LJ Care Homes Ltd

York House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 20, 21 and 22 July 2016 and was unannounced.

York House is situated in the village of Billinghay in Lincolnshire. It is registered to provide accommodation and personal care for 16 people who need care due to old age, dementia, physical disabilities or sensory impairment. There were 16 people living at the home when we inspected. The home is also registered to provide personal care to people in their own home. It does this under the name LJ Homecare. There were 25 people using the domiciliary care service when we inspected.

There was a registered manager for the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager ran the care home and there were two managers who ran the domiciliary care service with regular oversight from the registered manager.

Care plans for both the care home and the domiciliary care service had not identified all the risks to people while receiving care. However, where risks had been identified care had been planned to keep people safe. In addition, the registered manager and the domiciliary care managers reviewed accidents and incidents and where necessary made changes to people's care to reduce the risk of further accidents in the future. People's support needs relating to their medicines were clearly recorded. However, there was a lack of recording around topical medicines such as creams. People's dietary needs were identified and recorded in their care plans. People were supported to make choices about their meals and to maintain a healthy weight.

People were involved with planning their care and were able to make decisions about the way their care was tailored to meet their individual needs. This level of detail was reflected in the care plans. There were systems in place to ensure any information about people's changing needs were made available to care workers.

There were some activities for people living at the care home to engage with and people were supported to access the local community. In addition, the provider had developed links with community groups so that they could visit the home. However, people felt that more activities would enhance their experience of living at the home.

There were systems in place to ensure that there were enough care workers available to meet the needs of people who lived at the care home and people who received care in their own homes. However, at busy times in the care home communal areas were not fully monitored. The domiciliary care service had systems in place to ensure care workers were available to provide care to people at the correct times. However, staff application forms for the domiciliary care service did not contain enough information for the domiciliary

care managers to assess if people had appropriate skills and experience.

Care workers were kind and caring and had good relationships with people. In addition, care workers were supported to get to know people's needs, abilities and communication skills and so could identify when people deteriorated or were unwell. Staff working for the provider were supported with appropriate training and supervision. Care workers had received training in the Mental Capacity Act and supported people to make decisions about the care they received. Where people were unable to consent to living at the home and were under constant supervision appropriate Deprivation of Liberty Safeguard applications had been submitted.

People had received information on how to complain from the provider and people told us they knew how to make a complaint. However, no recent complaints had been received. People living at the home and care workers told us the registered manager was approachable and would listen to concerns. In addition, people using the domiciliary care service told us that the domiciliary care managers were reliable, approachable and available to them if needed.

The provider has systems in place to gather the views of people who used the services they provided. While the provider had systems in place to monitor the quality of care people received we saw that they had not been fully effective and failed to identify some of the concerns we identified.

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 consistently safe.

Care plans did not identify all the risks to people and so did not contain information to care workers on how to keep people safe.

There were enough care workers to meet people's needs but systems around employing care workers did not fully support the registered manager to assess people's skills and knowledge.

People's medicines were stored safely and available when needed. However, there were insufficient records kept of what creams people needed applying.

Staff had received training in how to recognise abuse and to protect people from harm.

Is the service effective?

Good

The service was effective.

Staff received appropriate training and support.

People's abilities to make decisions were assessed when necessary and people were supported to make decisions about their care.

People's nutritional needs were assessed and people were able to make decision about their meals.

People were able to access health care professionals when needed.

Is the service caring?

Good

The service was caring.

The way the service was run supported care workers to build kind and caring relationships with people and to know their needs and abilities.

People were supported to be involved in planning their care.

Is the service responsive?

Requires Improvement

The service was responsive.

Care plans contained information needed to enable care workers to provide person centred care.

There were systems in place to ensure any changes in people's care needs were known by the staff caring for them.

People living at the care home told us that they would like more support to be entertained and active.

People had received information on how to make a complaint and were happy to raise concerns.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Systems to monitor the quality of care provided were not fully effective and had not identified the issues we found during our inspection.

The registered manager and homecare managers were approachable and listened to the views of people using the service and staff.

The provider had systems in place to gather the views of people using the service to help them develop the care provided.

