Leisure Care Homes Limited

Westcotes Residential Care Home

Inspection report

70 South Parade
Skegness
Lincolnshire
PE25 3HP

Tel: 01754610616

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Westcotes Residential Care Home on 28 June 2016. This was an unannounced inspection. The service provides care and support for up to 17 people. When we undertook our inspection there were 14 people living at the home.

People living at the home were older people. Some people required more assistance either because of physical illnesses or because they were experiencing difficulties coping with everyday tasks.

There was a registered manager in post. The registered manager also managed another home for the provider in Lincolnshire. 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.

CQC is required by law to monitor the operation of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way. At the time of our inspection there was no one subject to such an authorisation.

We found that there were insufficient staff to meet the needs of people using the service. The provider had not taken into consideration the complex needs of each person to ensure their needs could be met throughout a 24 hour period.

We found that people's health care needs were assessed, and care planned and delivered in a consistent way. This was through the use of a care plan for permanent admissions to the home. People were involved in the planning of their care and had agreed to the care provided. The information and guidance provided to staff in the care plans was clear. Risks associated with people's care needs who were permanent admissions were assessed and plans put in place to minimise risk in order to keep people safe. However, this was not so for three people who were on a short stay admission to the home. There were no care plans in place and there was no evidence to support how they had been assessed and how staff were meeting those people's needs.

People were treated with kindness and respect. The staff in the home took time to speak with the people they were supporting. We saw many positive interactions and people enjoyed talking with staff. Staff had taken care in finding out what people wanted from their lives and had supported them in their choices. They had used family and friends as guides to obtain information.

People had a choice of meals, snacks and drinks. Meals could be taken in a dining room, sitting rooms or people's own bedrooms. Staff encouraged people to eat their meals and gave assistance to those that required it.

The provider used safe systems when new staff were recruited. All new staff completed training before working in the home. The staff were aware of their responsibilities to protect people from harm or abuse. They knew the action to take if they were concerned about the welfare of an individual.

People had been consulted about the development of the home. However, the audits to test the quality of the services being provided had not been sustained through out the year. Therefore the provider had no means to judge whether the services provided met people's needs. No systems were in place to monitor the upkeep of the building, that fire equipment was safe to use and that the safety of people from intruders was being monitored.

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.

Checks were not made to ensure the home was a safe place to live.

Insufficient staff were on duty to meet people's needs.

Staff in the home knew how to recognise and report abuse.

Medicines were stored safely. Record keeping and stock control of medicines were good.

Is the service effective?

Good

The service was effective.

Staff ensured people had enough to eat and drink to maintain their health and wellbeing.

Staff received suitable training and support to enable them to do their job.

Deprivation of Liberty Safeguards and the key requirements of the Mental Capacity Act 2005 were understood by staff and people's legal rights protected.

Is the service caring?

Good

The service was caring.

People's needs and wishes were respected by staff.

Staff ensured people's dignity was maintained at all times.

Staff respected people's needs to maintain as much independence as possible.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care was planned and reviewed on a regular basis with them, when they were permanent admissions. This was not so for those on short term admission to the home.

Activities were not planned regularly each day but people told us how staff helped them spend their time and the activities they enjoyed.

People knew how to make concerns known and felt assured anything raised would be investigated.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

People were relaxed in the company of staff and told us staff were approachable.

Audits were not undertaken on a regular basis to measure the delivery of care, treatment and support given to people against current guidance.

People's opinions were sought on the services provided and they felt their opinions were valued. However these were not always recorded.

Westcotes 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 June 2016 and was unannounced.

The inspection was undertaken by an inspector and an expert by experience. An expert by experience is a person who has personal experience of using services or caring for someone who requires this type of service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Before the inspection we reviewed other information that we held about the service such as notifications, which are events which happened in the service that the provider is required to tell us about, and information that had been sent to us by other agencies.

We also spoke with the local authority who commissioned services from the provider in order to obtain their view on the quality of care provided by the service.

During our inspection, we spoke with seven people who lived at the service, a relative, a visitor to the home, five members of the care staff, an activities organiser, a cook, a housekeeper and the deputy manager. The registered manager was not available on the day, but we spoke with them after the inspection. We also observed how care and support was provided to people.

We looked at five people's care plan records and other records related to the running of and the quality of the service. Records included maintenance records, staff files, audit reports and staffing rotas.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at the home. One person said, "I feel very safe. I felt like a prisoner at the last home." A relative told us, "It was nice to have open house but am concerned for residents safety, in light of the incident which happened a few months ago." The incident was given in detail to the inspector, but the registered manager was unaware of this incident. Steps were taken on the day to speak to the staff concerned at the time. The registered manager sent us a notification about the incident.

