Elliott Care Home Ltd

Elliott 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?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 28 November 2017 and was unannounced. This was the first inspection of this service since they registered with us.

Elliot Residential Care Home provides accommodation and personal care for up to 17 people and is based near the centre of Leicester. The service specialises in supporting people who are living with mental health needs. Accommodation is provided over three floors, accessible only by stairs. At the time of our inspection there were 13 people using the service.

There was a registered manager in post. 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.

Records showed people were involved in the development of their care and supported to make day-to-day decisions and choices. The provider had not undertaken assessments of people's mental capacity to make specific decisions about their care, support and treatment. Records did not reflect the possibility that people may lack mental capacity at times to make decisions in their best interests due to their health needs. This meant that people may not receive the support they need to make their own decisions and choices in line with relevant legislation and guidance.

People told us they felt safe in the service and relatives felt their family members were safe. Staff were trained in safeguarding and knew what to do if they had concerns about the well-being of people.

Potential risks people were exposed to and assessed and reviewed. Risk assessments lacked the detail and guidance needed regarding measures staff should take to reduce the risk of harm.

Care plans identified where people and others were at risk through behaviours that may challenge. However records did not include clear guidance on the nature of behaviours and interventions required by staff to keep people safe.

The provider had effective recruitment processes in place which helped ensure only suitable staff were employed in the service. There were sufficient staff to meet people's needs. People received their medicines safely and as prescribed.

Systems were in place to ensure the risk of infection was prevented and controlled. The registered manager reviewed incidents to improve safety within the service.

People's needs and choices were assessed and their care provided in line with their wishes and preferences.

Staff had most of the skills and knowledge to meet people's needs. Staff had undertaken training to enable them to provide effective care and support. We have made a recommendation that staff receive specific training in managing people's complex mental health needs as a matter of priority.

Staff felt supported in their roles through supervision and were encouraged to develop within their roles through additional training and opportunities.

People were supported to have sufficient to eat and drink and maintain their health and well-being. Staff supported people to use and access a wide variety of services and health professionals to ensure they received healthcare to meet their needs.

The provider was in the process of upgrading the premises to meet people's needs. This included replacement of furnishings and redecoration.

People had developed positive relationships with staff, who were caring and treated people with respect. Staff understood and promoted people's right to privacy and dignity. Staff were knowledgeable about people's needs and effective communication ensured people were supported to make decisions about how their care was provided. Staff encouraged people to be as independent as possible.

Staff were knowledgeable about the people they supported and knew their likes, dislikes, preferences and interests. Care plans were not consistently person centred as they did not always include details of people's life history, significant events, routines or how they liked their care to be provided.

People were supported to pursue hobbies and interests and were able to choose how they spent their time and where.

People knew how to raise concerns and complaints and were confident these would be listened to and acted upon. The registered manager took complaints seriously and used these to bring about improvements in the service.

The registered manager promoted an open culture which provided people and staff with opportunities to share their views about the service. The provider had introduced a new quality assurance system based on audits and checks and was in the process of evaluating the outcomes of these at the time of our inspection. The provider had identified where some developments were needed to the service. Further improvements were required in record-keeping and time-scales for developments within the service.

At this inspection we found that Elliot Residential Care Home required improvement in four areas. They were in breach of one regulation relating to supporting people to make specific decisions about their care and support through mental capacity assessments.

You can see what action we told the provider to take at the back of the full version of the 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 consistently safe.

Staff were knowledgeable about the risks people faced and actions they needed to take to keep people safe. Records did not always include the measures staff needed to take to manage risks. Records did not always support effective management and monitoring of behaviours that may challenge. People were supported to take their medicines safely. People were supported by sufficient numbers of staff who were skilled in meeting their needs. Information from incidents was used to bring about improvements to keep people safe.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were not always supported to make decisions and choices in line with legislation and guidance. People received effective care from staff who had the necessary skills and knowledge to meet their needs. People were encouraged and supported to maintain their health and well-being. Areas of the premises were in need of upgrade and refurbishment.

