Mrs M Fuller

Kinloch Tay Residential Care Home

Inspection report

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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 took place on 22 and 27 September 2017 and was unannounced. Kinloch Tay Residential Care Home provides accommodation and personal care for up to 21 people, who do not require nursing care. There were 20 people living at the home when we visited.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

Systems in place to manager risks relating to the health and safety of people using the service had not ensured that all risks were assessed or reassessed and action had not always been taken to reduce identified risks to ensure the safety of people.

Records of the assessment of people's inability to make informed decisions had been undertaken. However, there was no record to show why subsequent decisions to provide care or restrictive practices were in the person's best interest and had been discussed with relevant others as is required by mental capacity legislation.

A quality assurance process was in place. However, this had not identified the areas of concern above or other aspects of the service. Staff were not always following safe procedures when they assisted people to reposition. Action had not always been taken to ensure the safety of people from the actions or potential actions of other vulnerable people. Although staff were aware of the risks posed to people from care staff working with long acrylic finger nails no action had been taken to prevent staff having these.

Medicines were usually managed safely although systems were not in place to ensure times of administration were recorded where medicines needed to be taken at regular intervals. Otherwise there were appropriate arrangements were in place for obtaining, recording, administering and disposing of prescribed medicines.

People felt safe and staff knew how to identify, prevent and report abuse. Staff offered people choices and respected their decisions. People were supported and encouraged to be as independent as possible and their dignity was promoted.

Care plans provided individual information about how people wished to be cared for and staff were aware of people's individual care needs and preferences. People had access to healthcare services and were referred to doctors and specialists when needed.

People were encouraged to maintain relationships that were important to them. Kinloch Tay Residential Care Home was animal friendly and people were able to bring their pets with them when they moved in.

There were enough staff to meet people's needs. Staff worked well together, which created a relaxed and happy atmosphere that was reflected in people's care. The recruitment process helped ensure staff were suitable for their role. Staff received appropriate training and were supported in their work.

People and external health professionals were positive about the service people received. Most people were positive about meals and they were supported to eat and drink when required.

People and relatives were able to complain or raise issues on a formal and informal basis with the registered manager and were confident these would be resolved. This contributed to an open culture within the home. Visitors were welcomed and there were good working relationships with external professionals.

Plans were in place to deal with foreseeable emergencies and staff had received training to manage such situations safely.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Registration Regulations 2009. 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.

Risks to people were not always managed safely and documentation relating to risk assessment and management was not up to date.

Medicines were usually managed safely, although systems were not in place to ensure times of administration were recorded where medicines needed to be taken at regular intervals. Otherwise there were appropriate arrangements were in place for obtaining, recording, administering and disposing of prescribed medicines.

People were protected from the risk of abuse and staff knew how to identify, prevent and report abuse. Staff understood how to keep people safe in an emergency.

Recruitment practices ensured that all pre-employment checks were completed before new staff commenced working in the home and there were enough staff to meet people's needs.

Is the service effective?

Requires Improvement

The service was not always effective.

Where people lacked the ability to make decisions, such as those relating to care, best interest meetings or discussions had not been recorded. Where necessary Deprivation of Liberty Safeguards (DoLS) applications had been made.

People received the personal care they required and were supported to access other healthcare services when needed. People received a varied diet and were supported appropriately to eat.

Staff were suitably trained and supported in their work.

Is the service caring?

Good

The service was caring.

People were cared for with kindness and compassion. Staff knew people well, interacted positively and supported them to maintain valued relationships.

People and their relatives were positive about the way staff treated them. People were treated with respect and choices were met. Their dignity and independence were promoted.

Is the service responsive?

Good

The service was responsive.

People were receiving personalised care that met their needs as detailed in their individual care plans.

People received mental and physical stimulation in the form of organised and ad hoc activities.

The provider sought and acted on feedback from people. There was a complaints policy in place. People and relatives knew how to raise concerns.

Is the service well-led?

Requires Improvement

The service was not always well led.

A quality assurance process was in place, however, this had not identified the areas of concerns we found. Statutory notifications had not been made as required by the registered manager.

People and their relatives felt the home was well organised. Staff understood their roles, were motivated, worked well as a team and felt valued by the registered manager.

External professionals were welcomed and the registered manager consulted with them when required.

Kinloch Tay Residential 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 took place on 22 and 27 September 2017 and was unannounced. The inspection was undertaken by two adult social care inspectors.

