Care Quality Commission

Christchurch Housing Society

Avondene 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?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

An unannounced inspection took place on the 19 November 2015. The inspection continued on the 20 November 2015 and was announced. It was a planned comprehensive inspection carried out by one inspector.

The service is registered to provide accommodation and residential or nursing care for up to 11 people. The service does not providing nursing care. At the time of our inspection the service was providing residential care to 11 older people some of whom were living with a dementia.

The service provides accommodation over two floors. All the bedrooms are single occupancy and six have an en-suite toilet and wash basin. On the ground floor there are shower facilities in a wet room and on the first floor a bath. The first floor can be accessed via a central staircase or a lift. Each room has a call bell system that people could use if they needed to call for assistance. On the ground floor there is a communal lounge, dining room and a small conservatory. The porch area looks onto the front driveway and has seating that people also use to meet with friends and family. On the ground floor there is a well-equipped kitchen a small laundry that has one washing machine and one dryer and a sluice. Large items such as sheets are sent to an external laundry for ironing.

Summary of findings

The front door is kept locked and visitors need to ring a bell to get staff to let them into the building. Outside there is a small area at the front of the building which is used for parking. The service does not have any outdoor sitting areas.

The service 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.

We found that the service was not always safe. Peoples care files had risk assessments completed for skin care, malnutrition and moving and handling. In some cases the completed assessments showed that a person was at risk but no care plans had been put in place to detail what actions were needed to minimise the risk. Some care plans that were in place did not reflect the care that was actually being provided.

People did not have personal fire evacuation plans in place. Fire alarms and equipment had been checked weekly. Since January 2014 records showed us that a fire door into the lounge had a fault and had not been closing correctly. No action had been taken to repair the fault. Maintenance records for the lift, boiler and hoists were up to date. An emergency contingency plan had been put in place in the event of the service needing to be evacuated.

The building had a central staircase which accessed bedrooms on the first floor. A risk assessment had not been completed to consider whether people were at risk of injury and whether actions were needed to minimise any identified risks.

Medicine was administered safely by staff. One person self-administered their medicines. A risk assessment had not been completed to show how any risks to the person or others had been minimised.

People who lived at the service, their families and other professionals told us they felt the service was safe. Staff had received training in safeguarding and understood how to put this into practice.

Staff were recruited safely which included criminal records and eligibility to work in the UK checks. Processes were in place to identify and manage unsafe staffing practice.

We found that the service was not always effective. They were not fully working within the principles of the Mental Capacity Act. 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 were told that some people were living with a dementia. MCA had not been carried out to determine whether people were able to consent to restrictions on their liberty or if a DoLs application was required in line with the MCA legislation. Staff were verbally seeking a persons consent before providing any care or support. They had undertaken MCA and DoLs training but required a better understanding of the practical application of the legislation.

People enjoyed home cooded meals and were offered choices. Staff discreetly provided support people to at mealtimes and encouraged and supported people to maintain their independence. At the time of the inspection nobody required a special diet or had a swallowing pla in place.

Staff received appropriate induction and on-going training which included dementia awareness, dignity and person centred care, malnutrition, food hygiene, medication administration, moving and handling and safeguarding. A number of staff had achieved NVQ2 and 3 qualifications.

People had good access to healthcare. This included GPs, district nurses, chiropodist, optician, audiologist and specialist services at the local hospitals.

Summary of findings

We found that the service was caring. People, their families and other professionals all told us they felt the service was caring. People felt that the staff had a good understanding of their care needs. Staff responded quickly when asked for assistance. Care was provided in an unhurried, relaxed and friendly way and staff encouraged and supported people to be as independent as possible. People were involved in decisions about their health and care. Staff understood how to respect a person's dignity and privacy. An advocacy service was available when needed.

We found that the service was not always responsive. People did not have care plans for all their identified care needs. One person had care plans that had conflicting information in them. Care plans did not always reflect what was actually happening in practice which placed people at risk of inconsistent care or not getting the care and support they needed. People and their families had been involved in assessments and planning their care prior to moving to the service. People were not always involved in continued care and support planning.

Staff were kept informed through handovers and a communication book about any changes with people. Health professionals told us that the service respond quickly to changes in people's health and contact them quickly and appropriately.

People had activity profiles which contained information about how they liked to spend their time. Activities were organised at the service and their sister home nearby. The service had access to a mini bus once a fortnight and it was used for activities in the community. People were supported to maintain links with friends, family and interests in their local community Newspapers of people's choice were delivered daily. People had been supported to access their right to vote.