Is the service caring?

Good

The service was caring.

People and their relatives were involved in the planning of their care. People were cared for by kind and caring staff who were able to communicate with people well. Staff knew people's needs well and had the time to provide personalised care. People were treated with dignity and respect and their right to privacy was upheld.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People were involved in the planning of their care. Care plans did not include the detail or guidance staff needed to provide personalised care. People were supported to pursue hobbies

and interests and chose how they spent their time. People felt confident to raise concerns and complaints.

Is the service well-led?

Requires Improvement

The service was not alwasy well-led.

People and staff were supported to share their views about the service. The registered manager promoted a positive and open culture. Quality assurance systems were in place but were not yet effective in identifying and driving improvements in the service.

Elliott 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 28 November 2017 and was unannounced.

The inspection team consisted of one inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We had not sent the provider 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 provided the opportunity for the provider to share this information with us during our inspection visit. We checked the information we held about the service including statutory notifications. A notification is information about important events which the provider is required to send us by law.

During our inspection we spoke with eight people who used the service and two relatives. We also spoke with the registered manager, the deputy manager, the administrator and two care staff.

We reviewed three people's care records and other information including risks assessments, medicines records, staff training and two staff recruitment documents. We also looked at the provider's systems for monitoring the quality of the care provided. We spoke with local authority commissioners, responsible for funding some of the people using the service, to gain their feedback.

Requires Improvement

Is the service safe?

Our findings

People and relatives spoke positively about the care and support they received. One person told us, "I feel safe here because it's comfortable. It's a friendly atmosphere and everyone gets on." Another person told us, "I am safe here. I just feel safe, it's just nice here and all the staff are good." A relative told us they felt their family member was safe and that staff took action to keep them safe, such as referring to appropriate agencies to support them with their mobility.

Staff we spoke with were able to tell us about the signs and types of abuse and how they would respond if they suspected a person was at risk. Staff were confident about how they would report any allegations or actual abuse. One staff member told us, "I always check when people have come back (from the community) and ask how they are, if they have been approached or any incidents they need to tell us about. People have the right to go out on their own but we are aware they are very vulnerable too. We talk to them about staying safe whilst they are out and about." Another staff member was able to describe the actions they would take if they suspected a person was at risk from abuse. They told us they felt confident to raise concerns with senior staff, including the registered manager, and felt action would be taken in response to their concerns. This information was in line with the guidance in the provider's safeguarding and whistleblowing policies. These documents provided staff with the guidance and information they needed to identify safeguarding concerns and understand how to escalate concerns to keep people safe.

Staff told us they had completed training in safeguarding (protecting people from abuse) and this was confirmed in the records we saw. The registered manager kept records of when staff had completed the training and when training required updating to keep staff knowledge up to date and in line with current guidance.

The registered manager told us they ensured people were supported to manage their finances independent of the service, through appointees. Each person was provided with a weekly/daily budget which had been agreed with the person and their appointee. Staff kept records and evidence of all day-to-day expenditure and monies were only accessed by senior staff. This helped to protect people from the risk of financial abuse.

Risks people faced had been assessed and included in people's care plans. For example, risks associated with people's mobility, the environment or people's health conditions. Although risk assessments identified potential risks to people's safety, records did not always record the measures in place to control these risks. For example, where one person was at risk of poor nutrition and hydration through skipping meals, their risk assessment highlighted this risk and guided staff to monitor if the person had eaten/drank sufficiently. However, the risk assessment did not detail the action staff needed to take to encourage the person to have meals or what to do if they declined their meal. When we spoke with staff, they demonstrated a good understanding of this risk and were able to describe what actions they would take if the person had not consumed sufficient food or drink.

Where measures to reduce risks, such as the risk of falling, had not been effective, records did not clearly

reflect the measures taken to reduce the risk and why these had not been successful. For example, where people had refused to engage with external health professionals to reduce risks associated with their health condition. Records did not show actions staff had attempted to take, and the impact of the person's choice on the level of risk they continued to experience. This is important to demonstrate staff had the guidance and information they need to keep people safe. Where it is not possible to reduce risks to a safe level, records should clearly reflect people have been provided with the information they need to make informed choices which are acknowledged and respected in line with their human rights.

