Care Quality Commission

Thames Health Care Limited

Thames House

Inspection report

Thames Street
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Tel: 01706751840

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21 December 2016

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
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

Thames House provides accommodation and nursing care to people with Huntington's disease, acquired brain injury and other physical disabilities. It is purpose built with 20 en-suite bedrooms. There are fully accessible shared spaces for activities and private use.

The service were last inspected in September 2015 when the service did not meet all the regulations and were given an action for Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as staffing levels were insufficient for both nursing and care staff and they had not received formal supervision regularly. We found they met the regulations at this inspection. We undertook this inspection on 20 and 21 December 2016.

The service did not have 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The CQC place a limiter on the well-led domain which cannot be assessed as anything other than requires improvement if there is no registered manager.

Staff we spoke with were aware of how to protect vulnerable people and had safeguarding policies and procedures to guide them, which included the contact details of the local authority to report to.

Recruitment procedures were robust and ensured new staff should be safe to work with vulnerable adults.

The administration of medicines was safe. Staff had been trained in the administration of medicines and had up to date policies and procedures to follow. Their competency was checked regularly.

The home was clean and tidy. The environment was maintained at a good level and homely in character. We saw there was a maintenance person to repair any faulty items of equipment.

There were systems in place to prevent the spread of infection. Staff were trained in infection control and provided with the necessary equipment and hand washing facilities to help protect their health and welfare.

Electrical and gas appliances were serviced regularly. Each person had a personal emergency evacuation plan (PEEP) and there was a business plan for any unforeseen emergencies.

People were given choices in the food they ate and told us it was good. People were encouraged to eat and drink to ensure they were hydrated and well fed.

Most staff had been trained in the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). The registered manager was aware of her responsibilities of how to apply for any best interest

decisions under the Mental Capacity Act (2005) and followed the correct procedures using independent professionals.

New staff received induction training to provide them with the skills to care for people. Staff files and the training matrix showed staff had undertaken sufficient training to meet the needs of people and they were supervised regularly to check their competence. Supervision sessions also gave staff the opportunity to discuss their work and ask for any training they felt necessary.

We observed there were good interactions between staff and people who used the service. People told us staff were kind and caring.

We saw that the quality of care plans gave staff sufficient information to look after people accommodated at the care home and they were regularly reviewed. Plans of care contained people's personal preferences so they could be treated as individuals.

People were given the information on how to complain with the details of other organisations if they wished to go outside of the service.

Staff and people who used the service all told us managers were approachable and supportive.

Meetings and supervision with staff gave them the opportunity to be involved in the running of the home and discuss their training needs.

The manager conducted sufficient audits to ensure the quality of the service provided was maintained or improved.

There were sufficient activities to provide people with stimulation if they wished to join in.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

The service had policies and procedures to protect vulnerable adults from abuse. The service had followed the local authority guidelines to report any suspected abuse. Staff had been trained in safeguarding topics and were aware of their responsibilities to report any possible abuse.

Arrangements were in place to ensure medicines were safely administered. Staff had been trained in medicines administration and managers audited the system and staff competence.

Staff had been recruited robustly and should be safe to work with vulnerable adults.

Is the service effective?

Good

The service was effective.

Staff understood their responsibilities under the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Staff had been trained in the MCA and DoLS and should recognise what a deprivation of liberty is or how they must protect people's rights.

People were given a nutritious diet and said the food provided at the service was good.

Staff were well trained and supported to provide effective care. Induction and regular training should ensure staff could meet the needs of people who used the service.

Is the service caring?

Good

The service was caring.

People who used the service told us staff were helpful and kind.

We observed there were good interactions between staff and people who used the service.

Some staff had received training in end of life. People's last wishes were recorded in the plans of care to ensure they received the care they wanted at the end of their life.

Is the service responsive?

Good

The service was responsive.

There was a suitable complaints procedure for people to voice their concerns. The registered manager responded to any concerns or incidents in a timely manner and analysed them to try to improve the service.

People were able to join in activities suitable to their age, gender and ethnicity.