A complaints process was in place. People and their families were aware of the process and felt able to use it if necessary. Regular meetings were held with people and their families to gather feedback on the service. Any concerns raised had been investigated and appropriate actions taken.

We found that the service was not always well led. Shortfalls we identified in managing risk, following the MCA and DoLs legislation and care planning had not been identified by the auditing processes carried out by the manangement of the service.

People, their families and staff found the manager approachable and accessible. The manager regularly worked alongside care workers and led by example. People and their families felt the manager had a good knowledge of peoples care needs. Staff felt that the manager listened to them and they felt able to share their ideas or any concerns. Staff received an annual appraisal that included looking at their achievements and setting future development goals.

Notifications to CQC had been completed appropriately and in a timely manner. A notification is the action that a provider is legally bound to take to tell us about any changes to their regulated services or incidents that have taken place in them.

The service carried out a quality assurance survey twice a year. Forms were sent to people living at the service and their families. Feedback had been gathered on cleanliness, food, décor, activities and the complaints process. The areas were rated as either good or excellent. Findings of the survey were published in a newsletter that the service published monthly.

The service had shared the last CQC report with people, their families and staff and a copy was on display in the foyer.

There was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as risks were not always identified and managed. We also have recommended that the provider explores guidance to support people in line with the Mental Capacity Act 2005. You can see what action we told the provider to take at the back of the full version of the report

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

We found the service was not always safe. Risk assessments had been completed. Care plans had not been put in place to explain the actions needed to minimise any identified risk to a person.

People did not have personal fire evacuation plans in place. Fire drills and fire maintenance checks took place regularly. An identified repair to a fire door had not been acted upon.

Medicines were administered safely by staff. Risk assessments were not in place for people who administered their own medicines.

Risk assessments were not in place for areas of the building that could impact on a persons safety.

People, their families and other professionals told us they felt the service was safe. Staff had received training in safeguarding and understood how to put this into practice.

Recruitment practices were safe. There were enough staff to meet the needs of people.

Is the service effective?

Requires improvement

We found the service was not always effective. The service was not working within the principles of the Mental Capacity Act (MCA).

People were having their nutritional needs met.

Staff received appropriate induction and ongoing training.

People had good access to healthcare.

Is the service caring?

Good

We found the service was caring. Staff supported people in an unhurried, kind and caring way.

People were involved in decisions about their health and care.

Staff understood how to respect a persons dignity and privacy.

An advocacy service was available.

Is the service responsive?

Requires improvement

We found the service was not always responsive. People did not have care plans for all their identified care needs. Care plans did not always reflect what was actually happening in practice which placed people at risk of inconsistent care or not getting the care and support they needed.

Summary of findings

A range of activities took place at the service, their sister home nearby and in the community. People were supported to maintain links with family and friends.

A complaints process was in place. People and their families were aware of the process and felt able to raise a complaint if necessary.

Is the service well-led?

Requires improvement 

We found the service was not always well- led. Management audits and systems did not identify shortfalls in managing risk, MCA assessments and planning peoples care and support needs.

People, their families and staff found the manager approachable and accessible. They felt listened to and could share ideas and any concerns.

Quality assurance surveys were completed twice a year to gather feedback from people and their families and the findings reported in their monthly newsletter.

The manager understood their rsponsibilities for notifying CQC of any changes to their regulated services or incidents that had taken place.

Avondene 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.

The inspection took place on the 19 November 2015 and was unannounced. It continued on the 20 November 2015 and was announced. The inspection was a planned comprehensive inspection carried out by one inspector.

Before the inspection we looked at notifications we had received about the service and information that had been shared with us from other professionals and the public since the last inspection. We did not request 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. We gathered this information from the provider during the inspection.

We spoke with five people who live at the service, four relatives who were visiting. We spoke with the Registered Manager, five care workers and an agency worker. After our inspection we spoke with a social worker and two district nurses who had experience of the service.

We reviewed four peoples care files and checked their accuracy. We checked health and safety records, maintenance records, medicine records, management audits, meeting records and the results of quality assurance surveys. We walked around the building observing the safety and suitability of the environment and observing care practice.

Requires improvement

Is the service safe?