We discussed risk assessment records with the registered manager. They told us they were in the process of updating and developing new electronic care plans and would ensure this information was included where required.

The provider had a fire risk assessment in place which had recently been reviewed. People had personal evacuation plans in place which detailed the level of support they required in the event they needed to evacuate the building. People confirmed they were involved in regular fire drills and evacuations and this was confirmed in the records we saw.

We looked at how the risks associated with behaviour that challenges us were managed. We found people's care plans did not provide clear guidance for staff to respond and manage challenging situations. For example, records identified people may demonstrate behaviours that may challenge due to their mental health needs. However, guidance for staff on how to intervene and respond to these situations was limited and incomplete. For instance, one person experienced delusional thoughts and hallucinations. Their care plan did not elaborate on the nature of these thoughts, possible triggers or at what point staff should intervene and how they should support the person and others around them. Daily handover records did not support staff to easily identify if there was a pattern to any behaviours. Staff informed us that one person's behaviour had become a concern and had referred to mental health services for support. However, records did not enable staff to easily identify the frequency of incidents and the outcome following intervention from staff. This meant staff may not have the information or guidance they need to enable them to manage behaviours that challenge consistently and keep people safe.

Staff demonstrated they understood the needs of people who had behaviours that could challenge and how to respond to reduce people's anxiety and distress. We discussed our concerns with the registered manager who acknowledged that records did not support effective management of behaviours that challenge. They told us they would develop behaviour management strategies where required and ensure records supported effective monitoring and evaluation of incidents to keep people safe.

People were supported by a consistent team of staff who had supported them for sometime. Staff were skilled and knowledgeable about people's needs and committed to providing the best levels of care and support for people. The registered manager told us staff were flexible when covering rotas to ensure people were supported by the number of staff required to meet their needs. Staff told us they felt there was enough staff to provide safe care and senior staff were always available to support if needed. One person told us, "I think there is enough staff. They [staff] are always about to ask anything." We observed sufficient numbers of staff to support people and rotas showed that staffing levels were consistent.

People were protected from the risk of unsuitable staff as the provider followed safe recruitment procedures. Staff files we looked at included evidence of employment history, proof of identity and Disclosure and Barring Service (DBS) checks. The DBS carry out a criminal record and barring check on individuals who intend to work with people using care services and helps employers to make safer recruitment decisions. This helped to reduce the risk of people being cared for unsuitable staff.

People received the support they needed to take their medicines safely. One person told us, "They [staff] help me with my tablets. I can't remember what they are for but staff know." We saw medicines were stored safely in a designated area. However, staff were not regularly monitoring the temperature of the storage area or the fridge for refrigerated medicines. This is important to ensure the condition of the medicines is maintained. The registered manager told us they would install thermometers and implement daily temperature checks with immediate effect.

The provider used an electronic system for ordering, monitoring and administering people's medicines. This system enabled staff to identify which medicines people needed and the correct time to administer them. This included medicines that were administered as and when required, for example, pain relief. If staff scanned in and attempted to administer an incorrect medicine or missed a dose of medicine, the system flagged this up as an error and staff were quickly able to rectify their actions. This helped to ensure people received their medicines safely because the risk of errors in administering medicines was significantly reduced.

Electronic records included a photograph of the person, together with any allergies and the level of support they needed to take their medicines. The system was linked to a local pharmacist who was able to log in and identify when stocks were running low and prompt staff to re-order. This ensured people's medicines were always available for them. The system provided the registered manager with a daily report which highlighted any errors or near misses and any improvements required. For example, if a medicine round took too long. This, together with CCTV of the medicines area, helped to ensure people received their medicines safely and as prescribed.