York 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 inspection took place on 20, 21 and 22 July 2016 and was unannounced. The inspection team consisted of an Inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the home. This included any incidents the provider was required to tell us about by law and concerns that had been raised with us by the public or health professionals who visited the service. We also reviewed information sent to us by the local authority who commission care for some people living at the home. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with five people living at the home and two relatives who visited them. We also spoke with two people who used the domiciliary care service and two relatives of people who used the domiciliary care service. We spoke with the registered manager and a senior carer and team leader who worked in the home. In addition, we spoke with the two managers who manage the domiciliary care service, and a care worker who supported people in their own homes.

We looked at four care plans for people who lived at the home and two care plans for people who used the domiciliary care service and received care in their own home. We also looked at other records which recorded the care people received. In addition, we examined records relating to how the service was run including staffing, training and quality assurance.

Requires Improvement

Is the service safe?

Our findings

Some risks to people had been identified and care was planned to reduce the risk of people experiencing harm. For example, risk assessments had been completed around people's likelihood of developing pressure ulcers. Where people were at risk of developing pressure ulcers care plans noted that they should be regularly repositioned and what equipment would help them to be comfortable. Care workers were aware that people had different levels of protection against skin damage and that it was important each person had the correct pressure relieving cushion which had been prescribed for them.

However, there were some gaps in the care plans around risks to people. For example, risk assessments around the use of equipment to support people to move did not identify which sling should be used. This increased the risk of care not being person centred, inappropriate equipment being used and there being an accident. We saw one person being supported to move by two care workers with the use of equipment. The care workers gently positioned a hoist sling behind the person but they complained of hating the thick chest strap. A different style sling with a small strap was then used and the person consented to the process.

In addition, one person was at times distressed and expressed their emotion through challenging behaviour. Although we saw that a care worker was able to calm the person and enable them to be more settled, their care plans did not record this behaviour and that a referral to an appropriate healthcare professional to support the person had been made.

Where people had accidents their care had been reviewed to see if any action could be taken to keep make them safer. One relative told us, "He had a few falls but has been okay for the last six weeks. There's been an improvement in him. He's got a sensor system in his room now." The sensor allowed care workers to monitor when the person was mobile and to go and offer them assistance to move around the home.

The registered manager had developed an emergency plan of what action was needed in an emergency. The plan contained information on how to keep people safe. For example, in the care home there was information around the emergency evacuation procedure and in people's own homes environmental risks had been assessed.

The care workers were managed as two separate services and either worked in the care home or for the domiciliary care service. The domiciliary care rota ensured that care workers were kept in small geographical areas so that they never had long journeys between people's calls. In addition, rotas showed that care workers had enough time to travel between people's homes. This meant that care workers were normally able to arrive when people were expecting them. In addition, it was clearly identified when a person needed two care workers to care for them and rotas ensured that both were able to arrive at the same time. A relative of a person who required two care workers confirmed that they always arrived together.

Care workers working for the domiciliary care service told us that their rotas enabled them to spend the identified length of time with each person and that they also included adequate travel time to allow them to

go from one person's home to the next. Domiciliary care workers told us that they received their rota two weeks in advance and that this allowed them time to make any changes and to know when they were at work.

Both of the domiciliary care managers were also trained to provide care so that in an emergency if the care worker needed to stay with a person they were able to do so as their other calls could be covered. One relative told us, "If they are running behind the manager comes out." The provider has a list of people waiting to receive care in their own home and the provider was expanding that side of their business. However, they were clear that they would not agree to provide care for people unless they were confident that they had the care workers in place to consistently provide safe care without it impacting on the people they were already providing care for.

We found the registered manager had completed a staffing tool to help them identify the numbers of care workers needed to provide safe care for people living at the care home. Records showed that the home was staffed in accordance with the tool.

However, we saw that it was busy in the home in the morning with care workers helping people to get up. At times this left people in the lounge unobserved. We saw one person wanted to go to the toilet and a second person got up to help them and show them the way. However, the second person required a frame to walk safely and they neglected to use it which increased their risk of a fall. Care workers only noticed them when they reached the hallway and at this stage supported both people.

People living in the care home told us that care workers worked hard and they were happy with the care they received. However, they did say that at times they had to wait for care and for care workers to respond to their call bells. One person told us, "They don't seem to be here when you need them." Another person said, "Sometimes they get busy so we don't see them."

We saw that the application forms completed for people applying to work in the domiciliary care service did not provide enough information to allow the domiciliary care managers to check they were safe to work in the service. For example, they did not have space to record previous employment. Therefore the provider was unable to check where they had previously worked and if their reference was from the last company they worked for. We saw that the application form for care home staff was more detailed. We raised our concerns with the registered manager who told us they would immediately start to use the more detailed form across the domiciliary care service and they would review existing care worker records to ensure that they had received appropriate references. The required disclosure and baring checks had been completed to ensure that staff were safe to work with people who live at the service.