Plans of care were developed with people who used the service, were individualised and kept up to date.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The service did not have a registered manager. The CQC place a limiter on this domain which cannot be assessed as anything other than requires improvement if there is no registered manager.

There were systems in place to monitor the quality of care and service provision at this care home.

Policies, procedures and other relevant documents were reviewed regularly to help ensure staff had up to date information.

Staff told us they felt supported and could approach managers when they wished.

CareQuality Commission

Thames House

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 was unannounced and conducted on the 20 December 2016 by one inspector and an Expert by Experience and by an inspector on the 21 December. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before our inspection visit we reviewed the information we held about the service. This included notifications the provider had made to us. We asked the local authority contracts and safeguarding teams and Healthwatch for their views about the service. They did not have any concerns.

We requested and received 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 any improvements they plan to make. We used this information to help plan the inspection.

During the inspection we talked with four people who used the service, the operations manager, a registered nurse, the cook, maintenance person, a laundry person, senior housekeeper and two care staff.

There were 17 people accommodated at the home on the day of the inspection. During our inspection we observed the support provided by staff in communal areas of the home. We looked at the care records for three people who used the service and medication administration records for eight people. We also looked at the recruitment, training and supervision records for three members of staff, minutes of meetings and a variety of other records related to the management of the service.

Good

Is the service safe?

Our findings

People who used the service told us , "I feel very safe here", "I feel safe", "They [the staff] never threaten me", "I have never seen anything that concerns me" and "They [the staff] never leave me alone in the bath. Very good."

From looking at staff files and the training matrix we saw that staff had been trained in safeguarding topics. The safeguarding policy informed staff of details such as what constituted abuse and reporting guidelines. The service had a copy of the Rochdale social services safeguarding policies and procedures to follow a local initiative. This meant staff had access to the local safeguarding team for advice and to report any incidents to. There was advice on how to contact the local safeguarding board in the lobby. There was a whistle blowing policy and a copy of the 'No Secrets' document available for staff to follow good practice. A whistle blowing policy allows staff to report genuine concerns with no recriminations. The staff we spoke with were aware of abuse issues and said, "I am aware of the whistle blowing policy. It was on the safeguarding board a few weeks ago as well. If I saw poor practice I would be prepared to report it", "I would not be afraid of reporting any issues to make the person safe and have reported people in the past in another service" and "I am aware of the whistle blowing policy. I would be prepared to use it if I thought someone was being abused." There were safe systems to help protect vulnerable adults.

On the day of the inspection there was an operations support manager acting as home manager, a trained nurse working on each of the two floors, eight care staff, a cook, maintenance person, a person in the laundry, an administrator and two activities coordinators. We saw from looking at the off duty roster that this was normal for the service including the same number of care staff at weekends. One of the trained nurses was from an agency but was a regular member of staff and knew the people accommodated at the home well. A person who used the service told us, "I press the button and they come quick." Some people who used the service said there had been too many agency staff who were not as good as staff employed by the home. However, we saw evidence that four more permanent staff were being employed at the home and were due to start in early January 2017, which will reduce the need for agency staff. Two care staff members said, "You get lots of time to sit and chat or help with activities" and "We have enough staff to meet people's needs. We get time to talk to people, go out shopping or help with pamper sessions. We have quality time with people." The senior housekeeper also said, "There are two domestics and one laundry assistant. That is enough staff for us to keep the home clean and tidy. I like to help out every now and again with activities and helped with the Christmas shopping and the manager was ok with that." There were sufficient numbers of well trained and experienced staff to meet people's needs.

We looked at three staff files. We saw that there had been a robust recruitment procedure. The manager told us the computer system the service used would flag up when all employment checks had been made but they would not be able to employ a staff member until it had been cleared on the system. Each file contained at least two written references, an application form with any gaps in employment explored, proof of the staff members address and identity and a Disclosure and Barring Service check (DBS). This informs the service if a prospective staff member has a criminal record or has been judged as unfit to work with vulnerable adults. Prospective staff were interviewed and when all documentation had been reviewed a

decision taken to employ the person or not. This meant staff were suitably checked and should be safe to work with vulnerable adults.

