Sycamore Care Limited

Tancred Hall Care Home

Inspection report

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Whixley
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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?	**Requires Improvement**

Summary of findings

Overall summary

This inspection was carried out over two days on 17 and 18 August 2016 and the inspection was unannounced.

Tancred Hall Care Home provides personal and nursing care and accommodation for up to 49 people who have nursing and/or dementia care needs. The home is located in a rural setting on the outskirts of Whixley village between Harrogate and York. There is a large car park to the side of the home. Care is provided in two separate units. There is disabled access and two lifts to the rooms on the first floor. At the time of our inspection there were 33 people receiving a service.

The provider registered the service as Tancred Hall Care Home on 10 August 2012 and this was their first comprehensive inspection. There was a registered manager in post. A registered manager is a person who has registered with the CQC 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.

The registered provider had a medication policy in place however; we found this information required updating. The nurse in charge had received training in the management and administration of medicines in their previous employment but they told us this required updating and we were unable to see how their competencies were assessed by the registered provider. We found management and administration of medications was not always safe.

The registered provider completed pre-employment checks on care workers to help ensure they were of suitable character to work with vulnerable people. However, the induction process for new care workers failed to demonstrate how they were supported, skilled and assessed as competent before independently carrying out their roles.

We found the registered provider had established systems and processes in place to assess monitor and drive improvement in the quality and safety of the service provided. These measures included the review of policies and procedures and audits on documentation that included care plans. Despite the measures in place, we found these were not always up to date or effective in their purpose and information was sometimes out of date. They did not always reflect people's individual needs and care workers did not always have access to up to date records.

The registered manager discussed how they obtained feedback from people who received support and care at the home. They told us they had a schedule to send out questionnaires quarterly and that the results were evaluated to help improve any areas of concern. However, we did not see any evidence that suggested feedback was collated and evaluated to drive improvement to the quality or safety of the service.

There was a cleaner in the home and systems were in place to ensure the environment was clean which

helped people remain free from infections. However, the environment was not always free from odours despite a cleaning process in place.

A record was on people's file with regard to their interests and preferred activities. Activities were provided but at times, these were limited due to pressures on staff resources. Staffing was monitored by the registered provider. Due to concerns raised by other care workers we asked the registered provider to review their staffing dependency to ensure sufficient staff were available at all times to meet people's individual needs.

Risk assessments and associated support plans were in place to identify and manage risks to people and the environment, which helped people to live safely and maintain their independence and personal choices.

Staff had completed up to date training in safeguarding adults from abuse and understood how to keep people safe from harm and abuse and how to raise their concerns.

People received an assessment of need as part of their admission process to the home. This meant the provider could ensure they were able to meet the person's needs and the information formed the basis of their individual care plan. People were involved in development and review of their care plans and where they lacked capacity the registered provider followed the Mental Capacity Act 2005. Care workers we spoke with understood how to apply the principles of the Mental Capacity Act 2005 and they were clear any decisions made for a person had to be made in the person's best interests.

People had access to a range of health professionals to ensure there holistic needs were met. Care plans were reflective of their care needs but despite reviews, some information required updating. People were supported to maintain a healthy life, food was prepared freshly on site to meet people's individual dietary requirements, and wherever possible the cook catered to individual choices.

People were consulted on their end of life preferences and where they agreed this information was recorded in their care plans. When they did not have capacity to make those decisions families and other health professionals had been consulted and the outcomes recorded.

People received care from care workers who were kind and caring and who treated them with dignity and respect. Care workers knew and understood their likes, preferences, needs, hopes and goals and promoted people's independence wherever possible.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines were not always managed safely and associated policies and procedures for the safe management of medication required updating.

The environment was not always free from odours despite a cleaning process in place.

Staff understood how to keep people safe from harm and abuse and how to raise their concerns.

Systems were in place to identify and manage risks to people and others accessing the home, equipment and the environment.

Is the service effective?

Requires Improvement

The service was not always effective.

The induction process for new care workers did not demonstrate how they were supported, skilled and assessed as competent before independently carrying out their roles.

People were involved in development and review of their care plans. Where people lacked capacity the registered provider followed the Mental Capacity Act 2005.

People were supported to remain healthy and food was prepared freshly to meet people's individual dietary requirements and preferences.

Is the service caring?

Good

The service was Caring.

Staff understood the need to treat people with dignity and respect and understood how to maintain people's confidentiality.