People living at the care home told us that care workers supported them to take their medicines. One person told us, "As a rule they wait with us while we take pills but they may leave it with me when they see me take the first one, as they know I'll manage the rest ok." A relative visiting the home said, "It's all managed well for him." Care plans recorded people's preferences around taking their medicines. An example of this was when one person had requested that their tablets be cut in half to make them easier to swallow. In addition, by working in partnership with other healthcare professionals there was some anticipatory medicine prescribed for people at the end of their lives. This meant pain medicine would be immediately available to make people more comfortable.

Medicines in the care home were safely stored, apart from medicines which require refrigeration. We saw that these were in a lockable box in the kitchen fridge. This was not in line with the guidance for keeping medicines in a care home.

Records showed that medicine administration records had been completed both for people living at the home and for those who received care in their own home. The records clearly recorded what medicine needed to be taken at what times and on which days. However, care workers had not recorded why they had deviated from the prescription. For example, one person was prescribed a medicine which said three 5ml spoonful to be taken. Records showed that some days the person was given three spoonfuls and some only two. While this may have been appropriate there was no recording of why a smaller amount of the medicine had been administered and who had made the decision.

Furthermore, there were no topical medicines administration records in place to show where people needed creams and ointment applying or to record that it had been done. We also saw that people's prescribed nutritional supplements were not recorded on their medicines administration record.

Where people were living in their own homes, the support they needed around their medicines was clearly recorded in their care plans. For example, some people were able to manage their medicines independently with support from relatives while other people required full support. For some people the care workers also collected their medicines from the pharmacy. We saw systems were in place to ensure this was done on a weekly basis so the person always had their medicines available for them when needed.

People we spoke with told us that they felt safe in the home. One person living at the home told us, "I feel very safe. I'm not scared by anything here." A relative visiting the home said, "Her safety isn't a problem thankfully."

Staff had received training on the different types of abuse that people could be exposed to and were able to tell us how this may impact on people and how people may react to abuse. This allowed staff to be alert for any signs that may indicate a person was at risk of being harmed whether emotionally, physically or financially.

Staff were aware of how to raise concerns both within their own organisation and with the local authority safeguarding team. In addition, the staff handbook contained information on how to raise concerns and the telephone number for external agencies.

Good

Is the service effective?

Our findings

People said that the care workers were kind and caring and had the skills needed to provide safe care. One person told us, "All the carers are good, even the new ones."

Staff received an induction when they first started working at the home. This included training and shadowing a more experienced member of staff for two weeks. One care worker explained how they had a checklist of competencies they had to achieved and had been observed by a senior care worker and the registered manager to see if they were safe to care for people. People working for the domiciliary care service also had a good induction. A care worker told us how they had shadowed one of the managers for three weeks and had visited all of the people they would be providing support to before working on their own.

The registered manager told us how they required all staff to read through the provider's policies and sign to say that they had done so. In addition, new care workers were supported to complete the care certificate. This is a nationally recognised set of standards to support care workers. Furthermore, all staff received an employee handbook. Care workers were also encouraged to complete nationally recognised qualifications in care.

Following on from their induction care workers told us and records showed they were supported to maintain their skills and develop further through a comprehensive training programme which covered areas such as infection control, fire safety and the Mental Capacity Act 2005 (MCA).

Care workers told us they received regular supervisions and appraisals. Records showed that care workers working in the care home had received regular supervisions. However, we saw that the domiciliary care managers were behind on their supervisions. They were aware of this issue and had plans in place to complete the supervisions. In addition to supervisions they explained how they had completed spot checks on care workers. This was where the manager would go to a person's home when the care workers should be there. We were unable to confirm that these spot checks had been completed as there was no recording of when they had taken place and what the findings had been. Care workers working for the domiciliary care service told us that they were able to contact the office at any time for support or advice.

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 found DoLS applications had been appropriately submitted for people who were unable to make a decision about where they wanted to live and who were under constant supervision. In addition where there were concerns that a person may not be able to make a specific decision mental capacity assessments had been completed. Where people had not been able to make decisions, the people who knew they the best such as family, care staff and health and social care professionals had been involved in making decisions in their best interest.