We saw that the electrical and gas installation and equipment had been serviced. There were certificates available to show that all necessary work had been undertaken, for example, gas safety, portable appliance testing (PAT), the lift, slings, hoists and the nurse call and fire alarm system. The maintenance person also checked windows had restricted openings to prevent falls and the hot water outlets were checked to ensure they were within safe temperature limits. We saw that staff entered any faults in a booklet which was signed off when any work had been completed. The maintenance of the building and equipment helped protect the health and welfare of people who used the service and staff.

Fire drills and tests were held regularly to ensure the equipment was in good working order and staff knew the procedures. Each person had a personal emergency evacuation plan (PEEP) which showed any special needs a person may have in the event of a fire. The PEEPs were kept in a folder staff could get hold of in an emergency and in their individual files to inform staff if anybody had any needs during an evacuation. There was a fire risk assessment and business continuity plan for unforeseen emergencies such as a power failure.

We looked at three plans of care during the inspection. We saw people had risk assessments for falls, the prevention of pressure sores, the risk of choking, mental capacity, nutrition and moving and handling. Where a risk was identified the relevant professional would be contacted for advice and support, for example a dietician. We saw the risk assessments were to help keep people safe and did not restrict their lifestyles.

There was also environmental risk assessment to ensure all parts of the service were safe. This covered topics like tripping hazards, faulty or broken equipment and trips out in the community.

People who used the service said, "It's very homely here and it's very clean", "You have the freedom to wander round, and can do what you like with your room", "It's not bad living here, it's been refurbished since I came", "It's very clean" and "Lovely clean place."

During the tour of the building we noted everywhere was clean and there were no malodours. There were policies and procedures for the control and prevention of infection. The training matrix showed us most staff had undertaken training in the control and prevention of infection control. Staff we spoke with confirmed they had undertaken infection control training. The service used the Department of Health's guidelines for the control of infection in care homes to follow safe practice. The registered manager conducted infection control audits and checked the home was clean and tidy. We spoke with the senior housekeeper who showed us the infection control cleaning records which showed there was a system for keeping the home clean and tidy.

There was a laundry sited away from any food preparation areas. There were two industrial type washing machines and dryers to keep linen clean and other equipment such as irons to keep laundry presentable. The washing machines had a sluicing facility to wash soiled clothes. There were different coloured bags to remove contaminated waste and linen. There were hand washing facilities in strategic areas for staff to use in order to prevent the spread of infection, including the laundry. Staff had access to personal protective equipment such as gloves and aprons and we saw that there were plenty of supplies. We observed staff used the equipment when they needed to. We spoke with the person working in the laundry who told us the system and equipment worked well and the only problem was the heat in summer.

People who used the service told us, "I take all my medication with my meals" and "I always take a tablet in

the morning and one at night."

We observed a member of staff administering medicines and saw they used safe procedures. We looked at the policies and procedures for the administration of medicines. The policies and procedures informed staff of all aspects of medicines administration including ordering, storage and disposal. All staff who supported people to take their medicines had been trained to do so (registered nurses who told us they received refresher training and competency checks). We looked at eight medicines administration records (MARs) and found they had been completed accurately. There was a photographic record of each person to help prevent errors. There were no unexplained gaps or omissions. One staff member had signed they had checked medicines into the home and two staff members for any hand written prescriptions to help prevent errors.

Medicines were stored in a locked room in a trolley attached to the wall. Dressings were stored in separate cupboards. The temperature of the medicines room was checked daily as was the medicines fridge to ensure medicines were stored to manufacturer's guidelines. The room was clean and tidy.

There was a controlled drug cupboard and register. We checked the drugs against the number recorded in the register and found they were accurate. The controlled drugs were checked at the end of each shift and a member of staff witnessed that the nurse had administered them.