Care plans promoted a person's individual choice and

preferences and as appropriate.

People were supported by the use of independent advocacy support services.

People had been consulted and their end of life preferences were recorded.

Is the service responsive?

Good

The service was responsive.

People had personalised plans of care and support which helped care workers to provide support and care that was responsive to their individual needs. However, some areas of the care plan required updating.

Activities were provided and reflected people's preferences. However, at times there was insufficient staff to provide support for these activities.

People were provided with information on how to complain and raise concerns and processes were in place to respond.

Is the service well-led?

Requires Improvement

The service was not always Well-Led.

Systems and processes that were in place to assess monitor and mitigate risk including policies and procedures and staff induction were not always up to date or effective in their purpose.

Records were not always well maintained, accurate and up to date.

There was some evidence of quality assurance checks in place. However, there was no evidence to suggest appropriate checks had been implemented to drive improvement and shape service delivery.

There was a clear management structure in place and staff had an understanding of their roles and responsibilities.

Tancred Hall Care Home

Detailed findings

Background to this inspection

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

This inspection was carried out over two days on the 17 and 18 of August 2016 and was unannounced. The inspection team consisted of one adult social care inspector.

Before the inspection, the provider completed a provider information return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information we held about the service, such as notifications about any incidents or accidents that we had received from the registered provider and information we had received from the local authorities that commission a service from the home.

On the day of the inspection, we spoke with three people who lived in the home, three visiting relatives, two visiting health care professionals, the cook, four members of staff, the registered manager and a fire officer.

As part of the inspection, we reviewed the care records for five people including their medicine records and risk assessments. We also looked at five staff files and other records used in running a care home that included quality assurance systems, policies and procedures and health and safety records. We observed the care and support being provided to people and observed two medication rounds and the lunchtime meal in the dining room.

Requires Improvement

Is the service safe?

Our findings

We checked to see if the registered provider had systems and processes in place to administer and manage medicines safely for people. The registered provider showed us an administration of drugs policy but this was dated September 2012 and had not been updated. The registered manager told us the home had recently completed an audit and as a result, these documents had been identified as requiring an update. An agency worker told us, "I don't know where the policy or procedure for medicines is, it might be in the office but I don't work here so often."

We observed two medication rounds in the two sides of the home. Information for people's medicines was maintained in a Medication Administration Record (MAR) file. This included the person's name, a photograph of the individual, and their date of birth, details of any allergies and recordings of the medicines they had received.

The MAR file included a prescription label that provided the name of the medicine and directions for the time and dosage required but did not contain information about the actual medication. Agency staff told us they did not readily have access to reliable and up-to-date information about the medicines they administered.

A MAR we inspected at midday contained an omission for a medicine required in the morning for a person. The agency staff told us they were not out of bed yet and they did not want to disturb the person. This had not been recorded on the MAR. The registered manager told us, "[Person] goes to bed late and gets up late and consequently has their medicines at later times than those prescribed." They told us they would speak with the pharmacist to have the times of required administration of the medicines changed.

Two agency staff involved with medicines management told us, "I have received some medicines training from [other employment] and not from this home; it [medicines training] requires updating." And "I have not received training on medicines here but I do this as my job." The registered manager told us agency staff completed an induction to the service but this was not recorded and there was no documentation to demonstrate their competencies in the management of medicines had been checked and recorded.

Medicines were dispensed from a locked trolley that was kept in a locked room when not in use. We saw some medicines had been received and were in boxes outside the locked room. The registered manager told us, "These should have been checked in and locked away." They were removed during our inspection. One side of the home had a fridge for the storage of medicines that required refrigeration but the other side did not. Medicines were stored in a kitchen fridge and were mixed with other food produce and were not labelled or in their own container. These were moved during our inspection.

The above concerns meant that at the time of our inspection the management and administration of medicines was not always safe for people. This was a breach of the Regulation 12 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider undertook a monthly infection control audit. However, along with a bedroom in the home we noticed the reception, living room and attached corridors had stains on the carpets and a malodour. There were flies in and around the communal areas. We spoke with the registered manager about this and they told us they regularly had the carpets cleaned and that some flooring in the bedroom required replacement. They said, "Some flooring does need replacing, we try and keep it clean as best as we can; we use a rug doctor for the carpets," and "We are in a rural location and surrounded by farm animals and we do get flies." Despite this, there were no preventative screens or measures in place to control the flies and the malodour was still prevalent. The registered manager told us they would increase carpet cleaning and replace the flooring as a priority. This meant that at the time of our inspection the premises were not visibly clean and free from unpleasant odours. This was a breach of the Regulation 15 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