When we entered the home in the morning the front door was open. When the inspector and expert by experience arrived they were able to walk the full length of the building and were not challenged by any member of staff. We observed in the afternoon a trades person arrive, who was not challenged by staff. They walked through to the dinning room and placed their goods on a table. We brought this to the deputy manager's attention, but they and other staff were not aware of the event.

Staff informed us that a door between the main part of the building, which was used to access the laundry area and the outside of the building should be locked at all times. This was left unlocked for two and half hours. We saw members of the general public walking past this door from a lane at the back of the building. Staff had to be reminded during the day, by the deputy manager to lock another door at the back of the building, by which the general public could gain access to the home.Unlocked doors where members of the general public can have access to the building could pose a risk to people living at the home from intruders, which has happened once this year.

We observed that the fire escape stairs were in a poor state of repair. There was no record of when they had last been maintained and checked for safety of use. This could pose a hazard if people exited the building from that stair-way. The registered manager contacted the fire and rescue service to ask them to visit the home and give them advice. We were later informed by the fire and rescue service of what action they had asked to provider to take to ensure the stairway was safe to use.

When we visited people's bedrooms we saw that in some rooms the window restrictors were either not attached or were broken. Therefore, this could cause a risk of people falling out of the windows or people entering who should not have access. In one room a call bell cord did not reach the bed area. Staff had informed us that the person would ring for assistance, but if in bed would have to get up. this could result in a person falling as the care plan stated they were unsteady walking. In rooms where people had memory loss there were teeth cleaning tablets on display. Staff were unaware this could cause harm if the tablets were taken. Outside areas were unkempt. For example, the back entrance was full of cobwebs, a small patio area had uneven paving and the ramp to the front public pathway had unmarked sloping sides. One person told us, "I'm not so good on my legs and often wonder if I'm going to fall off the edge of the slope."

The provider had an action plan in place with the local authority about certain maintenance issues. We had been given a copy of this prior to our visit. The parts concerning the premises had not yet been completed despite the completion date having passed. This included the radiator covers not being put in place and the chemicals from the laundry not being all removed from display on an open shelf. The laundry was also full of

dust and debris behind the washing machines, which could be a fire hazard. Pull cords in bathrooms and toilets were an infection control hazard as they were not wipeable and were dirty. The provider did not have a maintenance and refurbishment plan in place to address areas which required repair. Therefore, this could put people at risk of harm.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was a breach of section 1a to f and section 2.

People told us their needs were being met, but that there were times of the day when staff were very busy. They told us tea-time, getting up and going to bed time were the worst times of day for staff to respond to their needs. One person said, "The staff always have lots of jobs to do."

Staff told us that the staffing levels were stretched and that at certain times of the day it would be beneficial if more staff were available. They informed us of non- caring tasks they had to complete through the day; such as the laundry and preparing the tea-time meal. One member of staff said, "We could do with one in the afternoon, especially around tea-time. We used to have one from 04:30 to 8:30 and it was stopped. We weren't given an explanation." Another member of staff said, "Tea-time is the busiest. We have to see to people's needs, cook, serve and wash up from tea and someone has to give out the medicines." Staff expressed their concerns if emergency aid was required and did not know whether there would be sufficient staff to respond appropriately.

We observed during the day that staff were always busy and did not have time to sit with people to give them quality time. We observed that during the afternoon for two periods of 15 minutes each time people were left in the sitting rooms; despite one person requiring reassurances about the time of day. During the tea-time period staff were constantly moving about the building completing tasks such as giving medicines, assisting people with their personal needs and serving the tea. They were pleasant to people, but did not have time to talk with people.

The registered manager told us there were no current calculations of the numbers of staff required to meet people's needs. Therefore, they did not know whether the numbers of staff on duty could meet people's needs. Contingence plans were in place for short term staff absences such as sickness and holidays. Gaps were filled by staff working more hours if required.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was a breach of section 1.

Staff had received training in how to maintain the safety of people and were able to explain what constituted abuse and how to report incidents should they occur. They knew the processes which were followed by other agencies and told us they felt confident the registered manager would take the right action to safeguard people. This ensured people could be safe living in the home.