People's care plans included an assessment of any risks associated with the person's medicines. At the time of our inspection, no people required medicines administered covertly. However, some people regularly declined their medicines and this had the potential to have an adverse effect on their mental health and well-being. People's care plans identified this risk and detailed action staff needed to take and timescales, such as contacting the person's GP or mental health worker. Staff demonstrated they were aware of the risks people faced and the action they needed to take. They told us they had completed training in the safe administration of medicines and in the use of the electronic system and this was confirmed in records we saw. This meant people were supported by staff who had the skills and knowledge needed to administer medicines safely.

People told us they were happy with the hygiene standards in the service. One person told us, "One staff does lots of cleaning. When I go into the bathroom, it's always clean." We observed staff followed safe infection control procedures. Gloves and aprons were available in communal areas for staff to support people with personal care and prepare meals. Hand sanitizers were also available for staff, people and visitors through dispensers in corridors. We saw staff used these when appropriate. A member of staff was responsible for domestic tasks and we observed them cleaning communal areas whilst following safe infection control practices. Standards of cleanliness were checked and monitored by the administrator and the registered manager through cleaning schedules and check lists.

The registered manager used the information from audits, incidents and complaints to make improvements to the service where people had identified concerns. For example, where one person had left the service unsupervised, they had reviewed access and exit arrangements for all people. They had concluded that it was not practical to introduce locked doors due to the needs of people but had applied for an authorisation for the person to be continually supervised in their best interest to ensure they were kept safe.

Records showed the registered manager reviewed accidents and incidents within the service and took

action to prevent further incidents, Action included referral to external agencies and moving people to ground floor rooms to help keep them safe.

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 any particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Where people's liberty had been restricted, for instance they were unable to leave the service without supervision due to the risk of harm, staff had made appropriate applications and authorisations were in place to support these measures.

Staff demonstrated they understood people's right to make choices and decisions about their care. We observed staff sought people's consent before they supported them and respected people's right to decline care and treatment. Staff used a variety of methods to support people to make choices, such as providing informed choices in line with known preferences, and gestures. Staff told us they had completed training in the MCA and had a basic understanding of the framework of this legislation.

Records showed that people had been involved in the review of their care and decisions as to how their care was provided on a day-to-day basis. However, assessments of people's mental capacity to make specific decisions about their care, support and treatment had not been carried out. Records did not reflect the possibility that people may lack mental capacity at times to make decisions in their best interests due to their health needs. For example, records did not show people were supported to make specific decisions about their health needs, or that they had mental capacity to decline care in their best interests.

This meant that people may not receive the support they need to make their own decisions and choices in line with relevant legislation and guidance. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us they would undertake mental capacity assessments following our inspection visit.

People and relatives we spoke with were positive about the competence of the staff who supported them. One person told us, "The staff are good." Another person told us, "Morning and night staff are here to help. They check if I am alright. Any problem, I just ask and they help me." The person gave an example how staff had supported them when they had been feeling unwell, including liaising with medical professionals to ensure they got the treatment they needed. A relative told us, "I am sure [name of family member] is well looked after." They went on to tell us that staff communicated with them about their family member's well-being, including health appointments which helped to keep them involved in their family members' care.

People's needs were assessed before they began to use the service to identify the support they required. Each person was supported to identify an outcome of their care which ranged from maintaining their health and well-being, to maintaining and developing their independence. The service worked with external health professionals, such as community mental health teams, and specialist agencies, for example substance abuse, to support people to achieve their outcomes. This joint working helped to provide people with care that was effective and in line with best practice.

Staff felt they had undertaken sufficient training and had the support they needed to enable them to provide effective care. Most of the staff employed had worked at the service for some time. One staff member told us, "I have just completed training in mental capacity and dementia. I hadn't done that before. Any training and [registered manager] signs us up for it." The staff member told us they were signing up for further development training to enhance their skills and knowledge. Another staff member told us, "There is enough training, and we talk about things as a team, for example changes in people's needs." They told us this helped them to share their knowledge and skills. Another staff member told us the registered manager had reviewed how training was provided and it was now a balance of electronic and face-to-face training which supported their learning.