Our findings

Peoples care files had risk assessments completed for skin care, malnutrition and moving and handling. One skin risk assessment score showed the person was at a high risk of skin damage. Another persons' skin risk assessment showed their risk had reduced from high to medium. No care plans had been put in place to detail what actions were needed to minimise the risk. Specialist air mattresses had been put on both beds to reduce risk and help protect vulnerable skin. We checked the setting on one and it was set correctly for the persons' weight. We saw no other evidence of specialist equipment being used such as pressure relieving cushions on chairs. On the days of our inspection both people sat for long periods on a chair in their rooms. A risk assessment for malnutrition showed one person had a score of eight. The form stated any score of eight or above required a care plan to be in place. This had not happened. However a record of their monthly weight showed that over a six month period the person had gained 4kg in weight. The manager told us that all risk assessments would be reviewed and care plans put in place where risks had been identified.

Moving and handling risk assessments had been completed. Care plans were in place but we found they did not reflect practice. One plan did not detail the type of sling needed to transfer a person safely. We found a sliding sheet in a persons' bedroom which staff told us they used but was not in their plan. One person described unsafe moving and handling practice. They said "One staff member gets me under the knees, one under my arms and they lift me from chair to bed". This person had not questioned this practice and had felt safe. There was a hoist kept on the ground and first floor. We discussed this with the manager who told us they felt the persons account would be accurate. The manager had not been aware of this practice and would review immediately. We reviewed another persons care file. The mobility plan stated bedfast. We spoke to a care worker about the persons moving and handling needs. They told us "Their mobility and standing is variable. We give her a frame but sometimes they will not use it. Hates the hoist and will shout out". We asked what size and type of sling was used with the hoist for this person. We were shown a toilet sling and medium sized sling which were kept in the office. Staff assumed these must be the correct slings as the only ones available. They showed us a sliding sheet in the room that they used to help with moving and handling. There was a care plan to support staff with this persons moving and handling but it did not reflect what was actually happening. The care plans were being reviewed regularly but did not reflect our findings at the inspection. We discussed with the manager our findings and concerns. The manager told us that they would introduce and carry out regular care plan audits in order to identify shortfalls and work with staff to bring improvement.

Personal fire evacuation plans for the people living in the service had not been completed. These are needed to ensure each person's individual risks are understood in the event of an emergency. We raised this with the manager who agreed to put personal fire evacuation plans in place.

We saw that medicine administered by staff was managed safely. However, one person had been self- administering their medicines at home and their care records showed us that on admission they had requested they would like to continue to do this. We saw their medicines kept on a table in their room. A risk assessment had not been completed to show how any risks to the person or others had been minimised.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People's Medicine Administration Records (MAR) were completed correctly by staff who had completed medicine administration training. Each person had a separate storage box in the medicines cupboard where their liquid and boxed medicines were stored. Most medicines were administered from a monitored dosage system. MAR sheets accurately reflected medicines that had been given. Staff recorded times on MAR sheets when administering pain management medicines to ensure appropriate time gaps before other medicines were given. One person was receiving a controlled drug that needed to be recorded and administered separately. We saw that the correct procedures were being followed. The controlled drug record book had been completed correctly by two staff when drugs had arrived from the pharmacy and when medicine had been administered. We counted the number of drugs remaining and they matched the number in the record book. One medicine had specific requirements

Requires improvement

Is the service safe?

associated with administration. Staff were able to tell us what they were to ensure the person was getting the full benefit of their medicine and it was being administered as directed by their GP.

We saw that fire alarm and fire equipment checks had been carried out weekly by a sub-contractor. Records showed that since 22 January 2014 there had been a fault on the lounge door which prevented it from shutting correctly. This could impact on people's safety in the event of a fire. We spoke with the manager who told us that both she and the sub-contractor had reported this to the provider. Maintenance records for the lift, boiler and hoists were up to date.

An emergency contingency plan was in place which contained information on how the service would keep people safe in the event of them having to be evacuated.

The building had a central staircase which accessed bedrooms on the first floor. The stairs did not have any safety restrictions and were open for anybody to use. A risk assessment had not been completed to consider whether people living at the service were being kept safe from falling on the stairs.

People we spoke with, their families and other professionals told us they felt the service was safe. One person said "No one is ever nasty". A relative said, "Feel mum is safe and well looked after". Training records showed us that staff received regular safeguarding training. Staff we spoke with understood how to recognise signs of abuse and what action to take if they suspected or saw abuse taking place. We saw safeguarding information on display on a noticeboard in the foyer which included contact numbers for the local authority and CQC.