People living at the care home and using the domiciliary care service told us that care workers always asked for permission before providing care. One person told us, "They always ask us first if it's ok to do something." Another person said, "Oh, they [care workers] are so polite. They always ask before they do things."

Care workers were able to tell us about people's individual abilities to make decisions. They also understood that although a person may not be able to make complex decisions they could have some control over their lives by making everyday decisions about what they wanted to wear and where in the home they chose to spend their time. One person told us, "There are no rules really; we can do what we like."

Care workers also respected that people who had capacity had the right to make decisions even if they did not agree with them. For example, they understood that people were able to refuse to take their medicine.

People living at the care home told us they were happy with the food offered. One person told us, "It's pretty good. If you don't like it, they find you something else. You can ask for an extra snack or fruit any time." Another person said, "If there's something you don't like, they always say there's something else you can have." A visiting relative said, "He's putting weight on now – they spoil him. He has cooked breakfast and can eat what he wants."

There was a two week menu plan on the care home notice board. We saw there was only one main lunch choice and one dessert but during the day we saw alternatives were provided if people did not want what was on the planned menu. In addition people were offered a choice of breakfast and we saw one person had cereal while another had chosen to have poached egg on toast.

We also saw that care workers had a good understanding of people's food likes and dislikes and we saw that this knowledge was used to encourage people to eat. For example, two people refused their chosen meal at lunch time. Care workers offered them alternatives to the meal they had chosen. Each person was offered a sandwich but with different fillings dependant on their likes and we saw that they both were pleased to accept. Another person had felt overfaced with the size of portion they had been given and another smaller meal was fetched for them.

The registered manager explained how they took advice and altered the food to adapt to people's individual dietary needs. An example of this was that the diabetic specialist nurse had been and spoken with the kitchen staff to support them in providing appropriate food for diabetics. Separate puddings with sweeteners were available for people with diabetes.

Care plans contained details of people's dietary needs. For example, if people needed a soft diet to be able to eat safely. They also contained information about a person's ability to maintain a healthy weight. People who were at risk of being unable to maintain a healthy weight had been identified and appropriate support from healthcare professionals had been sought. Their food was modified to increase their calorie intake, for example, potatoes were mashed with cream and butter instead of milk. Where necessary people had been supported with prescribed high calorie supplements.

People using the domiciliary care service did not always require support for their food and drink. However, what support they did need was clearly recorded in their care plan. One person who used the domiciliary care service told us how care workers always made sure that they had eaten something before they left and monitored their fluid intake to make sure they were drinking enough.

Individual care plans included all the information needed to support people's day-to-day health needs. Additionally, we saw people had been supported to arrange and attend for eye tests and their prescriptions had been updated where necessary. Records showed other health professionals such as GP's and the community mental health team had been included in people's care when needed. Care workers told us they had a good relationship with the GP practice who supported the home and that they could ring them for advice and support. A visiting healthcare professional told us that they had a good relationship with the registered manager and care workers at the home. They told us that concerns were raised appropriately and that if they left any instructions care workers always followed them. In addition they said when they visited care workers had a good knowledge of people's needs which supported them to provide appropriate care.

People told us they were happy that they were able to access appropriate healthcare when needed, One person told us, "They called the doctor out when they could see I wasn't well and I see the chiropodist when they come." Another person told us, "They got me a visit here when I needed new spectacles." A person using the domiciliary care service told us of a time they were ill and that the care workers had called for an ambulance and waited with them to make sure they were ok and that they had everything they needed to go into hospital.

Good

Is the service caring?

Our findings

People living at the care home told us the care workers were kind and caring. We saw care workers spoke politely and kindly with people, sometimes joking with them. One person told us, "They seem very kind and sociable." A visiting relative said, "They seem to be kind." One person whose relative used the domiciliary care service told us, "They are lovely; they turn up on time and do what they have to do. They never rush, I wouldn't be without them." Another relative explained how the care workers always talked with the person they provided care to and would joke with them. The relative told us, "They have a laugh with him and they make his day and they are always pleased to see him."

Both the care home care workers and the domiciliary care workers had a detailed knowledge of the people they were caring for which enabled them to personalise the care they provided to people's individual needs. An example of this was how care workers had helped a person to go to a support group for people with the same condition they had. This had helped to reduce the person's social isolation and supported them as their condition progressed.