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 the improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with nine people living at the home and seven visitors. We spoke with the registered manager, five care staff and ancillary staff including, the cook and housekeeping staff. We also spoke with a visiting activities provider, and two visiting healthcare professionals. We looked at care plans and associated records for five people, records relating to staff recruitment, training and support, records of accidents and incidents, policies and procedures and quality assurance. We observed care, support and activities being delivered in communal areas.

Requires Improvement

Is the service safe?

Our findings

We found there were risks to people which had not been addressed by the registered manager. Some of these risks were particular to people living with dementia. For example, we found staff and the registered manager were unaware of the risks fluid thickener powder posed to people if eaten dry and not mixed with a drink. We saw four tins of fluid thickener on a cabinet in an unlocked room, which people could have accessed. The laundry room was not secure and contained various laundry cleaning products which could pose a risk to people. We identified that a person's airflow pressure relieving mattress, which is a specialist mattress designed to help prevent pressure injury sores, was set incorrectly placing them at risk. The registered manager told us a person living with dementia entered other people's bedrooms and adjusted equipment or turned off lights. However, no action had been taken to protect people from this, such as the use of alert equipment to notify staff when the person was entering vulnerable people's bedrooms.

Not all individual risks to people were minimised through the use of effective risk assessments, which identified potential risks and provided information for staff to help them avoid or reduce the risks of harm. Staff did not always ensure risks were correctly managed, placing people at risk of harm. For example, one person who was cared for in bed, this required staff to assist them to change their position on a regular basis during the day and overnight. The person's risk assessment for repositioning specified the equipment required to do this safely. We saw this was in place in their bedroom. However, when asked to describe how they assisted the person to reposition, care staff described using inappropriate and potentially dangerous techniques. This did not correlate to the person's risk assessment or include the use of available equipment and was placing the person at risk of injury.

Documentation, such as individual risk assessments, were not always updated when the person's needs and risks changed. For example, one person's falls risk assessment stated that they had not had falls therefore the risk was low. However, other information in their care file showed the person had had several falls in August and September 2017. Their care file stated that the care plan and risk assessments had been reviewed since they had fallen and on a monthly basis. However this had not identified that the person's needs and risks had changed and the risk assessments had not been reviewed and amended as required. When people had fallen and sustained an injury to their head there were no records kept of monitoring or observation of the person to detect promptly any deterioration following the fall. We discussed this with the registered manager who agreed that whilst staff had monitored the person this was not formally recorded. They stated they would design a form to enable this to occur. For another person there was incomplete information to guide care staff as to how their risks related to a medical diagnosis of diabetes should be managed.

The failure to ensure risks relating to the safety and welfare of people using the service were assessed and managed was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed our concerns about the way risks were managed and the documentation in place around risk assessment with the registered manager. They amended the risk assessments we identified to them during

the inspection. The registered manager took action to ensure that staff always followed the correct procedures for the safety of people.

People told us they felt safe at Kinloch Tay Residential Care Home. One person told us, "I feel safe here." Another person said, "Yes, I feel safe, they [care staff] keep an eye on us." This was also the view of everyone else we spoke with. A visitor told us, "[My relative] is so well cared for and safe living here." Another visitor told us they visited most days and always felt their relative was, "safe and well looked after."

People were supported to maintain a level of independence by continuing to undertake some activities where there may be a risk. Where people were at risk of falls and may not remember to request care staff support before mobilising, movement alert systems were seen to be in use. Two people explained to us the reasons for these and recognised they were for their own safety. Both people told us staff came quickly if the movement monitor was activated. A similar movement alert system was also seen in place at the bottom of the stairs to alert staff if people were using the stairs.

At the previous inspection in July 2016 we identified some areas where the service could improve the systems to manage medicines. Immediate action was taken by the registered manager to address those concerns and we saw that these systems were still in place and being used. Procedures were in place and followed to ensure that the balance of medicines was correct and that people had received medicines as prescribed and as recorded on medication administration records (MAR). Staff were aware of how and when to administer medicines, to be given on an 'as required' basis, such as for pain relief. Should people be unable to explain they were experiencing pain a recognised pain assessment tool was available and used. Where people had been prescribed 'as required' (prn) medicines, they had a prn plan, which explained when the medicine could be given.