New staff completed an induction into the service through completing essential training and working alongside experienced staff. This helped them to get to know people before they began to support them. The registered manager told us two staff were working towards the Care Certificate. This is a set of nationally recognised standards which supports staff working in care and support to develop the skills, knowledge and behaviours needed in their roles.

Training records confirmed staff had undertaken a range of training and this was reviewed and updated on a regular basis. However, we found staff had not always completed training to support them to understand the needs of people living with complex mental health needs, though they demonstrated a basic understanding of mental health. We recommend that the service finds out more about training for staff, based on current best practice, in relation to the specialist needs of people living with mental health needs.

Staff told us they felt well supported in their roles. They told us there had been many changes since the provider had purchased the service and they had been supported to understand the need for changes. One staff member told us, "[Registered manager] is teaching us the importance of recording. She tell us, if it's not noted, it didn't happen. I have supervision each month and I feel well informed (about the changes in the service) and able to make suggestions." Another staff member told us, "I have the support I need. She [registered manager] is strict but she addresses things which is good."

People were encouraged to be involved in meal-times and to make their drinks if they wished to. We observed people were comfortable in helping themselves to a cup of tea and taking it to drink wherever they preferred. Staff offered snacks with drinks or a late breakfast if people had got up late. One person told us, "There is a choice of breakfast and drinks and snacks for elevenses. I'm having my favourite sandwich today for lunch. Then dinner later, Then supper. You can have a sandwich or yoghurt or just a biscuit, whatever you fancy. We just ask staff and they get you something. You can always make yourself a cup of tea or juice. Staff know us and what we like and they always ask what we want."

We observed the lunch-time meal. People were able to choose what they wanted to eat from two options or their own choice. Where people required support to make choices, staff provided this in line with their known preferences. One person was making their own sandwich. They told us, "I spread the bread. Then I take the bones out and make the sandwich. I am really looking forward to it." We observed the person enjoyed making and eating their own lunch. Another person asked for a saucepan after lunch as they

enjoyed peeling potatoes for the evening meal. They told us, "It's my job; I enjoy doing it. I'm good at peeling potatoes." We observed the person enjoyed the task, including cleaning up afterwards.

Staff supported people to meet their nutritional needs. For example, they were aware that one person was at risk of choking and provided all meals in a soft form and supervised them during meal-times to reduce this risk. Another person had expressed a consistent preference for English foods as opposed to foods associated with their culture which they had previously enjoyed. Staff told us they had responded to physical prompts by the person which they had used to indicate their preference and respected this as their choice. One person told us staff were flexible in providing meals. They said, "I just haven't got an appetite and didn't want anything, so staff said have a cup of tea with the others and we'll see what you fancy later. I might have an appetite later." Records showed staff had recorded this information in the person's daily notes to ensure they were offered a meal when evening staff came on duty.

Meals were planned in line with people's preferences and staff ensured choices included people's favourite foods, such as pilchards and burgers. One staff member told us, "I always cook a nice roast on a Sunday and special meals of buffets with cake for birthdays." People were supported to eat out in the community through pub lunches and takeaways if they wished.

Staff supported people to maintain good health. These included routine health appointments and specialist appointments. For instance, one person's care plan stated staff were to support for all health appointments as the person was unable to retain information due to their memory loss. A person told us how staff had supported them to access their GP when they weren't feeling very well and had supported them to go back when treatment wasn't working. They told us, "It's feeling better now and they [staff] are asking me all the time (how I am)."

Some people were living with health conditions for which they had declined medical treatment. One relative told us, "I know staff had tried to support him to get treatment, but no, [name of family member] won't." Where people had declined treatment, and health professionals had assessed they had mental capacity to do so, this was recorded in their care plans and staff continued to monitor the impact this decision had on the person's health and well-being. Staff told us if they felt people's health and well-being was at risk, they would review the decision with the person and relevant external professionals to ensure the person was aware of the impact of their decision. This demonstrated staff worked with other professionals to obtain the support people needed to stay healthy and well.