Accidents and incidents were recorded in the care plans. The immediate action staff had taken was clearly written and any advice sought from health care professionals was recorded. There was a process in place for reviewing accidents, incidents and safeguarding concerns on a monthly basis. This ensured any changes to practice by staff or changes which had to be made to people's care plans was passed on to staff. Staff told us they were informed through shift handover periods when actions needed to be revised.

To ensure people's safety was maintained a number of risk assessments were completed and people had been supported to take risks. For example, where people had a history of falls. A falls assessment had been

completed over a number of days. Staff had sought the advice of the local NHS falls co-ordinator to ensure the correct equipment was in place for each person and their falls recorded accurately and walking ability observed. This was recorded in each person's care plan. We observed staff assisting people to use a variety of walking aids throughout the day. Staff gave reassurance and advice to each person on how to walk safely around the building.

Staff told us and people's records confirmed that assessments had taken place on the capability of people to visit the community either with an escort or on their own. Staff told us that some people would not remember how to get back to the home; so a member of staff escorted them. This was recorded in people's care plans. We saw one person going for a short walk. They told us they did not go far and said, "I like a blow in the fresh air."

People had plans in place to support them in case of an emergency. These gave details of how people would respond to a fire alarm and what support they required. For example, those who needed help with walking due to poor mobility. A plan identified to staff what they should do if utilities and other equipment failed.

We looked at two personal files of staff. Checks had been made to ensure they were safe to work with people at this location. The files contained details of their initial interview and the job offered to them. There were no current staff vacancies.

People told us they received their medicines at the same time each day and understood why they had been prescribed them. This had been explained by GPs', hospital staff and staff within the home. This was recorded in people's care plans. Staff were observed giving advice to people about their medicines. Staff knew which medicines people had been prescribed and when they were due to be taken.

Medicines were kept in the main office area and the trolley was attached to the wall. There was a notice on the door stating the office door must be locked when the office was empty. We saw this was not the case for most of the day. This could result in people having access to medicines who were not authorised to do so. When notified of this the deputy manager immediately locked the door and reminded staff of their responsibilities. There was good stock control. Records about people's medicines were accurately completed. Medicines audits we saw were completed regularly as well as a monthly stock check, which we saw for May 2016.. Any actions from the May 2016 audit had been signed as completed.

We observed medicines being administered at lunchtime and noted appropriate checks were carried out and the administration records were completed. However, the trolley was left unlocked whilst the staff member administered two sets of medicines and they could not see the trolley. This could result in people having access to medicines who were not authorised to do so and medicines being stolen. We brought this to their notice and that of the deputy manager and actions were taken to rectify the situation. Reference material was available in the storage area and staff told us they also used the internet for more detailed information about particular medicines and how it affected people's conditions. Staff administrating medicines had all received training. Five members of staff had undergone further checks to test their competence in administrating medicines in April 2016 and May 2016. Each staff member had passed the tests.

Good

Is the service effective?

Our findings

The staff members we spoke with had all been employed by the provider for a long time, which showed a good retention record of staff employment and continuity for people living at the home. However, each staff member told us their induction had been suitable to their needs at that time. This included assessments to test their skills in such tasks as manual handling and communication. This provided the skills they needed to meet people's needs safely. Details of the induction process were in the staff training files. The registered manager told us that the provider was embracing the principles of the care certificate for all staff. This would give everyone a new baseline of information and training and ensure all staff had received a common induction process and core standards to follow.

Staff said they had completed training in topics such as manual handling and infection control. They told us training was always on offer and it helped them understand people's needs better. The training took the form of completing work books, with test certificates and external trainers attending the home. The training records supported their comments. Staff had also completed training in particular topics such as dementia, infection control and stroke awareness. This ensured the staff had the relevant training to meet people's specific needs at this time. Staff told us the provider was encouraging them to expand their knowledge by setting up courses on topics such as management development and vocational training courses.

Staff told us a system was in place to test their competences and also that they received formal supervision six times a year. They told us that they could approach the registered manager at any time for advice and would receive help and supervision until they were competent in a task. The records showed when supervision sessions had taken place, which was in line with the provider's policy. There was a planner on display showing when the next formal sessions were due.

The Mental Capacity Act 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 provider had followed the requirements in the DoLS, but no applications had been made to the supervisory body. The provider had properly trained and prepared their staff in understanding the requirements of the MCA and DoLS.

Staff told us that where appropriate capacity assessments had been completed with people to test whether they could make decisions for themselves. We saw these in the care plans of those living permanently in the home. They showed the steps which had been taken to make sure people who knew the person and their

circumstances had been consulted. However, on two forms staff had not recorded the times best interest meetings had been held and assessments completed to test their mental capacity and ability. We brought this to the attention of the deputy manager.

