Mr & Mrs S Munnien

South Wold Nursing Home

Inspection report

South Road
Tetford
Horncastle
Lincolnshire
LN9 6QB

Tel: 01507533393

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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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We inspected South Wold Nursing Home on 9 August 2016. This was an unannounced inspection. The service provides care and support for up to 16 people. When we undertook our inspection there were 16 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, with some having loss of memory.

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.

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, usually to protect themselves. At the time of our inspection there were two people subject to such an authorisation.

We found that there were sufficient staff to meet the needs of people using the service. The provider had taken into consideration the complex needs of each person to ensure their needs could be met through a 24 hour period.

We found that people's health care needs were assessed, and care planned and delivered in a consistent way through the use of a care plan. 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 were assessed and plans put in place to minimise risk in order to keep people safe.

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 to the staff in the home. The staff on duty knew the people they were supporting and the choices they had made about their care and their lives. People were supported to maintain their independence and control over their lives.

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 had not ensured that suitable measures had been taken to ensure the premises were safe to live in. Maintenance of the building was not planned and not all staff trained in fire safety.

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, but not all had received updated training. They knew the action to take if they were concerned about the welfare of an individual.

People had not regularly been consulted about the development of the home and quality checks had not been completed to ensure services met people's requirements.

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.

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

Staff in the home knew how to recognise and report abuse, but not all had received training.

Medicines were stored and administered safely.

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?

Good

The service was responsive.

People's care was planned and reviewed on a regular basis with them.

Activities were planned into most days and people told us how staff helped them spend their time.

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 to measure the delivery of care, treatment and support given to people against current guidance.

People's opinions were sought about their daily needs, but only occasionally about the services provided. However, they felt their opinions were valued when asked.

South Wold Nursing 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 9 August 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.

We used the Short Observational Framework for Inspection (SOFI). SOFI is way of observing care to help us understand the experience of people who could not talk with us.

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. We spoke to social care professionals before our visit.

During and after the inspection, we spoke with seven people who lived at the service, five relatives, two members of the care staff, two trained nurses, a member of domestic staff, a cook, two administration staff and the registered manager who also is the part owner in the home. We also spoke with two visitors to home. We spoke to an external trainer after the inspection. We also observed how care and support was provided to people.

We looked at four 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, minutes of meetings and audit reports the registered manager had completed about the services provided.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at the home. Coded push keypads were used at the home for the main doors into the home. A notice informed visitors and people living in the home to ask staff for the code. We observed visitors and relatives asking staff to let them out of the home, as only staff knew the code. This kept people feeling safe and secure. We were asked for identification on entering the home and instructed to clean our hands before being shown the way to the registered manager's office. However, people whose bedrooms had patio doors leading on to the garden had visitors who used that method of entry.We observed visitors entering by those doors. Therefore, staff may not be aware they were in the building in the event of a fire and could also be a means of entry for other persons not connected to the home. The registered manager said they would speak with those visitors.

We observed that in some rooms the window restrictors had come loose or were not attached correctly. This could mean that people could fall out of the windows or they could be used as a means of entry. The registered manager told us they would have to access an outside resource to repair the window restrictors.

We were informed by staff and people who used the service that there were hot water issues in some parts of the building. This affected one side of a corridor. The provider had begun to take remedial action to correct the lack of hot water for people's use, but more work was required. The staff were carrying containers of hot water to bedroom areas. At the time of our visit there was no risk assessment in place for the carrying of hot water. This was later sent to us.

The quiet room at the back of the building, which was the only other main sitting area for people living in the home to use was cluttered. This appeared to be being used for the storage of wheelchairs and other equipment. People could not access the computer, which had been placed in that room for their use. This was also a falls risk for people who were unsteady on their feet.

There were a number of uneven surfaces around the walkways of the premises. One set of patio doors had uneven paving slabs immediately outside the door, which would be a trip hazard. The ramp to the front door had raised edges with no hand rails and we observed one visitor nearly falling over the edge of the ramp.

Some areas of the home looked tired and the furniture was worn in places. The manager told us they redecorated people's rooms when they became vacant and if people requested them to be redecorated. However, there was no planned maintenance programme in place for other areas of the home. We saw a list of equipment which had been serviced, with most items requiring a review in 2018. A plan identified to staff what they should do if utilities and other equipment failed. Staff were aware of how to access this document.