The premises were clean and comfortable but there were areas where improvements were required. Some flooring areas were heavily soiled and worn, heating arrangements in some bathrooms were basic and insufficient in some communal areas, such as the dining area and some communal areas and corridors looked tired and drab. Corridors were narrow and accessible only by stairs. The provider discussed plans to upgrade the premises to provide more suitable accommodation. This included fitting a stair lift to support people as their mobility declined, an upgrade of décor and soft furnishings and on-going maintenance and repair of the building. Some bedrooms had been decorated and some furnishings had been replaced in the dining area. The registered manager told us they had to introduce changes slowly to people as they became very anxious and disturbed by any changes to their environment. They told us this work was on-going and a plan of refurbishment had been agreed with the provider.

Good

Is the service caring?

Our findings

People and relatives were positive about the staff who provided care, referring to all staff as being 'Friendly, caring and welcoming.' Staff spoke fondly about the people they supported and were committed to providing good care.

Staff understood the best communication methods for people and were knowledgeable about the people they supported. For example, one person no longer communicated in English but had reverted to their first language. Staff had supported the person to move around the premises independently through signage which included their name, directional signage in English and in their preferred language. Staff told us since using this system, the person had been able to find their way around without staff support. Staff had also used technology through Google to identify key phrases and sentences in the person's first language to enable them to communicate with the person, in addition to signs and gestures. This enabled the person to express themselves and be involved in their care.

People had information on how to access advocates. The service user handbook included contact details of a range of advocates, including specialist agencies who were experienced in supporting people living with mental health needs. An advocate is an independent person who can help someone express their views and wishes and help ensure their voice is heard. This provided people and their relatives with information about independent agencies who could offer support or advice if needed.

Relatives were supported to visit when they wished and confirmed that staff involved them in their family member's care which supported effective communication. Care plans included the involvement of relatives in their family member's care. For example, for one person it was important to attend a specific church every weekend. Staff had liaised with the family to ensure the person was supported to attend church every weekend in line with their wishes.

The team of staff had spent time building positive relationships with one another as well as people using the service . Staff spoke about working 'as a team' and feeling like 'a family'. This was evident through observations and discussions. Each member of staff had detailed knowledge about people's likes, dislikes, preferences and how to manage complex behaviours or health needs. A staff member told us, "I have worked here a long time and it's the people who keep me here, every day is different. I know people, their individual interests. I sit down and talk with them. It's important that they trust us." We saw staff had good banter with people which encouraged a relaxed and informal atmosphere for people. Staff told us the registered manager ensured rotas were arranged so that there were sufficient numbers of staff to spend time with people. This included one-to-one time where people required support to go out on activities. This demonstrated staff had the time they needed to provide person centred care.

Staff were aware of the need to ensure people's information was kept confidential and not disclosed to anyone without the appropriate consent and authorisation. Confidentiality statements were read and signed by staff as part of their employment. People's personal documentation was locked in the main office and daily records and care plans were held electronically, accessed only by relevant people. These were

accessed by a laptop. Each member of staff had their own password and any open screen was timed out once idle. This helped to ensure people's data was protected in line with legislation and best practice.

People were supported to be as independent as possible, with some people going out into the local community independently, Staff encouraged people to do as much as possible for themselves. People told us this was important to them. One person told us, "I like to walk around town most days. It's not far. That's what I like to do. Then I like to come back here." Throughout our visit we observed people were encouraged to be involved in the day to day running of the service, such as making drinks and snacks, cleaning and contributing to decisions such as shopping lists and meal choices.

Staff knew how to provide care in a dignified way. We observed staff offered support and prompts regarding personal care discreetly and with compassion. Staff addressed people by their preferred name and spoke to people with respect . This was confirmed by a person who told us, "Staff are okay, they are respectful to me." Staff encouraged and supported people to maintain their personal hygiene and appearance; supporting them to choose new clothes when required to help maintain their dignity.