We identified some additional areas where improvements could be made to ensure the safety of medicines management. When people were prescribed a nutritional supplement we saw they were receiving these however, they were not recorded on the MARs. When people were prescribed medicines, which were required to be administered up to four times per day, there was no system in place to record the exact time of administration. This included medicines, such as paracetamol, which should be given at least four hours apart. This placed people at risk of overdose and complications resulting from their medicines. We discussed this with the registered manager who took immediate action to introduce a new system to record the exact time people received regular medicines.

People were supported to receive their medicines safely. Everyone we spoke with told us care staff administered their tablets. One person said "The carers give them to me." Another person said "If you have a headache you just ask for some tablets and they'll get them for you." With the exception of fluid thickener powder all medicines were stored securely and appropriate arrangements were in place for obtaining, recording, administering and disposing of prescribed medicines. Medicine administration records (MAR) documented that people had received their medicines as prescribed. Training records showed staff were suitably trained and had been assessed as competent to administer medicines. Staff supporting people to take their medicine did so in a gentle and unhurried way. They explained the medicines they were giving in a way the person could understand and sought their consent before giving it to them.

Safe systems were in place for people who had been prescribed topical creams and these contained labels with opening and expiry dates. This meant staff were aware of the expiration of the item when the cream would no longer be safe to use. A lockable medicines refrigerator was available should any medicines require to be kept at cooler temperatures and records showed medicine refrigerator temperatures were monitored. This meant that any fault with the refrigerator would be noticed in a timely manner and the safe

storage of any items stored could be assured. The medicines storage room temperature was also monitored to ensure all medicines were kept at safe temperatures.

There were appropriate policies in place to protect people from abuse. Staff said they would have no hesitation in reporting abuse. One staff member told us, "I would speak to [name of registered manager]. If it was about them I would go to social services or CQC." Another staff member said, "If I had concerns I would contact my manager, I know they would sort it out." All staff were confident the registered manager would take the necessary action if they raised any concerns and they knew how to contact the local safeguarding team if required. The registered manager was aware of the action they should take if they had any concerns or concerns were passed to them. They described the actions they had taken when this had been necessary. This had included informing the local safeguarding team and acting to reduce risks to people.

The provider had a recruitment process in place to help ensure that staff they recruited were suitable to work with the people they supported. Staff completed an application form which requested information about previous employment. This had been completed but did not provide full dates, only years, for previous employment as is required to identify and explain any gaps in employment. Otherwise appropriate pre-employment checks, such as references and Disclosure and Barring Service (DBS) checks were completed for all of the staff. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Staff confirmed these processes were followed before they started working at the home.

There were sufficient staff available to meet people's needs. When asked if they thought there were enough staff, a person said "Yes, as far as I'm aware." Another person told us "If I ring the bell you don't have to wait long for them [care staff] to come." Another person said "I don't need to use the bell they [care staff] are always popping in." During the inspection call bells were heard ringing for only a very short time before being answered. Care staff told us they thought there were usually enough staff. Separate kitchen and cleaning staff were also employed meaning care staff could focus on their care duties. The registered manager told us staffing levels were determined by the needs of the people they supported. The staffing level in the home provided an opportunity for staff to interact with the people they were supporting in a calm, relaxed and unhurried manner. There was a duty roster system, which detailed the planned cover for the home. This provided the opportunity for short term absences to be managed through the use of overtime and the registered manager was also available to provide extra support when required.

Environmental risks were assessed and managed appropriately. The registered manager had assessed the risks associated with the environment and the running of the home; these were recorded along with actions identified to reduce those risks. They included the use of electrical equipment and fire risks. With the exception of some cleaning chemicals in the laundry room all substances hazardous to health (COSHH) were stored securely. Overall the home was clean with cleaning staff employed.

Emergency procedures were in place. Staff knew what action to take if the fire alarm sounded, and had been trained in fire safety and the use of evacuation equipment. Staff told us they received fire training, which was confirmed by records. People had individualised evacuation plans in case of an emergency, which identified the support and equipment they needed to leave the building in an emergency situation. Records showed fire detection and fire fighting equipment was regularly checked. Arrangements had been made should people need to be evacuated and require a safe, warm place to wait until they could return to the home or be moved to alternative accommodation. Essential emergency equipment such as torches was available should this be required. Staff had been trained to administer first aid.

Requires Improvement

Is the service effective?