People and care workers we spoke with voiced their concerns around the number of care workers available. We looked at staff rotas and at the time of our inspection, the home had one bank nurse, two carers and an activity coordinator who worked in one side of the home where people had complex behavioural needs and one bank nurse, and three care workers in the other part. One senior and two care workers were employed in each part of the building during the night time. One person said, "We have a fob that we wear and we can press it to summon assistance if we need it." Care workers we spoke with said, "We could do with one more staff so we can provide quality care and re-introduce activities for people", "There is a lot of agency staff which can be difficult", "We are short staffed; we use lots of agency and can really struggle at weekends if there are only two staff on duty." And "If there is one thing that should be improved; it is staffing." We spoke with the manager about this. They told us, "We are in a very remote location and we have difficulty in recruiting full time staff, we have a minibus and pick staff up and drop them off and we also have staff who come over from Ireland for a week at a time." They continued, "I am keen to ensure we have quality staff in post to provide care and support, I don't like to compromise on this, it's important for our residents."
We recommend that the registered manager carries out a review of their staffing provision so that they can be satisfied that there are sufficient staff on duty throughout the day.

People were protected against the risks of potential abuse and bullying. People confirmed they felt safe. One person told us, "Staff are around should you need them." Another told us, "Yes I do feel safe with the people around me." A relative said, "It was a difficult decision to move my wife into the home but I am pleased to say without a doubt, it is a very safe environment which puts me at considerable ease." The registered provider told us on the PIR, 'All staff are trained in safeguarding adults'. Care workers had completed training in safeguarding adults from abuse; those we spoke with were able to discuss signs of abuse they looked out for and what they would do if they had any concerns. One care worker said, "I would speak with the nurse in charge or the manager if I had any concerns." They continued, "If I had concerns about bad practice I know I could also undertake whistleblowing to the Care Quality Commission or the local authority safeguarding team; I wouldn't hesitate, it's our job to keep people safe from harm."

The registered manager showed us guidance on protecting vulnerable service users that was available for everybody at the home. This included information on potential abusers, definition and types of abuse, what to do if abuse was suspected and how related investigations would be completed. The registered manager discussed the process with us and showed us an example where concerns had been shared with the local authority. A resulting strategy meeting had been held that included other health professionals and the outcomes had been discussed with care workers for their feedback to help improve practice. These measures helped prevent re-occurrence of the event and helped to keep people safe from harm and abuse.

People were supported to take risks to retain their independence whilst any known hazards were minimised to prevent harm. People's risk assessments had been discussed and reviewed with input from family and

close friends. Risk assessments described the identified risk, who may be affected by the risk, controls that may be required and any further actions required to minimise the risk. Identified risks included mobility, falling, communication, mental health, nutrition, personal hygiene, and sleeping. For example, where people were at risk from falls equipment such as mobility aids and an increase in staffing had been identified as control measures.

People had been assessed to indicate the support they required in an emergency and a Personal Emergency Evacuation Plan (PEEP) completed. A PEEP is a document, which advises of the support people need to leave the home in the event of an evacuation taking place.

The registered provider had a record of measures and audits in place to help keep the home and the environment safe for everybody. These included monthly maintenance checks on electrics, flooring, fire doors, equipment, first aid box and hazards in the garden and outbuildings. Monthly checks had been completed on firefighting equipment and the kitchen environment. Where concerns had been highlighted, these had been recorded in a 'Corrective Action Register' and the date the concern had been resolved was recorded. Checks and tests had also been completed and recorded on water and fridge temperatures, risks from legionella, on call systems, gas safety, bed rails, lifts, slings and hoists. These measures helped to keep people and others who accessed the home and the equipment safe from avoidable harm.

We asked the manager for the recruitment records for seven members of staff to ensure pre-employment checks had been made. Information provided included checks such as those by the Disclosure and Barring Service (DBS). The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults that helped to ensure those employed were of suitable character. Other information provided included details of pre-employment references, application forms and right to work in the UK documents. We saw from the information provided that all staff had completed an application form and references had been obtained and this information had been obtained prior to employees working alone with people.