For people living at the care home we saw that their relationship with family members was encouraged and supported. For example, we saw people were able to invite relatives to join them for a meal if they wanted to. In addition care workers were attentive and knew peoples' needs. One person living at the home told us, "They [care workers] pay me attention. I only have to say something once." We saw one member of care workers encouraged a person to go down for their lunch. They told the person, "I'd love you to come down with me to have your dinner. It'll soon be time. Would you like to come down or have it in your room? We'd love to see your smile downstairs! Do you want your socks on before we go?" This supported the person to be more involved with others in the home and decreased their isolation.

For people using the domiciliary care service their relationship with the care workers was developed so that they were at ease with the people supporting them. The provider did this by enabling care workers to be at calls on time and by being formally introduced. The domiciliary care workers told us how their rotas allowed them to build relationships with people as they were consistently visiting the same people. One care worker told us, "Because I go every day, I know when something is not right. That's the good thing about going regularly."

Care workers providing care for people living at their own homes went above and beyond the care they were employed to do. An example of this was when one care worker took a person's bedclothes home to wash as they were soiled. They told us that although this was not part of their job description, they knew if they left them in the washing machine at the person's house they would have put themselves at risk dealing with them.

One relative of a person who used the domiciliary care service told us how care workers built up a good relationship and engaged the person by asking how they were going to spend their day and then saying that they looked forwards to hearing how it was at a visit later in the day. Another relative told us how they always ensured the person's glasses had been cleaned for them. They told us it was the little things they did

that made the difference and made you feel that they cared about you.

Care plans contained information about people's cognitive abilities. For example, one person's plan explained that they would get angry if they did not understand information. We saw that this person's care plan contained some information in picture format to help them understand the records kept about them. In addition the provider had picture cards for staff to use to help their communication with people.

People have been involved in developing their care plans and had signed them to show they agreed with the information recorded. A relative told us how they and the person receiving care had gone through the care plan with one of the domiciliary care managers and that they were happy with the information recorded.

There were two shared rooms in the home and screens were used to protect people's privacy while receiving personal care. However, we saw that the screens did not fully support people's privacy especially when using a hoist. One person who shared a room told us that care workers would use the screens if the person wanted them to but most times they were happy for it not to be used. We discussed this with the registered manager who told us they would look at the problem.

Requires Improvement

Is the service responsive?

Our findings

People told us that at times they had visiting entertainment and were supported to go to a local coffee morning but that they would like more support to engage in hobbies and activities. A noticeboard listed the weekly activities provided on four days of the week which included manicures, quizzes and bingo. One person told us, "I've no idea what goes on really. Not much." Another person said, "Every so often someone comes in, we had a good singer once. Things don't happen every day though. I sometimes go to the Thursday coffee morning." A relative told us, "I think they do things now and then. She'd like to go outside more."

The provider had employed two part time activity coordinators to support people with hobbies and accessing the community. As well as the planned activities they also encouraged people to take part in activities around the home such as the laundry. However, the activity coordinators only worked two hours a day in the week with extra time on a Thursday to take people to the coffee morning. This meant the level of support did not ensure that people were fully able to take advantage of enjoying their time as much as they could have. Furthermore on the day of our visit, the activity coordinator was off for the day and we saw no evidence of any activity support by staff.

Before people started to use receive care they had an assessment to identify their needs. This allowed the provider to know if they were able to provide safe suitable care for the person. People told us they were happy with the care they received. One person said, "I'm content with the way they care for me. They know my likes and dislikes."

Care plans for people receiving domiciliary care were fully completed and provided the information care workers would need to care for people in a person centred way. Domiciliary care workers told us that the care plans were always available for them in people's homes and the visit times allowed them time to read through the notes to see if there had been any concerns or changes in care since their last visit. In addition the domiciliary care managers told us that care workers were quick to raise any concerns they had about people's abilities and any deterioration in their condition. We saw action was taken when people experienced changes in their needs, for example, appropriate referrals were made to healthcare professionals. In addition, if anyone's need changed significantly all the care workers caring for that person would be contacted by telephone and informed about the change.

A person using the domiciliary care service told us how the care workers all worked together to support their needs. They gave us an example of when care workers had been at their physiotherapy appointment so that they could support the person to do the exercises at home. They also told us how care workers understood their needs so that if they were in pain when the care workers were there they would talk to the person to distract them until the pain eased.