Requires Improvement

Is the service responsive?

Our findings

People and relatives felt staff were responsive to people's needs. One person told us staff had identified they were struggling to go upstairs and had discussed moving to a ground floor bedroom to support the changes in their mobility. The person had agreed with the move and was proud to show us their new room and the positive impact this had had on their well-being. A relative told us staff had referred their family member to health professionals as they were concerned about their health condition. As a result, the person had a walking aid which supported them to move freely around the service.

The assessment and care planning process considered people's needs, hobbies and interests along with goals and wishes for the future. People had been involved in developing their care plans. A relative told us they had been involved in their family member's care by providing pictures to help them communicate. Although care plans detailed what was important to people, records did not always include key information about a person's life history and significant events. Records detailed support that people required, for example personal care, but did not provide detailed guidance as to how the support was to be provided. For instance, routines, approaches, or what people liked to have around them. This is important to enable staff to understand and relate to each person and to provide personalised care.

Staff demonstrated that they had this knowledge and were able to explain, in detail, how they supported people and key information that was important to know to build a relationship. However, staff who were new to the service would be reliant on experienced staff being available to share this information with them rather than following any guidance in care records. This could result in the potential loss of essential information and people receiving inconsistent care. The registered manager told us they would review records to ensure care plans were person centred.

People were involved in the review of their care and records reflected this. For example, people were supported to share their views about their care, review their desired outcome and make any changes to how their care was provided. Where people had made changes to their outcomes, these had been recorded as part of the review and the care plan updated accordingly. This helped to ensure care records reflected people's current needs.

The provider had plans to install Wi-Fi throughout the building and provide a desk-top computer for people to use. Staff made use of web applications to enable them to communicate with a person whose first language was not English, including downloading films for their viewing. This helped to promote effective communication with the person.

People told us they were able to explore hobbies and interests of their choice, and could choose how they spent their time. One person told us, "I'm not doing anything today. I like watching TV and I like going into town. I can get the bus or walk, but I just fancy sitting here today and playing a game." We observed students who were on a work placement at the service encouraging people to join in board games, with some success. One student told us, "We are playing board games this morning with people who want to play. They [people] sometimes say no but then enjoy it when they join in. Last week, a couple of people did some

painting, One person especially enjoyed making butterflies and painting them so we might do some this afternoon." We saw artwork was displayed on communal noticeboards and one person took pleasure in pointing their work out to us and was proud to see it on display.

We observed some people were able to leave the service with minimum reference to staff to go out to local shops or for a walk, if it was safe for them to do so. Staff told us it was important to support people to feel part of the local community and maintain their independence as far as possible. This helped to reduce the risk of social isolation for people.

The provider was developing a policy to comply with the Accessible Information Standard (AIS) should they need to support a person to access information in a specific way due to their disability or sensory loss. The AIS is a framework put in place from August 2016 making it a legal requirement for providers to ensure people with a disability or sensory loss can access and understand information they are given.

People we spoke with were confident to raise concerns or complaints if they needed to. One person told us, "I haven't complained but I know there's a form for it. It's in the hallway and you have to fill it in. I know who the manager is." Another person told us if they had any concerns they would, "Just tell staff."

People were supported to share concerns and complaints through the provider's complaints policy. This was available in a summary format in communal areas and in the service-user handbook which was accessible for people and their relatives. The policy provided people with clear guidance on how to make a complaint, the process for investigating and responding to their concerns, and contact details for external agencies should people wish to escalate their complaint. Records showed there had been no external complaints but four internal complaints had been received. The registered manager told us these had been linked to changes in a person's needs and care records detailed the action taken in response to these concerns. This demonstrated that the provider took complaints seriously, listened to people and took action to resolve their concerns to their satisfaction.

Requires Improvement

Is the service well-led?

Our findings

People were generally positive about the management and leadership of the service. Comments included, "The home is alright, I'm alright," and "I'm fine, it's okay here. I am well looked after," and "It's okay, a nice home," and "I've never seen anything bad here. It's alright here." A relative told us they thought their family member was well looked after and staff communicated well.