There was a daily check of medicines (a visual check of the MAR sheets) and a weekly audit by the nurses. The system was also audited by management. This helped spot any errors or mistakes. Staff retained patient information leaflets for medicines and also a copy of the British National Formulary to check for information such as side effects.

There was a separate sheet for 'as required' medicines. This gave staff details which included the name and strength of the medicine, the dose to be given, the maximum dose in a 24 hour period, the route it should be given and what it was for. This helped prevent errors.

Any medicines that had a used by date had been signed and dated by the nurse who had first used it to ensure staff were aware if it was going out of date.

There was a signature list of all staff who gave medicines for management to help audit any errors. The service had a copy of the NICE guidelines for administering medicines.

We saw that topical medicines such as ointments were recorded in the plans of care. A body map diagram was used to highlight where the medicines should be applied, which were colour coded if more than one was required. Staff who applied the medicines signed the records which were duplicated in the plans of care.

We looked in the trolley and saw it was a blister pack system. The trolley was clean and tidy as were the pots. There were sufficient supplies of medicines. Any medicines that required returning to pharmacy were done so in a tamper proof box and two staff signed to say they had witnessed the disposal.

We saw that all rooms or cupboards that contained chemicals or cleaning agents were locked for the safety of people who used the service.

Good

Is the service effective?

Our findings

We toured the building during the inspection and visited all communal areas, several bedrooms and the bathrooms. The home was clean, warm, tidy and did not contain any offensive odours.

The communal areas were well decorated and had sufficient seating for people accommodated at the home. Some people's seating was specifically designed for them. The communal areas were homely in character and a television was available for people to watch if they wished. Some people preferred to remain in their rooms.

Bedrooms we visited had been personalised to people's tastes. This included people's own televisions and equipment but also fish tanks, football themed memorabilia and photographs. Each room had an en-suite room which contained a shower, sink and toilet. The shower rooms were large enough to allow for wheelchairs to gain access.

There was a lift to access both floors and the corridors were wide enough for some of the larger electric wheelchairs. There were hand rails along the corridors to help people move independently if they could. Baths contained hoists which helped people take a bath if they wished.

The garden was accessible for people to use in good weather and contained chairs and tables for people to relax and socialise. One person said he liked to play football in the garden and other people who used the service went into the garden all year round to look after the rabbits they kept as pets.

There were hoists and slings to help mobilise people and other equipment we saw included personal wheelchairs, pressure relieving devices and enteral feeding machines.

People who used the service said, "The cook is a great cook. The food is lovely" and "If you want, you can have your meals in your room."

We checked to see if people were provided with a choice of suitable and nutritious food and drink to ensure their health care needs were met. We were present in the dining room for part of the inspection to observe a mealtime. People could take their meal in their room if they wished. We saw some people were able to take their own meal, some people needed equipment, for example plate guards or specialised drinking cups and some people needed assistance to have their meal. We saw that where required people used the specialised equipment and people were assisted to take their diet in an individual and dignified way. We saw one person being assisted and the staff member and person chatted during the meal.

There was a choice at each meal and other foods available at any mealtime which included sandwiches, jacket potatoes with fillings and or soup. There was a four weekly menu cycle. The menu was provided in a folder with pictures of the food to help people make their choices.

People could choose from any of the usual breakfast foods. There was a choice of the meal at lunch time,

which was the main meal of the day and a choice of a lighter tea. Hot or cold drinks were served with meals, at set times during the day and upon request. Each of the two floors had a kitchenette where drinks and snacks could be made at any time during the day including supper time.

We spoke with the cook who told us she attended meetings with people who used the service to see what they liked and also went to speak to any new admissions to see what their likes and dislikes were. Food preferences were also recorded in the plans of care. Each person had a nutritional assessment and we saw that where necessary people had access to specialists such as dieticians or speech and language therapists (SALT). This was for advice but also for help with care planning for people who were at risk of choking. People's weights were recorded regularly to ensure they were not gaining or losing weight.

The dining rooms contained sufficient seating for all although some people remained in their wheelchairs which they used to get to the table. The cook told us she was aware of people's special needs such as for people with diabetes or who required mashed food. There was also a lot of information about food allergies to ensure people did not eat food that harmed them.