The provider was working through the last fire and rescue services report from July 2015. There were still a couple of items still outstanding. The fire risk assessment had been updated in July 2016. This identified actions to be completed including sign posting and staff training. Some staff had not received fire training

since 2014. 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 because they would not remember where the exit doors were in the building. A relative told us they felt fire safety had improved as the provider had purchased fire sledges to help in the evacuation of the building if a fire or other incident occurred. We saw these had been placed around the premises. A fire drill notice informed people and visitors when the next drill would take place. A relative told us they had taken part in a role play exercise, unbeknown to staff, of a fire in the laundry. The staff response had been quick.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2015. This was a breach of Section 1 a to f of the Health and Social Care Act 2008.

People could choose whether to have their bedrooms doors locked or left open. One person requested their bedroom door to be kept locked while they were in their room. We saw that staff carried out that request. The person also confirmed that staff respected their wishes.

We were invited into eight people's bedrooms to see how they had been decorated. People told us of their involvement in the layout of the bedrooms. They told us they were happy how their rooms were kept clean. Staff had taken into consideration when writing the care plans of environmental risks for some people, especially those with loss of vision and memory loss, in case of trip or fall hazards . This included ensuring rooms were free of trip hazards from trailing wires.

Some staff had received training in how to maintain the safety of people, but not since 2011 and 2014, other staff were soon due to receive that training. Staff 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 and social care professionals was recorded. There was a process in place for reviewing accidents, incidents and safeguarding concerns, which the provider's policy stated should be completed on a monthly basis. However, this had last been completed in June 2016. The process ensured any changes to practice by staff or changes which had to be made to people's care plans was passed on to staff. Information was passed on to staff at shift handovers and meetings. We saw this in the staff meeting minutes for January 2016.

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. Staff had sought the advice of the local NHS falls co-ordinator to ensure the correct equipment was in place for each person. Where necessary permission had been sought for the use of bedrails, to ensure a person was safe in bed, this was being monitored by staff. 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. This was to ensure each person was capable of being as independent as possible.

People and relatives told us their needs were being met and there were sufficient staff available each day. One relative said, "Staff are busy people, but always make time for you."

Staff told us that the staffing levels were good. One staff member said, "We have enough staff. Sometimes at tea time it can be busy." Another staff member said, "Just enough staff." Staff told us that if there were short

term staff shortages that the registered manager would assist with the personal care and treatment of people who needed it. We observed this during our visit.

The registered manager told us how the staffing levels had been calculated, which depended on people's need and dependency levels. Contingence plans were in place for short term staff absences such as sickness and holidays to ensure that sufficient staff were available.

We looked at two personnel 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 was a current vacancy for a trained member of staff, and an interview had been set up by the registered manager.

People told us they received their medicines and understood why they had been prescribed them. This had been explained by GPs' 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 a locked area. There was good stock control. Records about people's medicines were accurately completed. The registered manager had last completed a medicines audit in January 2016. This had now been passed to an outside agency to monitor, which was confirmed by them. The local pharmacy had completed an audit in April 2016 and there were several actions to be completed. There was no record to show these had been completed.

We observed medicines being administered at lunchtime and noted appropriate checks were carried out and the administration records were completed. Staff informed each person what each medicine was for and how important it was to take it. They stayed with each person until they had taken their medicines. Staff who administered medicines had received training. 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.

Good

Is the service effective?

Our findings

People we spoke with told us their health needs were being met. One person told us about a medical condition. They said, "Oh, the tissue nurse comes to see me." A relative told us, "[Named relative] legs were bad, but here they have been made them a lot better."

All the staff we interviewed told us they had worked in the home for a number of years, which was confirmed in their records. However, they told us when they had been recruited their induction period had suited their needs. This included assessments to test their skills in such tasks as manual handling and first aid. Details of the induction process were in the staff training files. The registered manager told us that all staff were to be enrolled in the care certificate. This would give everyone the same standard of information and training and ensure all staff had received a common induction process.