Staff were recruited safely. Files contained evidence of criminal record and eligibility to work in the UK checks being completed. References from previous employers were obtained as part of the recruitment process. People said they felt there were enough staff. One person said "Staff are attentive. The call bell is answered quickly". When the manager or senior carer is not in the building a member of the care staff takes responsibility. The manager told us they had medicine administration and first aid training. We looked at the file of one member of staff which contained the training certificates for both courses. The manager and senior carer provide out of hours emergency cover. Processes were in place to identify and manage unsafe staffing practice. We saw evidence that disciplinary processes had been followed and appropriate actions taken.

Requires improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We found that the service were not fully working within the principles of the MCA. We were told that some people were living with a dementia. People's files did not contain any evidence that their capacity had been assessed when care plans had initially been developed or reviewed. One person had a sensor mat in their room. If the person stood on the mat staff were alerted and needed to respond quickly to check they were safe. We spoke with the person about their understanding of why the mat was in their room. They said, "I'm not sure, I suppose it's to stop anybody slipping". The person had not had their mental capacity assessed to determine whether they were able to consent to the restriction on their liberty or if a DoLs application was required in line with the MCA legislation.

Some people had bed rails in place that were used to reduce the risk of them falling out of bed. In the care files we saw that families had been involved in consenting to them being used. We saw an entry by a care worker in one person's care file that stated they had been unsettled for over a period of several hours during the night and had tried to get up out of bed. The notes recorded that they had said they wanted to go home. There was no MCA in place and no review of the use of bed rails after this incident.

The manager and nine staff had completed MCA and DoLs training. We discussed our findings with the manager and were told that refresher training would be arranged in order to get a better understanding of the practical application of the legislation.

We observed staff verbally asking consent before supporting people with getting up from a chair, walking with a frame, assisting with food and drink and joining in an organised activity.

Two files we looked at had completed 'Do not attempt resuscitation' forms. These had been completed with the involvement of the person, their family and a GP.

We observed staff verbally asking consent before supporting people with getting up from a chair, walking with a frame, assisting with food and drink and joining in an organised activity.

One person told us, "The foods smashing. I've put on weight. Plenty of choice". We saw meals being served in a pretty dining room, on a tray in front of the TV and in a person's room. One relative said, "The dining room is like a little restaurant. Food is home cooked and nicely presented". People enjoyed their meal in an unhurried manner. The mealtime was relaxed and staff were discreet with any support they offered. This included cutting up food for somebody and quietly encouraging a person to eat some of their meal. We saw people enjoying food that had been home cooked with fresh ingredients and looked appetising. With spoke with the cook who told us, "People choose what they would like to eat on the day. I speak to each person. There are a couple of ladies who are deaf so I write the choices in big letters". The meal choices were displayed on a board in the foyer which also detailed alternative dishes that were always available. Details were also displayed of known allergens in each dish. At the time of our inspection nobody required a special diet or had a dietician involved in their care.

We spoke with a care worker about their induction. They told us that it included information on their role and responsibilities. They had been given information about the organisation and about the service. On their second day they had been involved in a fire drill and looked at people's care files. They had worked with another care worker and supported a person with a shower. The care worker had explained how the person needs supporting to choose her clothes. They said that moving and handling,

Requires improvement

Is the service effective?

first aid and health and safety training had been planned. They had previous care experience and had achieved an NVQ3 in health and social care. We spoke with a care worker from an agency who had worked a number of shifts over a two month period. They said, "On my first shift they explained the building, health and safety, resident's different levels of communication. I felt I had enough knowledge to do my job". We spoke with a relative who told us, "Staff appear to be well trained. They are kind, thoughtful and efficient".

Training records and training certificates were on staff files. Training completed included dementia awareness, dignity and person centred care, malnutrition, food hygiene, medication administration, moving and handling and safeguarding. Six staff had completed their NVQ2 in health and social care and two staff had completed an NVQ3. Staff told us that they felt supported in their roles and that there was good teamwork.

People had good access to healthcare. People had access to a GP of their choice and district nurses visited regularly. Care files had evidence of people having access to a chiropodist, optician, audiologist and specialist services at the local hospital. We spoke with a district nurse who told us that the service were very good at contacting them for support. They said "They are straight on the phone. One person had recently been discharged from hospital and they rang to ask if we could come and look at a problem with her leg. They didn't wait for the hospital to contact us. They know the residents well". Another district nurse said, "We were visiting a person with quite complex needs. Staff followed our instructions; we felt they were on the ball, caring and knowledgeable".

We recommend that the service explores the relevant guidance on how to ensure that people are being supported within the principles of the Mental Capacity Act 2005.

Good

Is the service caring?