Our findings

Where people lacked the ability to make decisions, such as those relating to care, best interest meetings or discussions had not been recorded. 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 decisions made on their behalf must be in their best interests and as least restrictive as possible. Some people had a cognitive impairment and were not able to make certain informed decisions. These included decisions around the delivery of personal care, the use of bed rails, the use of alarms to alert staff they were moving about the home, and the administration of medicines. Records of the assessment of people's inability to make these decisions had been undertaken. However, there was no record to show why it was in the person's best interest to provide care or restrictive practices. The registered manager had completed training in the MCA however they had not used the training to inform their practice.

The failure to ensure that, where people lacked the capacity to give informed consent, action was taken to comply with the Mental Capacity Act when providing care was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

At the previous inspection in July 2016 we found that the provider had not ensured people's legal rights were ensured as Deprivation of Liberties (DoLS) applications had not been made in respect of people whose liberty was being restricted.

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 Mental Capacity Act 2005. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). At this inspection we checked whether the service was working within the principles of the MCA, and whether DoLs applications had been made appropriately. We found the provider was following the necessary requirements and where appropriate, DoLs applications had been made. Staff had been trained in MCA and DoLS; they were aware of the people that these restrictions applied to and the support they needed as a consequence.

Care staff had completed MCA training and were able to describe the actions they would take to support individual people. Care staff told us how they offered choices and sought consent before providing care and were clear about the need to seek verbal consent before providing care or support. We heard care staff seeking verbal consent from people throughout our inspection. When asked what they would do if a person declined required care one care staff member said, "I would leave them for ten minutes then go and check on them and see if they then wanted to get ready. If they have been incontinent and need personal care I would try and help then to understand why I would need to wash and clean them." One person told us, "They [care staff] do ask and if I say not yet they will come back later."

The home was working with the local health centre to improve the ongoing monitoring of people's health. Staff had received training to use a 'healthlink' system, which enable care staff to undertake some

monitoring procedures, such as blood pressure and urine testing. The results were then submitted via the 'link' for review by health professionals. The registered manager was positive about the system and felt this had helped promote people's health management.

People's general health was monitored and they were referred to doctors and other healthcare professionals when required. A person told us, "They [care staff] will always call the doctor if I need one". A visitor said, "[Name of relative] had an eye test recently, they came in here to do it, and the staff always tell me if they [their relative] has been seen by the doctor". People were seen regularly by doctors, opticians and chiropodists as required. The registered manager was aware of how to contact health professionals, including home visiting opticians and dentists should these be required for people not be able to go out to clinics or surgeries. Should people require to be transferred to other care settings, such as hospital, the registered manager stated that a member of staff would always accompany the person if a relative was unable to do so. They explained this was to ensure essential information was provided to hospital staff and support the person in the unfamiliar environment. We spoke with a visiting healthcare professional who was complimentary about the home. They said they were consulted appropriately and in a timely way and felt people's health care needs were met.

People received the personal care they required. One visitor told us, "[Name of relative] is well looked after here." Care staff described how they supported people, which reflected the information in their care plans. Staff recorded the personal care they provided to people, including if people had declined offered care such as a shower or bath. These records showed people were supported to meet their personal and other care needs. Where requested, people were able to bath as frequently as they wished with records showing some people received several baths each week.

People's nutrition and hydration needs were met by staff who had time to support them to eat, when necessary. A person told us "I don't eat some meat and they give me fish or something else." People received the appropriate amount of support and encouragement to eat and drink. Where people required support this was done in a kind, unhurried way. Staff were attentive to people and noted when people required support. Staff also noted when people had not eaten well. For example, care staff noticed that one person had not eaten a lot of their dinner. They offered to get them a sandwich instead, which the person accepted. Care staff then encouraged the person to eat saying "Are you going to have a bit of your sandwich?" Staff also recorded when people had not eaten much within care records and passed this information over during handover meetings to the next set of care staff.

Most people told us they were happy with the food provided at the home, which they felt was very good. One person said "I like the food – its fine for me." However, another person told us they would like more choice and that the food was not always hot when they received it. They did confirm that when they made specific requests, such as, for an egg at tea time this was provided. A visitor said, "I have seen the food and it always looks good," The cook was aware of people's preferences and dietary needs. They told us that where people had dietary needs linked to medical conditions, such as diabetes, they were aware and able to provide a suitable meal. Drinks, snacks and fresh fruit were also offered to people throughout the day. Staff told us they could provide people with food at any time this was requested or required.