People told us that the food was good. One person said, "I am full to bursting." After they had eaten their meal. We observed the lunchtime meal and there were empty plates going back to the kitchen area. We saw that at the start of the meal staff had poured glasses of juice for everyone, but did not give people the option of other cold drinks or the offer to decline a drink. We saw staff offering drinks throughout the day to people, but there were no jugs of cold drinks available for people to consume unaided.

The dining room had been redecorated and the tablecloths and cloth napkins matched the décor. Table linen was refreshed after each meal.The menu board in the hall way was blank and the menus could only be accessed from staff and were kept in the kitchen. The people we spoke with were unsure of the menu for the day. There were no menus on the tables in the dining room. This means people had no means of referring back to a menu at meal times as a reminder about the forth coming meals. We observed staff assisting people at lunchtime. Staff spoke quietly with people who required assistance, maintaining eye contact and informing people of what was on their plate if they could not see easily. People told us staff respected their wishes if they wished to take their meals in their rooms. During the afternoon one person was cutting up fruit such as apricots and a banana and offering them to others, after checking with staff this was acceptable.

The staff we talked with knew which people were on special diets and those who needed support with eating and drinking. Staff had recorded people's dietary needs in the care plans of people living their permanently; such as when a person required a special diet and for someone who needed assistance to eat their meals. This ensured people received what they liked and what they needed to remain healthy. We saw staff had asked for the assistance of the hospital dietary team in sorting out people's dietary needs when required.

We observed staff attending to the needs of people throughout the day and testing out the effectiveness of treatment. For example, one person was being encouraged to walk during the day to help their mobility and take some fresh air by sitting outside. We heard staff speaking with people about hospital appointments and other appointments.

People told us staff obtained the advice of other health and social care professionals when required. In the care plans of people living permanently in the home staff had recorded when they had responded to people's needs and the response. For example, when people's behaviours had changed and when they required health checks such as opticians appointments. We also saw in the records when people had visited the chiropodist and dentist. Several of the people had hospital appointments which they had attended. Staff had recorded outcomes of those visits. Staff told us they had a good rapport with other health professionals and felt supported by them when they required assistance. This has ensured people are offered the services of other health professionals to maintain their health and well-being.

Good

Is the service caring?

Our findings

People told us they were well cared for by staff. They said that staff were always polite, respectful and protected their privacy. One person said, "These people who run this place are so so good." Another person said, "Staff are really good." A relative said, "On the whole brilliant." People told us they were supported to make choices and their preferences were listened to.

People were given choices throughout the day of what they wanted to do. Some people joined in activities in a sitting room, whilst others choice the dining room or their bedrooms to relax in. Staff respected people's choices.

All the staff approached people in a kindly manner and were knowledgeable about each person. They were patient with people when they were attending to their needs. For example, one person was worried about moving about with a walking frame. Staff spoke quietly to the person, reassuring them they were there for them and we observed the staff member walking with the person. Another person wanted some reassurance about a forthcoming medical appointment. Staff took them to one side and explained the process and did not leave them until they were happy with the information given to the person. Another person was using the stair lift and they told us staff had ensured they could work it independently before they used it. The person said, "I know it's not much, but it still helps with my independence. Staff spoke in terms I could understand so I can use the lift easily."

Throughout our inspection we saw that staff in the home were able to communicate with the people who lived there. The staff assumed that people had the ability to make their own decisions about their daily lives and gave people choices in a way they understood. They also gave people the time to express their wishes and respected the decisions they made. For example, when asking people about their choices of where to sit during the day. Staff asked them if they were comfortable, had everything they needed to hand and during the day continually asked each person if they wished to be assisted to move or were happy where they were sitting.

Staff told us that they had never witnessed any poor practices in the home between staff members, the people who lived there or visitors. They told us how they would approach this if it occurred, which followed the provider's policy on dignity and respect. One staff member said, "I don't know any member of staff who would not treat people with compassion and dignity. I love it here, and I can confidentially say so does each and every member of staff."

Staff and people told us about the death of a person which had occurred. The person had been living in the home for a long time and their life had finally come to an end. We were told this had affected everyone, but each person had been able to express their thoughts. Offers had been made, which some people accepted, to go to the funeral, whilst others remembered the person on that day in their own ways, which staff respected. One person said, "[Named person] was a character and sorely missed, but staff were there for us and I think we helped them as well. Some young staff don't know about death and dying so we can help them as much as they help us."