The registered provider had undertaken some additional checks when recruiting agency staff. We looked at the agency file and saw that information recorded included training undertaken, DBS checks and PIN numbers for nurses that were checked monthly. A PIN number means the nurse is registered with the Nursing and Midwifery Council and will undertake continuing professional development to maintain their registration. The registered manager told us, "We ask for a profile for agency staff and they receive a brief introduction to the service our policies and systems." This meant the registered provider had procedures in place that helped to ensure agency staff were of suitable character to work with vulnerable adults.

We looked at the recording of accidents and incidents. An incident report was completed that documented events, outcomes, and evaluations had been completed to identify trends and reduce the risk of re-occurrence of the event for people. For example where a person had a pattern of recurring falls in the home, the registered provider referred the person to the local NHS Falls Team. The documented care and support plan for the person was updated and changes were discussed at group supervisions.

Requires Improvement

Is the service effective?

Our findings

Care workers told us they had received an induction to the home and the induction process was documented in staff files. A care worker said, "I was provided with some policy and procedures, a handbook and had a tour and then I was straight into the job." Documented induction included fire awareness, first aid, call bell functions, an information pack and a range of policies and procedures.

New care workers did not complete any formal induction and there was no evidence to demonstrate how new staff were supported, and assessed as competent before independently carrying out their roles. A care worker told us, "I shadowed existing employees for a time but there was no formal induction process." We found from speaking with agency staff that pre-employment checks were carried out but formal inductions and competency checks were not always carried out or recorded.

The registered manager told us existing care workers completed a recognised national qualification at a minimum of level two in health and social care. Records provided confirmed that two out of fourteen care workers had undertaken and completed this training. We asked for records of this training for other employees but this was not provided.

Existing care workers told us and we saw from their files that they had completed a range of role specific training that included diet and nutrition, mental capacity act, first aid, fire, safeguarding, dementia awareness, food safety, infection control and managing challenging behaviour. Training was managed using a training matrix. This highlighted when refresher training was due. Moving and handling of people training was provided however, records showed that refresher training had not been completed for sixteen employees and was out of date. The registered manager told us the trainer had been away. They showed us communication to rearrange this that would ensure people were up to date.

This was a breach of the Regulation 18 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us they knew the care workers who worked in the home and they confirmed that care workers understood their individual needs and how to support them. Comments included, "The staff are great, they look after me very well", "I feel very well supported" and "They [Staff] are a great bunch but I do have to wait for my coffee sometimes." Care workers we spoke with told us they understood people's needs. Those we spoke with said, "People have information about them in their care plans but it is from talking with people, their friends and relatives that we can really get to know the individual." "People living here have some very diverse needs; everyone is different which makes it even more important that we understand people as individuals and respond to their individual needs."

Care workers were supported to undertake their role and feedback was provided to ensure they were following best practice. Documented supervisions and appraisals confirmed this. The registered manager told us, "We aim to have supervision every month and when that is not always possible then I have an open door policy and make myself available at all other times." The registered provider told us on the PIR, 'All staff

receive formal supervision at least six times per year.' In addition, care workers told us, "We have group supervisions when we discuss feedback from inspections, sickness, breaks and person related information such as turn charts." Minutes of these meetings confirmed this was the case.

People had been involved in both the development and review of their care plans. Where people had the capacity to do so, they had signed these documents to formally record their consent to the care and support described. People told us they were able to make choices about how their care was provided and that staff respected their decisions. One person told us, "Care workers are very good at talking with me about my needs and when I have appointments I couldn't manage without them." Where people did not have capacity the registered provider involved family, advocates and other health professionals to determine that care was appropriate to a person's needs.

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 and found the service was working within the principles of the MCA, and any conditions on authorisations to deprive a person of their liberty were being met. The registered provider showed us a mental capacity policy that included guidance on assessing a person's capacity to make a single and multiple decisions and included information on DoLS and best interest decisions making. People had documented assessments in their care plans and where a lack of capacity had been identified, the registered provider had submitted applications to the local authority for an assessment and authorisation for a DoLS. At the time of the inspection, the registered manager had submitted twenty-four DoLS applications to the local authority and had received twelve approvals. Care plans contained monthly evaluations to ensure the DoLS remained effective and applicable. Care workers we spoke with demonstrated a good awareness of the DoLS and what it meant for the people who lived there.

People were supported to maintain good health. Care plans contained detailed information to ensure people were not at risk of malnutrition. We saw the use of 'Malnutrition Universal Screening Tool' ('MUST') was completed in people's care records. A care worker said, "We use MUST to monitor people's diets, if we have concerns we call the GP who can refer the person to a dietician." Other records detailed people's food and fluid intake.