Staff were aware of people's dietary needs and preferences. Meals were appropriately spaced and flexible to meet people's needs. People were able to choose where they ate their meals. Some were happy to eat in the dining area, others in their bedrooms. Mealtimes were a social event and staff engaged with people in a supportive, patient and friendly manner.

People were supported by staff who had received an effective induction into their role, which enabled them

to meet the needs of the people they were supporting. Each member of staff had undertaken an induction programme, including a period of shadowing a more experienced member of staff. Staff who were new to care, received an induction and training, which followed the principles of the Care Certificate. The Care Certificate is a set of standards that health and social care workers adhere to in their daily working life. New staff confirmed they had received an appropriate induction including shadowing and formal training.

Staff were supported to undertake vocational qualifications and had access to other training focused on the specific needs of people using the service, such as, dementia awareness. When asked if they felt staff were suitable trained, one person told us, "Yes, they [care staff] seem to know what they are doing." Care staff were positive about the training they received, which was a mixture of work books and practical classroom based training, such as for moving and handling and first aid. Although staff had failed to put this training into practise when repositioning one person, at other times we observed them applying training they had received. For example, we saw staff supporting a person appropriately to stand from their chair and walk with their walking frame and the correct use of equipment to help a person stand.

Staff had regular supervisions including observations of practise with a senior member of staff or the registered manager. Supervisions provide an opportunity for management to meet with staff, feedback on their performance, identify any concerns, offer support, assurances and identify learning opportunities to help them develop. One staff member told us, "I have lots of informal supervision from the manager and deputy manager and there is always someone on call. I also have 1:1 sessions." However, staff were not receiving a formal annual appraisal, with the registered manager, to assess their performance and identify development objectives. The registered manager stated they used time within the supervisions to cover appraisal topics rather than undertaking a separate meeting with them. Staff said they felt supported by the management team and senior staff. There was an open door policy and they could raise any concerns straight away.

The home was a homely environment suited to the needs of people living there. Most bedrooms were for single occupancy and some with ensuite facilities. The lounge/dining room provided a communal sitting areas and people could choose to sit in quieter areas, if preferred. First floor bedrooms were all accessible via a passenger lift. Outside there was an enclosed garden with a patio area accessible for people with mobility needs or using a wheelchair. The registered manager said they had started using signs to help people living with dementia orientate themselves around the home, such as to identify people's bedrooms, toilets and bathrooms.

Good

Is the service caring?

Our findings

People were cared for with kindness and compassion. People and visitors spoke warmly about all of the staff. When asked if they liked living at the home. One person said, "I love it here and although I have been here a long time, I am happy to stay." The person added "They are so good to me, always," Another person told us, "The carers are very good and helpful". A third person said, "The staff here are so caring, I can't fault them for that. They are lovely." A visitor said, "I have always found the care staff at Kinloch Tay friendly, welcoming." These comments were echoed by other people and visitors we spoke with, including a visiting health professional who told us, "They [care staff] seem to be caring and don't change often so they have got to know the residents." We saw staff arranging a pillow so a person could sit more comfortably whilst they rested in the lounge.

Interactions between people and staff were positive and friendly. We saw staff kneeling down to people's eye level to communicate with them. Staff gave people time to process information and choices were offered. Staff did not rush people when supporting them. Before leaving a person seated in the lounge care staff ensured the person was all right. They said, "Do you want your cardigan off, are you hot?" We heard good-natured banter between people and staff showing they knew people well. People were clearly relaxed and comfortable in the company of staff. Staff spoke warmly about people and knew how to relate to them in a positive way.

Staff treated people with dignity and respect and described the practical steps they took to preserve people's dignity when providing personal care. Before entering people's rooms, staff knocked, waited for a response and sought permission from the person before going in. Care staff explained how they always closed curtains, kept people covered as much as possible and told people what they were about to do. This would help ensure people's privacy and dignity during personal care. Most bedrooms were for single occupancy and many had ensuite facilities. Where bedrooms were shared we saw privacy screens were available to use when personal care was being provided. This meant personal care could be provided in private. One bedroom was situated just inside the front door. As a person liked the bedroom door left open we saw the privacy screen had been used to provide privacy whilst ensuring the person did not feel shut in.