The kitchen had achieved the five star very good rating from the last environmental health inspection which meant food ordering, storage, preparation and serving were safe. We went into the kitchen and found it to be clean and tidy. We saw there was a cleaning rota and a good supply of fresh, frozen, dried and canned foods. This included fresh fruit although the cook said they were limited in what could be taken into the dining room for people to pick because of the risk of people choking. There was tinned fruit as a replacement.

We saw that new staff completed an induction. Each member of staff was given a workbook which told them all about the induction process. The induction lasted seven days and included all mandatory training, for example, moving and handling, infection control, health and safety and first aid. Staff were then enrolled on the care certificate which is considered best practice for people new to the care industry. We saw the paperwork was being completed for all new staff. Two staff members told us, "I completed the seven days induction. It was useful and some things were new to me. It gave me some insight into the job. When I came out of induction I felt able to do the job by about 95% but I always think there may be more to learn. They supported me with an experienced member of staff. They helped me a lot. They are still helping me although I have previous experience with Huntington's disease cases" and "I completed the induction when I started. It was very good." New staff were given the skills and support to work with people who used the service.

We saw from looking at the training matrix, staff files and talking to staff that training was ongoing. Training included MCA, DoLS, first aid, food safety, medicines administration, moving and handling, infection control, health and safety, safeguarding and fire awareness. Staff were encouraged to take a recognised course (NVQ or Diploma) in health and social care. Other training included care of people with Huntington's disease, equality and diversity, behaviours that may challenge, the use of equipment such as bed rails, customer care and person centred approach planning. We saw that refresher and further training was planned for future dates. A staff member said, "I have done all my refresher training except fire safety but it has been arranged. I have also completed the training for the care of people with Huntington's and for behaviours that may challenge." Staff were sufficiently well trained to perform their roles.

Trained nurses were being given support to revalidate their registration to practice with the Nursing and Midwifery Council.

Two staff members said, "I am due my next supervision but have had several in the past and my appraisal. You can discuss your career when you have supervision" and "I have already had supervision and they ask

you how you are doing. All staff are very supportive." We saw that appraisal was held once a year and supervision around every two months. All the records were kept in the staff files. Regular supervision and appraisal gives managers and staff time to reflect upon practice and decide how best each individual can improve their knowledge and performance.

From looking at three plans of care we saw that people who used the service had access to professionals, for example psychiatrists and other hospital consultants, community nurse specialists and district nurses. Each person had their own GP. The service liaised with the Huntington's disease society to keep up to date with good practice. A specialist in Huntington's disease came to the home every three months to conduct a 'ward round'. This meant people's treatment was regularly followed up and any new treatment could be commenced.

All the people we spoke with said staff were quick to arrange any appointments, with two people who used the service saying they had seen the doctor or one had been arranged on the first day of the inspection.

We looked at what consideration the provider gave to the Mental Capacity Act 2005 (MCA). The 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. Most members of staff had been trained in the Mental Capacity Act 2005 (MCA 2005).

We saw from three plans of care that people had a mental capacity assessment which was reviewed regularly. Three people who lived at the care home were under a DoLS for care within the home and a further ten applications were in the process of application with the local authority. We saw that people signed their consent to care and treatment where possible and that best interest meetings were held if not. Best interest meetings included professionals and family members if appropriate.

There was a flow chart for staff to follow the correct procedures. There was also information about DoLS which was in an easy read format to help people who used the service understand the process. There was information about the advocacy service available for people who used the service to contact should they wish an independent person to act upon their behalf. We saw that staff asked people for their agreement before they gave any assistance.

Good

Is the service caring?

Our findings

People who used the service said, "The staff are excellent", "Staff are brilliant", "They are really nice staff" and "I've made really good friends here and that absolutely includes the staff." A visitor said, "They interact really well with the residents." People thought staff were friendly and caring.