We saw people's dietary requirements noted in their care plans. The cook told us, "We receive information on people's individual dietary needs from care workers," "We cater for people's individual health needs and always try and cook food that people choose to eat and we try different options." They said, "Fresh food is bought in twice weekly, meat is bought fresh from the butcher's and cakes are made in house; we encourage people to eat healthily."

The home had two dining rooms where people could eat. They could also eat in communal areas or their rooms. We observed care workers attending to people, providing drinks and assisting people by asking them if they required their food cutting up or assistance with eating. Feedback on the food was positive from people who told us, "The food is plentiful and we are offered a choice, it is very good.", "We have a healthy menu to choose from and lovely cakes and puddings."

The kitchen had an environmental health officer food hygiene rating [FHRS] award of 5. Ratings are based on how hygienic and well-managed food preparation areas are on the premises. A food preparation facility is given FHRS ratings from 0 to 5, 0 being the worst and 5 being the best. An FHRS rating of 3 is acceptable.

People told us they had access to a range of health professionals that included their GP. The registered provider told us on their PIR, 'We have a registered chiropodist who visit the home at approximately six weekly intervals and service users are supported to access support from dieticians, speech and language therapy, dentists and opticians." Two community support workers we spoke with told us, "The nurse in charge was knowledgeable about [the person's] food and fluid intake," "We find the home is quick to refer people should their health needs change and the registered manager is good with communication."

The home was suitably adapted to meet the mobility needs of people who lived there. Corridors and doorways accommodated wheel chairs and there was a lift to access the first floor rooms.

Good

Is the service caring?

Our findings

It was clear from our observations during the inspection that care workers were caring towards people. We saw care workers speaking gently to people when they showed signs of distress and offered reassurance and distractions to calm people. We observed an incident when one person took hold of a person's arm whilst showing signs of confusion. The care worker stopped what they were doing and spoke with the person encouraging them to move to a seat where they provided a drink and reassuring words. Relatives we spoke with said, "The staff are so caring, what's nice is [person] has no restrictions, they go to bed and get up when they are ready and staff are there to help" and "We always turn up unannounced and [the person] is always clean and has eaten; there's no change in the service it consistently meets the person's] requirements."

The registered provider told us on the PIR, 'Care plans identify the service user's wishes and preferences for their care provision'. People had their own individual care plan. People told us they had been involved with some or all of the information. One person said, "[Care worker] goes through this [care plan] with me; I have signed and agree to the contents." Care plans we looked at included a 'Care Plan Protocol' that was signed and dated as the care plan was completed and a 'Consent to Care and Treatment' that was completed by the person.

Care plans promoted a person's individual choice and preferences. Care workers told us they used them to ensure people were involved and supported in the planning and delivery of their care. Care workers said, "I use care plans as a guide but I would always ask a person to make sure they understood and agreed with any activity I was undertaking." And "Care plans are centred on the person and I would always respect people's wishes and treat them with dignity." Our observations during the inspection confirmed this.

A care plan we looked at included a DNACPR form. The purpose of a DNACPR decision is to provide immediate guidance to those present (mostly healthcare professionals) on the best action to take (or not take) should the person suffer cardiac arrest or die suddenly. The person did not have capacity to sign the form however, we saw that the registered provider had consulted with the person's relative and the form had been signed by a GP with details of the reasons for the decision.

The registered provider had consulted people about their wishes for end of life. Where the person had agreed this was documented. Care plans included details on people's funeral wishes, whom to contact, their preferences for burial or funeral and where they wished to be laid to rest. The registered provider told us on the PIR, 'When the service user is at end of life we provide refreshments and snacks for family and visitors and overnight facilities are provided should they wish to stay with their loved one.' This meant the registered provider had plans in place to respect the wishes and preference of people and to help support their families when the need arose.

Care workers understood the need to respect people's confidentiality and understood not to discuss issues in public or disclose information to people who did not need to know. Any information that needed to be passed on about people was placed in the service's confidential communication book or discussed at staff

handovers, which were conducted in private.

Discussion with care workers revealed where people using the service had any particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010 that applied to people living there: age, disability, gender, marital status, race, religion and sexual orientation, that their needs were respected and provided for. We saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this.