People were offered choices and their decisions were respected. For example, we saw some people were provided with hot drinks in mugs and others in cups and saucers. One person said "I like a mug, they [care staff] know that." We heard a staff member ask a person if they wanted a cup of tea. The person asked if there was anything else and the care staff member offered a variety of hot drinks. The person chose a named brand of milky drink and the staff member went to the kitchen to make this for the person. This showed people felt comfortable telling staff what they wanted. The chef explained that whilst there was usually only one main choice at meal times if people did not want this they would be provided with an alternative. One person told us they did not like meat and confirmed that they were always provided with something of their liking. Some people living at the home had a diagnosis of dementia. This can affect their ability to make choices. Care staff described how they supported people by showing them clothing options from their wardrobe.

People's independence was promoted. At lunch time staff encouraged a person to eat without taking over and adapted plates were provided where necessary. A range of drinking cups was available to suit the various needs and preferences of people. Care staff were seen encouraging people to rise from their armchairs safely by pushing themselves up using the arms of the chair rather than relying on staff or equipment to stand up. A person got them self up from a chair in the lounge and, using their walking frame, proceeded to go to the toilet. A care staff member asked if they were ok but didn't interfere promoting the person's independence. Signs had been provided for toilets and bathrooms to help people identify these rooms should they be looking for them on their own.

Care files contained information about people's lives, preferences and what was important to them. Staff were able to tell us about people's individual preferred routines. For example, a care staff member told us about one person who liked to pour some juice onto their dinner. They said "I know this seems unusual but when we have tried to suggest this is not a good idea, the person becomes upset, they eat up their dinner when after they have poured some drink on it."

Staff supported people to maintain family and other important relationships. Visitors told us they were made welcome and felt able to visit at any time. They told us they were offered refreshments and able to have a meal if requested. The registered manager told us relatives were invited to spend Christmas day with people should they wish to do so. There was a resident cat who people told us was friendly and they loved to see. One person had been enabled to bring their much loved dog with them when they moved to the home. We saw the dog was enjoyed by all people with staff supporting the person to ensure the dog received all the care it required.

Where people had spiritual needs these were known and met. Care plans detailed any spiritual beliefs or needs a person may have and how they liked these to be met. The registered manager was aware of how to access religious leaders of various faiths if required.

The home had a system of using keyworkers. A keyworker is a designated member of care staff with additional responsibility for a person, such as ensuring they have everything they need and have someone they can ask about things. People were aware of their key workers. A keyworker explained their role and told us how they enjoyed having additional responsibility for the person.

Good

Is the service responsive?

Our findings

People and relatives were happy with the way their personal and other care needs were met and told us that the care staff knew their preferences and respected their wishes. One person said, "The staff help me when I need help." A visitor told us the registered manager had met with them to discuss their relatives needs prior to their moving into the home. Initial assessments of people's needs were completed using information from a range of sources, including the person, their family and other health or care professionals. Care plans were then developed, which contained information about people's life history, preferences and medical conditions. They also contained information about the care people required, covering needs such as washing, dressing, bathing, continence and nutrition. These detailed what people could do for themselves and how they needed to be helped. This helped ensure people received consistent support and maintained their skills and independence levels. Copies of care plans were kept in bedrooms and were accessible to care staff should they need to refer to these whilst providing care. Reviews of care were conducted regularly by senior staff although these did not always involve the person or their families.

Staff used the information contained in people's care plans to ensure that care provided met people's individual needs. Care staff were able to describe the care and support required by individual people. For example, one care staff member was able to describe the support a person required with their personal care, meeting nutritional needs and when mobilising. This corresponded to information within the person's care plan. A health professional told us, "The staff seem to know the residents well." People's daily records of care were up to date and showed care was being provided in accordance with people's needs. For some people, staff were recording what they had eaten and drunk and what had been offered. One person was reluctant to drink much and this had been discussed with the person's GP. Although recording the amount the person was drinking staff were not adding this up to give a daily total, which would help ensure action was taken if this was inadequate several days running. The person's care plan did not include adequate information to guide staff as to what action they should take if this occurred. The registered manager agreed recording this would help staff identify actions required and stated they would update the person's care plan.

The registered manager reviewed all accidents and incident, such as where people had fallen and considered additional measures that could be taken to protect the person. For example, one person's bedroom had been rearranged to enable staff to have better observation of the person from the doorway. Where people had lost weight we saw action had been taken to consult with medical staff. Care staff described how one person was prescribed a food supplement. They said that, if the person did not eat much they would provide the supplement following the meal. This showed staff were responding to the person's changing needs.