The service had a registered manager in post and they were supported by a deputy and an administrator. This simple structure supported effective communication and information sharing between management and staff. Staff were positive about the leadership of the registered manager. One staff member told us, "She [registered manager] has inherited a lot of work here. The transition to improve things is not easy but first impressions are good. The training and development is better now. She is someone you can work with, make suggestions and feel listened to, she addresses issues." Another staff member spoke of an 'Open-door' culture where they felt they could raise issues or queries with the registered manager when they needed to. Another staff member said, "It's an open culture here. We are like a big family, we know one another and enjoy the work. I would like to see improvements in the decorating and state of the home but [registered manager] is aware of this and it is being planned for."

Staff were supported to share their views through staff meetings. We looked at records relating to a meeting held in August 2017 and saw a range of issues were discussed. These included reviewing working practices under key policies, such as infection control and food hygiene, in addition to any changes to the needs of people. The registered manager used these forums to share information with staff, such as planned changes and development in the service.

The registered manager recognised and supported equality and diversity amongst the staff team. These values were embedded in working relationships between staff, who spoke of working well as a team, supporting and respecting each other. One staff member told us, "We are a multi-cultural staff team. Where some staff are unable to work certain dates due to their religious beliefs and practices, other staff respect this and support by working those shifts. We celebrate key festivals from all faiths and recognise when staff may need extra support, for example for fasting." Another staff member explained how staff covered for each other during key cultural festivals and celebrations which worked well and supported awareness of different faiths and cultures amongst the staff team.

People were supported to share their views directly, through staff, at their care reviews and resident meetings. One person told us, "We have meetings but I can't remember when or what we talked about. I went to Butlins once because we talked about it. If I did want to know about anything, I would ask the staff." Another person told us, "We do have meetings about any problems and the rules." One person felt actions were not always resolved from meetings, such as people seeking cigarettes from other people. We looked at the minutes of a meeting held in November 2017. Records showed discussions around security, safeguarding and behaviour expected, including people not borrowing cigarettes. Staff also used this forum to advise people of the changes in weather and the need to wear appropriate clothing.

The provider had introduced a new system of quality assurance for the service. The impact of quality assurance systems could not be evaluated at the time of our inspection visit. This was because the registered manager had only recently began to undertake quality assurance within the service; with the first audit having been undertaken three days before our inspection visit. The registered manager had not yet had chance to evaluate findings but explained these would be discussed within the management team and actions plans shared with staff. Audits included reviews of care records, staff records, health and safety, maintenance and medication. The registered manager told us they would use outcomes of quality assurance to ensure people were receiving good care and drive improvements and the development of the service.

The registered manager demonstrated they were clear and understood their responsibilities and what was expected of them regarding their legal obligation to notify us about certain events. They kept themselves up to date on best practice by linking with a number of organisations, locally and nationally. This had enabled them to make improvements to the service, such as updating key policies to support best practice and reviewing training and development for staff. Commissioners who we spoke with told us they had no concerns about the service since their contractual relationship started and had not yet carried out a quality assurance visit.

The registered manager demonstrated they were aware of the challenges and limitations of the service. When we inspected the provider was in the process of upgrading the premises. Furniture in some communal areas had been replaced and some bedrooms were in the process of being decorated. We observed that some areas of flooring, heating and decor were in need of replacing and upgrading. The registered manager told us this would be addressed as part of the service on-going improvement plan. However, they were unable to provide us with timescales regarding actions as they had prioritised structural repairs.

During the inspection we noted that some improvements were needed to record keeping. For example, we found care plans did not include mental capacity assessments. Care plans did not always include the detail and guidance staff needed to provide effective, personalised care. The registered manager was aware that some improvements were needed to records and told us they would address this following our inspection.

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 11 HSCA RA Regulations 2014 Need for consent People were not always supported to make choices and decisions in line with legislation and guidance.