Having both a care home and a domiciliary care service enabled people to blend their care to meet their needs. For example, one person who mainly received care in their own home visited the care home once a week to spend time with people living at the home. Another person who had received care in their own

home had moved into the care home for some respite care. Their relative told us, "She used to have the home carers from here, so they knew about her before she came on respite stay."

In the care home a verbal handover was given when shifts changed and in addition the information was recorded in the handover book. This meant that if a care worker had not worked for a few days they could read the book and find out about any changes in people's needs. The care home care workers we spoke with knew people's needs and how they could personalise care for a person so that it was a pleasant experience for them. For example, a care worker told us about one person whose dementia meant that they found it increasingly hard to follow instruction and that this made them frustrated. Another example of this was a person who smoked but was unable to as they were on bed rest. The senior care worker had contacted the GP with a view to obtaining some nicotine replacement therapy for them as it would enable them to be more comfortable and settled.

We saw that care workers had the skills needed to care for people, an example of this was when we saw that two people were getting agitated with each other. We saw a care worker steadily step in and calmed the situation and remove one person. A visiting healthcare professional told us that the home was normally quiet and calm and that if people did get distressed care workers had the skills to respond and calm the person down.

No-one we spoke with had felt the need to raise a concern or complain. One person living at the home told us, "I don't think I could find a complaint to make. There are three or four carers I could ask if needs be." A relative visiting the home said, "I've not had to complain as yet. [The registered manager] is the one I'd see."

We saw there was a notice in the main entrance with information on how to complain. In addition, people received a booklet telling them how to complain. The registered manager confirmed that no complaints had been received in the last year.

Requires Improvement

Is the service well-led?

Our findings

We saw that the provider had systems in place to monitor the quality of the care they provided to people, for example, we saw audits relating to medicines and infection control. They also monitored the care home environment to ensure that it was maintained to an acceptable standard. We saw that where the monitoring identified concerns there were plans in place to ensure effective action was taken.

However, we found that the systems were not fully effective as they had not identified some of the concerns we found around how safe the services provided were. For example, the registered manager had not identified concerns around the application forms, the planning of risk and how nutritional supplements and topical medicines such as creams were monitored. This meant people could not be assured that the care they received was at a consistently good standard which kept them safe.

While the provider had submitted notifications about most incidents they were required to tell us about they had not identified that we needed to know about low level incidents that were reported to the local safeguarding authority on a monthly basis. We discussed this with the registered manager who immediately agreed to notify us about such incidents in the future. People told us they liked living at the home and found that it had a pleasant atmosphere. One person told us, "It's a lovely place." A visiting relative said, "It's all very welcoming." People using the domiciliary care service also said what a good standard of care they received.

People told us that the provider had gathered their views about the care they received. In the care home, records showed that residents' meetings were held every three months. We saw that people had been able to input into the discussion around the decoration of the home and any activities that were planned. People had also been able to comment of the menu and to make any requests for food they wanted. One person told us, "We have a chat afternoon when we can voice an opinion. I think they take notice." People using the domiciliary care service received a visit from one of the domiciliary care managers on a monthly basis. This was to check if they were happy with the care they received and if it was still meeting their needs. Surveys had been completed by both people in the care home people receiving domiciliary care in January 2016 showed people were happy with the care they were receiving.

The registered manager told us and care workers confirmed that they held staff meetings on a three month basis. Minutes were displayed on the notice board for all staff to read if they had been unable to attend the meeting. In addition, one of the domiciliary care managers told us that care workers contacted the office on a daily basis so they would let them know verbally about any changes in practice needed following staff meetings.

People living at the care home told us that the registered manager was approachable and that they could raise any concerns they had with them. One person told us, "She's quite good and I could talk to her. But I'd talk to the carers first." A visiting family member said, "They [the registered manager] seem ok and I could talk them."

Care workers told us that the registered manager was approachable and would listen to their concerns. They also said that the provider visited regularly and would also listen to the care workers if they had any concerns. One care worker said, "[The registered manager] is very approachable and if you have a problem you can go to her and she will help." They told us they would be happy to raise any concerns they had with the registered manager.

The provider had taken steps to ensure that they kept up to date with any changes in legislation which may affect the company. For example, they contracted with reputable external companies to provide health and safety and fire safety expertise. In addition, the registered manager told us how they met with the provider on a weekly basis to discuss the care provided and any actions that were needed. Furthermore the registered manager explained how through courses and accessing appropriate health and social care literature they kept up to date with changes in best practice.