, mobility, nutrition, daily and social preferences and health conditions. We saw that people had corresponding risk assessments in place.

Examination of care plans showed they were person-centred. Person centred planning (PCP) provides a way of helping a person plan all aspects of their life and support, focusing on what is important to the person. This was helpful to ensure that care and support was delivered in the way the person wanted. From our discussions with staff it was evident they knew the individual care and support needs of people. Staff told us they had a handover meeting at every shift change where any changes to people's needs were made known so they were able to provide appropriate care.

We could see that people's care had been reviewed and their plans amended where needed. For instance we saw that one person had lost weight and had been referred to the dietician and now required their food and fluid intake to be monitored. We saw the corresponding records for this. This meant that the person's changing needs had been being monitored.

We looked at people's daily notes and saw the information provided a picture of how the person had spent their day. The detail in these records meant people's needs could be monitored and any changes picked up at an early stage.

People and their relatives told us they were included in developing their plan of care. One relative told us, "My family were always included in {name} care and we were treated as part of his care team."

The service employed designated staff to arrange activities for people. The programme included a variety of activities to suite people's needs. We received positive feedback about the activities on offer and in the annual survey sent to people their satisfaction was referred to by a high percentage of people. Where people were living with dementia, activities were provided more spontaneously in order to maximise the person's enjoyment and engagement.

We found that the service had a Complaints Policy in place and that all staff we spoke with knew how to advise people on how to make a complaint. People told us they would feel confident in raising concerns with managers or staff. One visitor we spoke with said, "I have taken concerns to the manager and they respond in a timely manner."

We looked at the complaints log and saw complaints were recorded with details of investigation and the outcome reported to the complainant. All were resolved to the satisfaction of the complainant. The registered manager explained they had developed policies and procedures in relation to the implementation of a new regulation of the Health and Social Care Act 2008, Duty of Candour which requires providers to tell people who use services when something goes wrong and to apologise.

The provider completed an annual survey of people who used the service, their relatives, staff and other professionals to gather feedback on all aspects of the service provided including care, privacy, staffing, activities, food, quality of life, laundry and the environment. Results were published with appropriate action plans put in place in response.

Good

Is the service well-led?

Our findings

Those people who we spoke with living at the service told us they knew who the registered manager was and that they had a regular presence around the home. One person said, "We see her more or less every day and of course when we have a residents meeting. She seems ok and is always cheerful." A visitor commented, "The manager is approachable, I have meet with her on a number of occasions and she has always taken any of my comments on board."

The registered manager had a clear understanding of the challenges facing the service particularly with regard to recent staff recruitment issues. They said they had found it particularly difficult without a deputy manager to 'share the load'. They said they had been supported by the provider, through supervision and regularly met other registered managers from across the organisation. They went on to comment that now a deputy manager was in place, the management team, which included unit managers and senior staff, would be able to concentrate on developing the service.

During our inspection the registered manager was able to answer all of our questions about the care provided to people showing that they had a good overview of what was happening with staff and people who used the service. They said they utilized the internet to keep up to date with NICE (National Institute of social care excellence) guidance and up to date current good practice. They told us they were proactive in developing good working relationships with partner agencies in health and social care.

There was a clear management structure at the service. The staff we spoke with were aware of the roles of the management team and they told us they had an open door policy and was approachable. One staff member told us, "I feel like I can approach the manager."

Staff meetings had been held at regular intervals, which had given staff the opportunity to share their views and to receive information about the service. Staff told us that they felt able to voice their opinions, share their views and felt there was a two way communication process with managers and we saw this reflected in the meeting minutes we looked at. They said the registered manager was fair and honest with them.

The registered manager explained there were a range of quality assurance systems in place to help determine the quality of the service the service offered. This included formal auditing, meeting with senior managers and talking to people who received a service and their relatives. Audits ranged from regular daily, weekly, monthly and annual checks for health and safety matters such as passenger lifts, firefighting and detection equipment; care plan and medicines audits which helped determine where the service could improve and develop.

Monthly audits and monitoring were in place. These were undertaken by regional managers which facilitated managers and staff to learn from events such as accidents and incidents, complaints, concerns, whistleblowing. This reduced the risks to people and helped the service to continuously improve.

People who used the service, their representatives and staff were asked for their views about their care and treatment and these were acted on. The service had carried out an annual satisfaction survey. Results had been collated and analysed and action plans put in place in response to these which were agreed and actioned. Some of the negative comments we saw in surveys included reference to the laundry service and access to the minutes of relatives/ residents meetings with an action point to send minutes out via email to people unable to attend. Positive comments included reference to 'excellent activities on offer' and 'staff treat people with kindness, compassion and respect."

Any incidents or accidents were investigated, recorded and dealt with appropriately. Where any learning was taken from accidents or incidents, this was shared through regular supervision, training and relevant meetings. The registered manager had sent us statutory notifications about important events at the home, in accordance with their legal obligations. They kept us regularly informed of the progress and outcome of investigations they completed when issues or concerns were raised.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with the consent of service users in relation to the care and treatment provided for them in accordance with the Mental Capacity Act 2005 and the Deprivation of Liberty safeguards.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The registered person did not have suitable arrangements in place to ensure the deployment of staff protected people from risk of harm.**