The registered manager told us there was nobody receiving a service that required the support of an advocate but they knew the details of who to contact should this be required. We saw information on Independent Mental Capacity Advocates (IMCAs) that the registered provider used. IMCAs can provide support for people who lack the capacity to make specific important decisions. The registered manager showed us information from North Yorkshire Safe Hands Project. In addition to supporting people with difficult decisions, the advocacy service provided specific independent support to people to help them manage their post and finances. These measures helped people to have independence, choice and control in their everyday lives.

Good

Is the service responsive?

Our findings

We reviewed the care records for five people who lived at the home. We found there were very detailed assessments and care plans in place that included a pre-admission assessment. This helped the registered provider to ensure the service could respond to the person's individual needs, and formed the basis of the care plan. A summary called, 'This is me' was included that had a picture of the person and some important information on their medicines and health requirements. We found these were not always up to date. The registered manager was aware of this and they told us this information was available elsewhere in their care plans and that these were routinely updated. They told us they would review them all to ensure information recorded on the summary sheet also reflected people's current individual needs.

The care plans we looked at included risk assessments and associated support plans, which helped care workers to provide support and care that was responsive to their individual needs. For example, we saw that one person had leisure time activities recorded that included going out into the garden, coffee with family and bowling however, this information had not recently been updated. We observed people in the home sat in chairs for long periods and that there was no significant activities for people. We spoke with the activities co-ordinator who told us, "I have lots of ideas; I would like to improve the garden area and encourage people to participate in growing food for the kitchen because we have people who are interested in this," "The problem at the moment is that I have to provide one to one support to [person] so I have no time for other activities with people." We asked care workers what they thought could be improved for people receiving a service and they told us, "People would benefit from more trips out but we would need more staff to support this.", "We need to encourage people to participate in and provide more activities." One person receiving a service told us, "There are things to do on offer but it can be difficult to get people interested." The registered manager told us, "We do provide activities for people, at the moment this could be improved as the activities coordinator is tied up providing one to one support."

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A range of dependency assessments were in place for people for daily living activities and personal care which included mobility, continence, pressure areas, bowels, communication, dressing and feeding. These were scored against the person's ability to be independent in the given activity. Where they were evaluated as requiring assistance support plans were implemented and staffing was adjusted to reflect the level of assistance required. Where people were fully reliant on the registered provider to support their needs multidisciplinary meetings that included additional health professionals were held and documented. This meant the person received appropriate levels of care and support to meet their holistic needs.

People spoke of care and support that was responsive to their individual needs. Relatives we spoke with told us how the service was responsive to the needs of a family member in the home. They said, "[The person] was off their food and was not eating well, staff picked up on this straight away and introduced some blended food to a smooth pureed consistency and ensured they had plenty to drink," "[The person] managed to maintain their weight quite well and is now eating healthily again." They told us, "It's the same with continence, if [The person] has any problems staff respond immediately and are straight there to clean them up and make them feel clean and comfy again."

A care worker we spoke with discussed how a person had struggled with washing their hair. The care worker described how the process was difficult for the person and caused anxiety. They said, "We had to look for some other way to provide [the person] with personal care that included them having their hair washed. We discussed this and came up with the idea of a 'No Rinse Shampoo Cap'." They continued, "This does not require water and after warming is a relaxing experience for the person." They told us the trial had worked better than expected and the person regularly requests the process.

We saw some people in the home liked to smoke. The registered provider had a smoking room and people had risk assessments and support plans in place to manage this. The room did not have a smoke detector and we observed burns from cigarettes in the lino floor. The registered manager told us they had received a fire safety inspection, which did not identify this as a concern. We spoke with the fire inspector who told us, "The room has no flammable furniture and is not considered a flash point or risk, people are accompanied by care workers and the room is checked after each person has had a cigarette which further reduces any risk." They told us, "The marks on the floor are old and have not increased over the years, it's not ideal to have smoking in any building but the risks are small and well managed." The registered manager showed us a smoking policy that respected individual's rights to choose to smoke and protected the rights of others to a smoke free atmosphere.

Care plans were reviewed quarterly as a minimum or more frequently if there was a significant change to a person's needs or presentation. Evaluations were completed monthly on specific areas of care where additional intervention was required or had been implemented. However, from care plans we looked at we saw this information was not always up to date.

Discussions with the manager confirmed that where they could not meet the needs of a person they worked with other health professionals to meet their needs. During our inspection, we looked in people's rooms

(with their permission). One room was simply furnished and access to the en suite bathroom was restricted. The registered manager told us the person had complex needs, which they struggled to meet. We saw they had spoken with other health professionals and an assessment of the persons needs was planned to move the person to accommodation where care and support was more appropriate.