People who used the service also told us, "They always knock before they come in", "Staff always knock on the door", "Staff don't always remember to close the door behind them but always remember to knock", "Staff always close the door when bathing but not always when in my room" and "They treat me and the residents with politeness and respect." We spoke to the manager about the possible breaches of privacy when staff enter bedrooms and do not always close the door and they said it would be brought up at a meeting.

We observed staff during the inspection and how they interacted with people who used the service. Staff were professional, polite and had a good rapport with them. We did not see any breaches of privacy or witness anyone being treated in an undignified manner.

It was noted that staff called all residents by their first names or nicknames and they also acknowledged regular visitors by their first names. During informal conversations, staff spoke about individual residents with knowledge of their backgrounds, likes and dislikes, as well as their current individual needs and behaviours. We observed that staff regularly went into the communal areas as well as their bedrooms to check on the residents and had time to talk to them. We overheard comments such as "Are you OK", and "Do you need anything." Staff were attentive to people's needs.

Staff told us, "I would be happy for a member of my family to be looked after here. I would say it is a good here. We feel like a part of the team", "I like working here. They give you the motivation to care for people" and "We have a good team. I love working here. I like the banter with the people who live here, it is a nice environment. I would be happy for a member of my family to live here."

Staff were trained in confidentiality and data protection issues. Confidentiality was also included in the staff handbook. We saw that care records were stored safely and only available to staff who needed to access them. This ensured that people's personal information was stored confidentially.

Plans of care were personalised to each person and recorded their likes and dislikes, choices, preferred routines, activities and hobbies. There was also information about what a person was capable of doing which helped them remain independent. There was also a record of a person's spiritual or religious needs although we were told that nobody at the time of the inspection required any assistance to attend church or a minister of their choice.

Some staff had attended a recognised palliative care course. People's end of life wishes were recorded in the plans of care. This meant that staff should be aware of how to support people and their families if their condition deteriorated.

We saw that visiting was open and unrestricted. We observed that any visitors were welcomed into the home and were told people could have their visits in private if they wished. People were encouraged to maintain relationships with their family and friends.

Good

Is the service responsive?

Our findings

People who used the service had mixed views about the activities they were able to attend. Comments included, "I like to watch films", "(Staff member's name) takes me to the cinema. I love going to the cinema", "The new activities coordinator is useless", "Activities are naff", "The Christmas Party was very good", "The pantomime was fantastic" and "I play chess, not really much to do". We attended a meeting on the second day of the inspection which was attended by the people who used the service who wanted to. Activities were brought up and whilst we were there nobody brought up anything further they would like to do except horse riding which had been done before.

Activities we were told were provided included going to the cinema, football matches, shopping, garden centres, art galleries, parks and animal centres and eating out. Indoor activities included watching DVD's, computer games, creative writing, mobile library, pamper sessions, exercise therapy, quizzes, board games, chess, arts and crafts, karaoke and one to one sessions. There was a weekly planner which informed people what was on offer. Some people who used the service looked after some rabbits which were kept in the garden which they told us they enjoyed. Some people also kept fish in their rooms.

People who used the service told us, "I have no confidence to complain to anyone, don't know who to trust anymore", "I have no concerns about going to the manager with any issues" and "I would have no problems saying something to the support manager) if I needed to." On the two days of the inspection nobody made any complaints. We looked at how management investigated any concerns. We saw that one complaint that had been raised to us had been fully investigated and a satisfactory conclusion reached. Another concern we saw ended in action being taken against a member of the bank staff.

There was a suitable complaints procedure located in the foyer. Each person also had a copy in the documentation provided on admission. The complaints procedure told people how to complain, who to complain to and the timescales the service would respond to any concerns. This procedure included the contact details of the Care Quality Commission. There was also documentation available called NHS speak up advice. This gave people who used the service another option they could use to contact people outside of the service.

We looked at three plans of care during the inspection. Arrangements were in place for the registered manager or a senior member of staff to visit and assess people's personal and health care needs before they were admitted to the home. The person and/or their representatives were involved in the pre-admission assessment and provided information about the person's abilities and preferences. Information was also obtained from other health and social care professionals such as the person's social worker. Social services or the health authority also provided their own assessments to ensure the person was suitably placed. This process helped to ensure that people's individual needs could be met at the home.