People told us staff treated them with dignity and respect at all times. One person said, "They are so good with everyone the staff treat them all marvellous." We observed staff knocking on doors prior to being given permission to enter a person's room. They asked each person's permission prior to commencing any treatment and respected if they wanted pain relief medicine prior to commencement of treatment. We observed staff ensuring people had suitable clothing on when going out of the building and sitting in communal areas.

People told us they could have visitors whenever they wished. We saw several signatures in the visitors' book of when people had arrived at the home and saw several people visiting. Staff told us families visited on a regular basis and they were offered refreshment and opportunity to speak with staff. This was recorded in the care plans. A visitor told us how they had been a resident for a short while in the home. They felt the staff had looked after them well, helping with their independence and expressed how caring the staff were with them. The person said, "The staff are brilliant, just look at me now." This ensured people could still have contact with their own families and friends and they in turn had information about their family member. People told us staff would telephone their family members when they wanted to speak with them.

Some people who could not easily express their wishes or did not have family and friends to support them to make decisions about their care could be supported by staff and the local advocacy service. Staff knew how to contact the local advocacy service. Advocates are people who are independent of the service and who support people to make and communicate their wishes. We saw details of the local advocacy service on display. There were no local advocates being used by people at the time of our inspection.

Requires Improvement

Is the service responsive?

Our findings

People told us staff had talked with them about their specific needs. This was detailed in reviews about their care. Those who lived at the home permanently told us they were aware staff kept notes about them. Those people told us they were involved in the care plan process, but if they could not read their notes staff would do this for them. However, there were no other methods for staff to use except the written English word for notes and assessment tools. No nationally recognised assessment tools were used for people who had a learning disability, impaired cognitive ability or other communication difficulties; such as those associated with dementia. This meant people may not understand their care plans. Staff were aware of people's needs and could describe what each person required to meet each person's individual needs. They told us they did this by talking and listening to people and people's family members. There had been no auditing for care plans since last year.

We looked at three information sheets for people on respite admission to the home. This means they were only in the home for a fixed number of weeks. Each person did not have a care plan in place. On two of the information sheets there was only the name of the person and who to contact in an emergency. On one sheet there was the same information plus a sentence stating they required help. There were no details available to staff about how each person required their needs to be met and how they were being met. Staff told us of the needs of each person; for example that one person had problems moving and could not look after their personal hygiene. This could pose a risk if staff were unaware of each person's specific needs and how to help them maintain their independence safely.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was a breach of section 3 a to i.

Staff received a verbal handover of each person's needs at each shift change so they could continue to monitor people's care. Staff told us this was an effective method of ensuring care needs of people were passed on and tasks not forgotten. Staff used a communication handover book to write down specific tasks which needed completing. We saw entries about medical appointments, medicines and visitors comments.

People told us staff had the skills and understanding to look after them and knew about their social and cultural diversity, values and beliefs. People told us that staff knew them well and how their beliefs could influence their decisions to receive care, treatment and support. Staff knew how to meet people's preferences with suggestions for additional ideas and support. This means people had a sense of wellbeing and quality of life. Staff had used local resources from health and social care agencies to ensure messages were received by people about health matters. Social care professionals we had contact with before the inspection told us staff informed them quickly of any issues. They were confident staff had the knowledge to follow instructions and did so.

People told us that staff took time each day to discuss their care and treatment. As well as the opportunity to speak with other health professionals. This was recorded in each care plan. For example being able to see a dentist when they wanted one for both routine and urgent treatments. A relative told us the health needs

of their family member were being met, but they were charged extra when staff had to accompany them to outside appointments.

We were informed that there was no activities co-ordinator employed, but that recently a bank member of staff was facilitating activities for two hours, four times a week. We observed this person having a bingo session during the afternoon for people who wanted to play. Some people choose to move to a quieter sitting room. People and relatives told us there was a lack of any meaningful stimulation at times. One relative said, "We had to fight tooth and nail to get real stimulation for the residents." The registered manager was aware that activities had recently been given a low priority by staff and was now addressing this issue by ensuring staff had more training in this area, especially for people with memory loss. There were no activities programmes on display, but there was information about local events in the area.

Any activities which had occurred in the last year were recorded in the care plans. This was mainly group events such as art sessions, music to movement and entertainment. Staff told us no one had any current hobbies that they were involved in. We observed staff talking to people about family photographs on display and about television or radio programmes when visiting them in their bedrooms.