Our findings

People, their families and other professionals all told us they felt the service was caring. One person said "They never make you feel that they can't be bothered". Another person told us "Staff are very friendly. We have a laugh; it's like a home from home". We spoke with a relative who said, "Feel people are very well looked after. It's a small home and so feels very personal". After our inspection we spoke with a social worker who said, "Staff seem to have a good understanding of care needs. My impression is that people are well supported".

We observed good examples of staff communicating with people in a caring and kind way. One person became anxious over lunch as they were worried about another person at their table who they felt was struggling to manage their knife and fork. The care worker reassured the person and thanked them for letting her know. They then quietly explained that they knew the person and that they preferred to manage their meal independently albeit it took them a little longer. The person appeared reassured, smiled and returned to their own meal. Another person had their lunch in front of the TV as they were enjoying a tennis match. Staff engaged with the person each time they passed, discussing the game, sharing comments, laughing together. We saw that people who were in their rooms had a call bell within reach. People told us they were answered quickly.

People and their families told us they felt involved in decisions about their health and care. One person had an outpatient hospital appointment arranged. We saw evidence in their care file that they had decided not to attend. They had discussed the reasons for their decision with family and staff and it had been respected. A care worker was observed asking a person if they would like any pain killers. To help the person make a decision they explained when they had last had them and how many more they could have that day. Staff explained how they involved people in decisions about their care. One care worker said, "We offer a choice in the mornings of a bath or shower. We always offer a choice of clothes and support people to look nice". A relative told us, "Feel we can ask any questions. The staff will always let me know what is going on". Another relative said, "They always ring me if there are any worries". People had access to an advocacy service. A poster was displayed on the notice board with contact details.

Peoples rooms had lots of personal belongings, were individual, warm and clean. One person proudly told us, "My room is always lovely and pristine. The bedlinen is lovely. I was shown a selection of bedlinen and chose this one". People were supported to keep their clothes looking well cared for. We saw that some ladies had been supported with their makeup and hair accessories. A poster about dignity and what you should expect had been put onto the noticeboard for people, their families and staffs information.

People felt their privacy was respected. One person told us, "A person in the next room was wandering into my room when I'm not there. It upset me but I've got my own key now and keep my room locked when I'm not in it". We observed people's dignity being respected. Staff closed people's bedroom doors when providing care. Support was offered discreetly and in an unhurried way. We observed staff supporting people to be as independent as possible. One person was walking slowly with the aid of a frame and a care worker was walking alongside offering encouragement to the person. Staff explained to us how they can support people to maintain independence. One care worker said, "You can put food onto a spoon and guide the persons hand to their mouth to help them keep some independence. Also when providing care you can give the person the flannel and encourage them to do some bits themselves".

We saw a folder in the foyer that contained compliments from people, one read 'Appreciate the kind staff who care for mum'.

Requires improvement

Is the service responsive?

Our findings

We found that people had individual care plans but that there was not a care plan for all their identified care needs. People's care plans were being reviewed regularly but did not always reflect what was actually taking place. This placed people at risk of inconsistent care or not getting the care and support they needed.

One person was identified as having a high risk of skin damage but there was not a care plan in place to explain to staff the actions needed to prevent skin damage. The night staff had recorded that they had supported them with continence at 6.30am which had involved changing their night clothes, using continence materials and that they had requested to stay in their armchair rather than go back to bed. At 3pm we found the person in their nightclothes asleep in their armchair. We asked the care worker if they had been offered the toilet during the day and they told us that they hadn't. They told us that the person usually would use their call bell if they needed to go to the toilet. We spoke with the manager who felt this would not always be the case. There was no care plan in place to explain to staff how this person needed to be supported with their continence. The care plans that had been written contained conflicting information. The nutrition and personal care plan stated that the person sits in chair at times.

One person had a specialist air mattress on their bed although an assessment showed they were not at risk of skin damage. Their family told us they were concerned it may affect their mums sleep. We spoke with the manager about why the air mattress was on the bed and were told that there wasn't a normal mattress available to replace it with.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Peoples care files had evidence that assessments had taken place prior to a person moving to the service. The assessment involved the person and their family. People had been asked about areas of their care they could manage independently and areas they needed support with. Information had been obtained about how people liked to spend their time and one file we looked at had a summary of the persons' life biography. Information had been recorded of the person's emergency contacts including family and GP and any planned health appointments. We found no evidence that people or their families remained involved in continued care and support planning. We spoke to one relative who told us "Never been asked to look at care files".