The plans of care showed what level of support people needed and how staff should support them. Each heading, for example personal care, tissue viability, mental health, diet and nutrition, mobility or communication showed what need a person had and how staff needed to support them to reach the

desired outcome. The plans were reviewed regularly to keep staff up to date with people's needs. The quality of care plans was regularly audited by management.

We saw that where people had special needs, for example, communication problems staff were given clear advice about how best to approach and communicate with them. One plan of care we looked at told us the person had limited communication which told staff how best to approach them and ask questions in a way the person found easiest to respond to.

We also saw that there were many details about what equipment a person needed, what type and for any specific instructions such as how to clean an enteral (peg) machine, catheter and skin area.

The plan had been developed with the person and was written as though the person had completed it themselves. This gave staff the chance to sit and talk with people who used the service to produce a plan that was personal to them. The daily records we saw told us what a person had done, if they had attended activities or appointments and how their day had been.

Staff had a handover at the beginning of their shift. A handover is used to keep staff up to date with any changes to a person's care or if they were attending activities or appointments they needed staff support with.

Requires Improvement

Is the service well-led?

Our findings

The service did not have 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The CQC place a limiter on this domain which cannot be assessed as anything other than requires improvement if there is no registered manager. A new manager was due to start in early January.

We asked people and staff how they felt the home was run. People who used the service told us, ""I like things just as they are", "The support manager is great. I like him he is a lovely man" and "The support manager seems alright." Staff said, "The unit managers and nurses are very supportive. You can approach the manager, he is very nice", "The manager is supportive. He is lovely. He asks us if we are OK. He talks to us every day. You can also go to the team leaders" and "He is a supportive manager. You can go to him if we need anything. I like working here." People thought managers at the service were supportive and approachable.

People were able to attend meetings if they wished and one person told us they attended them all and another person said they had been to one a couple of months ago. The activities coordinator said they tried to hold meetings regularly but attendance was poor and usually ended up as an activities session. We were invited to attend a meeting which six people attended but who did not appear to want to engage. It was noted that the two people who did not think activities were very good decided not to attend. All the people present were invited to have a say in the meeting and discuss what they wanted. However, from the last available notes, it was very evident that residents' views were noted and included comments about staffing, planned activities, required activities, and minibus issues. The Support Manager informed us that, after one meeting, he had implemented a spot check on night staff activity.

We saw the minutes from the last staff meetings which included head of departments meetings as well as ones were all staff were invited to attend. Most meetings were constructive and staff were able to bring any ideas forward to the meeting. The last meeting we noted was classed as a supervision record so we were not able to tell if staff were able to have any input.

The registered manager conducted audits regularly. The audits included a daily walk around where they looked at the environment, including infection control, met with both nurses to discuss any clinical issues, staffing for any shortfalls, appointments, accidents and incidents. Part of the process was to look at the diaries to see if anything needed to be passed on to other staff or any equipment needed replacing. Any actions required were noted and we saw a television being replaced on one day of the inspection. Other audits included care plans and medicines.

The area manager visited frequently and the visits may be unannounced. This member of staff looked at the overall quality of the service, health and safety issues. We saw records of the last visit which included any actions that were required and who was responsible for undertaking the task.

We looked at some of the policies and procedures which included Infection control, safeguarding, whistle blowing, behaviours that challenge, mental capacity and DoLS, complaints, confidentiality, health and safety and medicines administration. Policies and procedures were updated regularly and available for staff to follow good practice.

We saw there was a service user guide and statement of purpose. These documents gave people who used the service and professionals the details of the services and facilities provided at this care home.

During our inspection our checks confirmed the provider was meeting our requirements to display their most recent CQC rating. A copy of the latest inspection report was also made available for people to read.

The service had recently sent out quality assurance questionnaires and were awaiting the return of the forms prior to providing a summary.