People confirmed that a religious leader from a local church visited once a month to offer support for people's spiritual needs. One person explained their love of dancing and how staff had arranged to take them out to dances. They said, "Had a few dances while I have been here." Another person told us they went for a walk each day and that the staff had encouraged them.

We observed an external provider who had arrived in the morning to facilitate a reminiscence session with people. Eight people joined in and the theme was old days on the buses and trams. The facilitator had a good knowledge about each person partaking in the session, so was able to help them join in. They told us their session times had been cut down, but they still came four times a year. People became very animated and involved as they remembered trips they had taken years ago.

People were actively encouraged to give their views and raise concerns or complaints. People's feedback is valued and concerns discussed in an open and transparent way. People told us they were happy to make a complaint if necessary and felt their views would be respected and staff always listened to any concerns. Each person knew how to make a complaint. People told us they felt any complaint would be thoroughly investigate. We saw the complaints procedure on display.
The complaints log detailed the formal complaints the manager had dealt with, but there had been none since 2011. It recorded the details of the investigations and the outcomes for the complainant.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post. People told us they were well looked after, could express their views to the registered manager and felt their opinions were valued in the running of the home. One person said, "The deputy manager has been lovely." Another person said, "The manager does come, but I believe she runs another home, so we don't see her so much these days. [Named staff member] is lovely though when she is in charge." We were aware that the deputy manager at this home has applied to CQC to become the registered manager, which will give continuity to people and staff.

The provider had a website to inform people of the services they provide. However, this was not up to date. This did not give the full details of the services currently being provided and the video was narrated by a previous manager. This did not give a true reflection of the home and could misinform people. The last CQC inspection report and the provider's certificate were on display, but this was in the staff office. This could not be seen by visitors and it is a requirement this be on display. The deputy manager was having these moved during our inspection.

People who lived at the home and relatives completed questionnaires about the quality of service being received. People told us they had completed questionnaires. The last questionnaire had been in early 2016 for people who used the service and was very positive. Comments included, "get looked after" and "nothing I'm happy". Relatives had completed a questionnaire in early 2016. This had positive results. Comments included, "try home from home" and "staff caring." Staff told us meetings were held with people who used the service, but these were infrequent. We saw the minutes of the last meeting, which was in June 2015.

Staff told us they worked well as a team and felt support by the registered manager. One staff member said, "Staff work together." Another staff member said, " I can speak up and know my views make changes."

Staff told us staff meetings were held. They said the meetings were used to keep them informed of the plans for the home and new ways of working. We saw the minutes of the staff meeting for January 2016. The meeting had a variety of topics which staff had discussed, such as; rotas and training. This ensured staff were kept up to date with events, but the staff meetings did not occur very frequently. Staff told us they felt included in the running of the home. This was reflected in records seen. One staff member said, "I can voice an opinion." However, the provider did not have a staff management tool to address issues such as staffing levels at different times of the day.

The deputy manager was seen walking around the home during our inspection. They talked with people who used the service and visitors. They could immediately recall items of information about each person. They gave support to staff when asked and checked on people's needs. Where necessary they also assisted with some personal care tasks; such as assisting someone at lunchtime.

There was some evidence to show the registered manager and deputy manager had completed audits to test the quality of the service. These included cleaning, wheelchairs and call bells. However, the majority of the audits had not been regularly completed. For example the environment audit has not been completed

since April 2016. Where actions were required these had been clearly identified, but not signed when completed. There was some duplication of audit process, which meant that staff did not know where to go for the latest information. Any changes of practice required by staff were highlighted in staff meetings, which occurred occasionally and daily shift handovers so staff were aware if lessons had to be learnt.

There was a policy manual in place which was available for staff to refer to at any time. However, this had not been reviewed since April 2014. Staff had signed in 2015 when they had read the manual, but this did not include new staff. This could result in staff not having sufficient up to date information about to enable them to do their job.

People's care records and staff personal records were stored securely which meant people could be assured that their personal information remained confidential. The registered manager understood their responsibilities and knew of other resources they could use for advice, such as the internet and local multi-agencies.

Services that provide health and social care to people are required to inform CQC of important events that happen in the service. The registered manager of the home had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.

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 9 HSCA RA Regulations 2014 Person-centred care Three people resident in the home did not have care plans in place. Therefore staff were not aware of their needs and how these were required to be addressed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment There was no method in place for monitoring the upkeep of the premises and no refurbishment plan. The fire escape stair way was in a poor standard of repair.