Handover meetings were held at the start of every shift and provided the opportunity for staff to be made aware of any relevant information about changes to the needs of the people they were supporting. We saw that relevant individual information was provided to staff at the start of their shift, including, information about the personal care people had received and if they had eaten and drunk well. A visiting health care professional told us staff noted changes in people's needs and contacted them appropriately. There were

systems in place to respond to changes in people's prescribed medicines. The registered manager told us that they were able to obtain medicines promptly by collecting these from out of hours pharmacies, meaning there would not be a delay in the person commencing treatment. We saw that when a person had been prescribed additional medicines these had been provided promptly and administration commenced the same day.

People received mental and physical stimulation in the form of organised and ad hoc activities provided either by care staff or visiting activities professionals. People told us they felt there was enough to do and that they could choose to join in or not. A person said, "We play cards, games like bingo and things like that. We also have music." During the inspection we saw people involved in an activity provided by care staff and, on the second day, an external activity provider worked individually with people using a tablet computer. This was enjoyed by people and helped stimulate reminiscence conversations. Ad hoc activities were also available including jigsaw puzzles. A care staff member interacted with a person doing a jigsaw puzzle. They asked, "How are you doing with that?" and proceeded to help find the pieces with the person. People were happy with the level and type of activities provided by the home.

People and visitors said they would make any complaints to the registered manager, who many knew by name. Everyone we spoke with said they would feel able to raise a complaint but none had any complaints or told us they had ever needed to complain. The registered manager told us people and relatives were informed about the complaints procedure when they undertook a pre-admission assessment and written guidance was also provided in the home's entrance hall. The complaints log was reviewed and showed that when formal complaints had been received there were systems in place to deal with these. Records viewed showed that any complaints were investigated by the registered manager and a written response provided where appropriate. The registered manager said they spoke with people and visitors every day and was therefore able to resolve many issues before they became formal complaints.

Requires Improvement

Is the service well-led?

Our findings

Providers are required by law to notify CQC of significant events that occur in registered services. This allows CQC to monitor occurrences and help keep people safe. We identified safeguarding incidents, which had not been reported to us. Discussions with the registered manager showed they had taken action to report these to the local safeguarding team and ensure the safety of the person concerned. However the registered manager had not fulfilled the statutory requirement to notify the CQC this meant that we were unable to use the information as part of our regulatory duty to monitor events that occurred in the home. The registered manager understood they needed to report these incidents to us and could not explain why they had not done so.

The failure to notify CQC of incidents or allegations of abuse was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

People and visitors were happy with the care provided and felt the home was well run however we identified areas where improvements were required. The registered manager was aware of legislation designed to protect people's rights and freedoms and had completed assessments of people's ability to make some decisions. However, where this had shown people were unable to make decisions about various aspects of their care this had not been followed by best interest discussions and recording to evidence why the planned care was in the person's best interest. Risk assessments were not always up to date, placing people at risk of not having all their needs met in a consistent and safe way. Although staff had received training they were not always following safe procedures when they assisted people to reposition. Action had not always been taken to ensure the safety of people from the actions or potential actions of other vulnerable people. We noted that some care staff had long acrylic finger nails. This can pose a risk to people when they are providing personal care as well as preventing good hand hygiene. Care staff said they knew they were not really allowed to work with these nails however nothing had been said to them. We discussed these areas with the registered manager who took action to address the areas of concern we identified.

Each year the registered manager undertook a comprehensive review of all aspects of the service and produced a report for the provider. We were told the registered manager and provider frequently visited the home at times outside of planned visits enabling them to monitor the quality of care provided but records of this were not kept. However, the audits and management quality assurance procedures had failed to identify the breaches of regulations we identified during the inspection and other areas we noted, which required improvement and were therefore not fully effective. We spoke with the registered manager about the breaches and concerns we had identified. The registered manager had been aware of some of the standards required in relation to the breaches of regulations but had failed to make necessary improvements. On pointing out failures to meet regulations the registered manager quickly made some of the necessary improvements. This demonstrated that the registered manager did not have a proactive approach to ensuring standards were met and the provider visits had failed to address this.

Providers are required to display the ratings from inspections so that people, relatives and visitors are aware of these. The rating from the previous inspection undertaken in July 2016 was not initially displayed at the

home. We brought this to the attention of the registered manager who arranged for this to be displayed during the inspection.