The registered provider told us on the PIR, 'Complaints are investigated and a response given within 28 days or sooner dependent on the nature of the complaint.' There was a policy and procedure in the statement of purpose that provided guidance on complaints process and some other information was available should a person need to raise a concern or make a complaint. Care workers told us people were encouraged to raise any concerns. One care worker said, "I always ask people if they are happy or if they have any concerns they want to share." A relative told us, "We don't have much to complain about, [The registered manager] is very approachable and I am sure they would address any concerns." The registered manager showed us a policy and procedure to manage complaints and said, "We have an open door policy and encourage any feedback."

Requires Improvement

Is the service well-led?

Our findings

We found the registered provider had established systems and processes in place to assess monitor and drive improvement in the quality and safety of the service provided. However, we found that these were not always up to date or effective in their purpose. For example, we found a medication policy was in place for the management and administration of medication but this was out of date and failed to ensure medicines were managed in a safe way.

There was a process in place to audit, review and update people's care plans at least every three months but we found this process did not always reflect people's current needs. This meant the registered provider had failed to maintain accurate and complete records in relation to each person receiving a service and care workers did not have access to all necessary information.

Systems and processes were ineffective in ensuring care workers were competently assessed during their induction period to deliver the care required by them and robust records of completed training were not always available.

The registered manager discussed how they obtained feedback from people who received support and care at the home. They told us they had a schedule to send out questionnaires quarterly and that the results were evaluated to help improve any areas of concern. We asked for this information but the registered manager told us, "The process has not finished, we send questionnaires out to about ten families each quarter and will analyse the findings when they are all back." We did not see any evidence that suggested feedback was collated and evaluated to drive improvement to the quality or safety of the service.

The above concerns were a breach of Regulation 17 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

There was a registered manager in place. The registered manager supported us throughout our inspection. Relatives told us that the home was well run by the registered manager. Comments included,"[Registered manager] is brilliant, they are always about and are fully aware of [the person's] needs", "I can pick up the phone at any time and the manager seems to be available, they are supportive of visitors as well as people who live here [in the home]."

Staff told us there was an open culture of communication with the registered manager and that they would listen and was approachable about any ideas or concerns. One staff member said, "It is such a caring and supportive environment.", "At times this is not an easy job, but you know you have their full support." We found from our inspection, there was a clear management structure in place and it was evident staff had an understanding of their roles and responsibilities.

The registered provider had a statement of purpose. We saw that this included a mission statement detailing the visions and values of the service, a philosophy of care people could expect and information on the home. Other information included complaints, a service user charter, fire procedure and an evacuation

procedure in the event of a fire. The registered manager told us, "Our values and visions are re-enforced through regular team briefs, staff meetings and handovers."

The manager knew about their registration requirements with the CQC and was able to discuss notifications they had submitted. This meant they were meeting the conditions of registration.

The registered manager discussed a 'health and safety management' audit they showed us that had been completed in early August 2016. The home had achieved an overall score of 50%. Areas of identified strength relating to care and support included peoples welfare at 78% and accidents and incidents at 70% with an area of weakness identified as policy generation and maintenance at 8%. The registered manager told us the findings would be used to target areas for improvement and to implement or revise systems and procedures in the home.

There was a 'Continuity and Disaster Recovery Plan' in place. This ensured management plans were in place in case of an emergency. The document included details of alternative accommodation should an evacuation of the home take place, redeployment of staff to ensure continuity of care, a financial strategy, emergency contacts, what to do in the event of flooding or other inclement weather and alternative supplier contact information. Contact details included those of other health professionals. This meant the registered provider had taken steps to anticipate a major incident and had measures in place to work in partnership with external sources to mitigate the impact of any emergency.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Policies and procedures for medication required updating. Management and administration of medications was not always safe for people. Regulations 12 (1) (2)(a)(b)(f)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Premises was not visibly clean and free from odours that were offensive or unpleasant.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes in place to assess, monitor and drive improvement in the quality and safety of the service provided were not always effective in their purpose. Systems and processes for the maintaining of records were not effective and information was not always accurate. Regulations 17 (1) (2)(a)(b)(c)(d)(e)(f)

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

Induction to the service for care workers failed to prepare them for the role or assess their competency.

Regulations 18 (1) (2)(a)