One person had returned from a hospital admission just prior to our inspection. We spoke with a care worker who told us, "We discussed her return from hospital at the start of our shift at handover. We discussed her care plan and there are some changes in relation to her skin so have been asked to check her body and record these on a body map". We spoke to a district nurse who told us that staff responded quickly to changes in health and would contact them. We were shown a communication book that is used in staff handover meetings. Staff told us they read the book to update themselves on what's been happening if they have returned from any days off.

People had activity profiles which detailed a person's likes including music, TV programmes and other interests. There was a record for each person detailing daily activities. Planned activities had included gentle exercise classes and quizzes. During our inspection a shoe and gift sale was held which people enjoyed. The service had fortnightly access to a mini bus and this had been used for trips to a local garden centre and the local pub. People had been out to a local supermarket Christmas shopping. The organisation has a larger home nearby and the service had regularly organised for people to go along and join in when there was an entertainer. People were encouraged to continue with their links in the community. One person had a friend who came each week and they went together to a local bingo hall. Another person enjoyed being outside. The service doesn't have an outdoor sitting area but they told us "There is a cricket field across the road. Staff would take me and my friend over to a bench and then come and collect me later." People had newspapers of their choice delivered and the library visited regularly. Staff had supported people to arrange for a postal vote for the last general election.

The service had a complaints process which is described in their 'Statement of Purpose'. The complaints information included details of other organisations people can contact if they are not happy with the service. People we spoke with told us they knew how to make a complaint and felt they could if they needed. We looked at the complaints log

Requires improvement

Is the service responsive?

and there had been no written complaints in the last 12 months. The manager kept a separate log of concerns raised by people. The records included details of concerns raised and any actions taken. The records provided good evidence that the service listens to what people told them and takes appropriate actions. One relative told us, "The family have set up a communication book in mum's room and staff have been using it to write activities and messages to the family". A meeting had been held the previous week with residents and relatives and people had the opportunity to share their views and ideas about the menu, activities and staff. A relative told us, "My sister went to the meeting and found it very good. Minutes of the meeting are produced for everybody. Every so often we are asked to fill in a form about the care and so is my mother". At one residents meeting people had said they would like a pet and it had been agreed to get budgerigars. We saw two in their cage in the lounge.

Requires improvement

Is the service well-led?

Our findings

We found that the service did not have management systems in place that always identified risks to people. Shortfalls we identified in managing risk, following the principles of the MCA legislation and care planning had not been identified by the auditing processes carried out by the management of the service. However, some audits had been carried out which included medicine administration, accidents and incidents and infection control. The manager told us that a medicine audit had been introduced as they had become aware of recording errors. The audit had been successful in identifying issues. Audit findings had been shared with staff individually and at staff meetings and actions agreed that had led to improvements. We looked at medicine audits and they reflected the improvements. We spoke with the manager about our findings and they told us they would be reviewing their management systems.

People and their families found the management approachable. One person said, “Mel is lovely, she is very approachable”. A relative told us, “The manager is very accessible. We see her with both staff and residents. Can be very hands on. Feel she knows my mums needs well. Very efficient, very good”. Another relative said “Mel has been brilliant. She has been very supportive, understanding of the situation, knowledgeable, caring”.

We spoke with staff who said “The manager is really good. When we’re busy she always helps. Feels she listens, you can talk with her”. We observed interactions between the manager and staff and they were friendly and relaxed. Staff had an annual appraisal and it included achievements and goal setting. We saw evidence of completed appraisals on staff files. A care worker told us that they had discussed an idea with the manager about a different process for staff administering creams which they felt would be more efficient and that this was going to be shared at the next staff meeting.

Links had been made with the local college and a student had carried out work experience at the service. They had been involved in making tea and coffees and having chats with people. The aim had been to give them an opportunity to understand care work.

Records evidenced that notifications to CQC had been completed appropriately and in a timely manner. A notification is the action that a provider is legally bound to take to tell us about any changes to their regulated services or incidents that have taken place in them.

The service carried out a quality assurance survey twice a year. Forms were sent to people living at the service and their relatives. The majority of ratings from both groups had been good or excellent. Feedback had been gathered on cleanliness, food, décor, activities, and the complaints process. The service produced a monthly newsletter which had been used to publish the survey results. Copies of the newsletter had been left in the foyer for people and their families.

The service had shared the last CQC report with people, their families and staff and a copy was on display in the foyer.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **People did not always have risk assessments and care plans in place that protected them from receiving unsafe care and treatment and prevent avoidable risk of harm. Regulation 12 (1)(2)(a)(b).**