Meetings were held several times each year with people to discuss their views about the service and see if there were any changes they would like. We viewed the minutes of these meetings, which covered areas such as activities and menus as well as providing information for people about any changes which may affect the home.

People were positive about their experience of living at the home. One person said, "I like my room, the staff are lovely and kind. Yes I like living here." People, family members and healthcare professionals said they would recommend the home to their families and friends. Two visitors told us they had booked a room. A visitor said, "It's [the care home] not too big, you get to know the staff so you feel able to talk about any issues." Some people and visitors were aware of who the provider for the service was. One person said, "I think her name is Maureen, she comes in and has a chat with me." People and visitors were aware of who the registered manager was and all said they felt able to talk to her if required.

The manager told us they ensured the quality of the service provided by talking to people, relatives and staff. More formal quality assurance systems were also in place, including seeking the views of people about the service they received. Surveys had been sent to people, visitors and external professionals in February 2017. The surveys could be completed anonymously and those which had been returned showed everyone was happy with the service provided at the home. There were also systems in place to monitor the safety of the home, such as monitoring the temperature of water and cleanliness of people's bedrooms.

Providers are required by law to follow a duty of candour. This means that following an unexpected or unintended incident that occurred in respect of a person, the registered person must provide an explanation and an apology to the person or their representative, both verbally and in writing. The registered manager understood their responsibilities in respect of this although they had not needed to follow the procedure as no significant incidents had occurred. Visitors told us they were kept informed verbally of minor incidents and changes in their relative's health.

The registered manager described their goal for the home as being to provide, "A happy place where people could live and enjoy their lives." Staff also described their goal as being to make people as happy as possible. All staff members said they would be happy for a member of their own family to receive care at the home.

There was a clear management structure, which consisted of the provider, registered manager, deputy manager and senior team leaders. Staff were confident in their role and understood the part each other played in delivering the overall service for people. One staff member said of the provider, "The owner is lovely, she talks to staff. I know I can get her if I need to in an emergency or if I needed to escalate problems if the manager was not doing this." However, another staff member was less positive and said they would raise concerns with the registered manager or deputy.

The registered manager said they encouraged staff and people to raise issues of concern with them, which they acted upon. One staff member said, "There is a book of concerns so if you want to speak to the manager about something you can write in that. She will usually ring you then so you can talk to her in confidence about anything that is worrying you." Another staff member said, "I can go to the manager or the deputy if there is a problem and they will help me." Care staff told us that if it was serious, such as someone fell or died the owner or the registered manager would come in to support them. A new care staff member said, "I feel supported by all the staff." They and all staff said how much they enjoyed working at the home.

Most staff had worked at the home for several years. We observed staff worked well together, which created a relaxed atmosphere and was reflected in people's care.

The registered manager had an open door policy for people, families and staff to enable and encourage open communication. Staff told us there were staff meetings. One staff member told us, "Staff meetings are held." We saw the minutes of the most recent staff meeting were available for staff to read. This meant any staff unable to attend would be aware of what had been discussed. Where necessary, such as following some of the concerns we identified during the inspection, memos were sent to all care staff. This meant they would be aware of important information.

The registered manager told us they had developed links with the managers of other local care homes. They identified this helped keep them up to date with current best practice and to develop the service for the benefit of people. For example, they had realised that it would be good for people to have the option of a shower and had identified a bathroom which could be converted to a wet room. When we identified areas, which could be improved the registered manager was receptive to these and where necessary took immediate action. This showed they were willing to listen to others opinions and views about the service.

Policies and procedures were supplied via an external company and had been adapted to the home and service provided. We were told policies were reviewed yearly or when changes were required and updates were received from the external company when legislation or best practice guidance changed. We saw these were available for staff in the office and ensured that staff had access to appropriate and up to date information about how the service should be run.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered person did not notify CQC of relevant incidents involving the people who used the service. Regulation 18 (1) and 18 (2) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered person had failed to ensure that where people lacked the capacity to give informed consent action was taken to comply with the Mental Capacity Act when providing care and treatment. Regulation 11 (1)(3)(4)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person had failed to ensure risks relating to the health and safety of people using the service were assessed and action taken to mitigate identified risks to ensure the safety of people. Regulation 12 (1)(2)(a)