Staff said they had completed training in topics such as manual handling and health and safety. They told us training was always on offer and it helped them understand people's needs better. A staff member told us the training records were not completely up to date. However, we spoke to staff who told us when they had been booked on a variety of courses such as infection control. We also spoke to an external trainer who confirmed the topics and dates when staff had been booked on to mandatory courses. 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 specific topics. This included national vocational awards and topics suited to their department such as nutrition and the use of chemicals.

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

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

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

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that the provider had followed the requirements in the DoLS. Two applications had been submitted to the local authority. 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. They showed the steps which had been taken to make sure people who knew the person and their circumstances had been consulted. Staff had recorded the times best interest meetings had been held and assessments completed to test each person's mental capacity and ability.

People told us that they liked the food. A relative told us their family member required to have a soft textured diet and this was always well presented. Another relative told us, "[Named relative] eats well and has put on weight."

Staff 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 such as when a person required a special diet. The cook also kept a dietary profile on people in the kitchen area. This included people's likes and dislikes, foods to avoid and the type of diet required. There were also lists on display in the kitchen area to aid staff on how people liked their hot drinks presented, such as requiring sugar and what they usually liked to have as a bedtime drink. 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.

Menus were available and on display at the entrance to the dining room. The menus were in word and picture format and were changed after lunch to show the tea time menu. We observed staff reminding people about the times of various meals and what was on offer. If people did not want the choices on offer the cook went to speak with them and offered alternatives if people did not have a special preference.

We observed the lunchtime meal. The dining room was small, but there were enough seats for people not to be squashed into the area. Staff respected people's wishes of where they would like to eat, such as their own bedroom or a sitting room. Staff ensured each person was sitting comfortably and had all the utensils and condiments they required. We observed staff sitting with people who needed help to eat and drink. They spoke kindly to them, maintaining eye contact and informing them what was on the plate or bowl. Staff did not hurry people. People were offered hot and cold drinks throughout the day and there were jugs of juice or water available which people could help themselves to or staff were observed helping them. People were not always offered clothing protectors when they ate and some were observed spilling food on their clothing. One person asked for their trousers to be changed following lunch, which staff attended to.

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 with the aid of a walking aid, but staff followed with their wheelchair in case they became tired. We heard staff speaking with relatives about GP visits and hospital appointments, after obtaining people's permission. This was to ensure those who looked after the interests of their family members' knew what arrangements had been made. We heard staff discussing with people the effectiveness of some new medicine and asking them how they felt about the treatment. All events and comments we saw staff record in the care plans.

People told us staff obtained the advice of other health and social care professionals when required. In the care plans we looked at staff had recorded when they had responded to people's needs and the response. For example, when people's behaviours had changed after a relative had left the home and when they required health checks such as blood tests for a medical condition. Staff had recorded when people had seen the optician and dentist. Some 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.

Good

Is the service caring?

Our findings

People and relatives told us they liked the staff and felt well cared for by the staff. One person said, "I am really well cared for." Another person said, "The staff cannot do enough for you." A relative said, "I cannot speak highly enough of the care that my [named relative] receives." Another relative said, "Really very kind staff,"

People told us staff treated them with dignity and respect at all times. One person said, "Care is marvellous." A relative told us, "We have seen when [named relative] goes into the lounge everybody is treated like family."

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 medication prior to commencement of treatment.

The people we spoke with told us they were supported to make choices and their preferences were listened to. One person said, "The staff are always patient with me." A relative told us, "When I reach that age I would willingly be resident here."

People were given choices throughout the day if they wanted to remain in their bedrooms, bed or where they would like to sit. Some people joined in happily and readily in communal areas. Others declined, but staff respected their choices on what they wanted to do.

All the staff approached people in a kindly manner. They were polite and sensitive to people's needs. For example, when a person asked continually throughout the day about the time their relative would visit, staff were patient with that person and ensured they consistently gave the person the same message. We also observed people who wanted to mobilise independently, but slowly, being allowed to do.

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. When we had difficulty in communicating with one person we asked a staff member for assistance. We could immediately see the person we had been trying to communicate with was at ease with the staff member and recognised them.

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. However, the visitors signing in book was a remarks and comments book and people had recorded in and out times in different columns. This could lead to confusion if a head count was required in the event the building had to be evacuated. Staff told us families visited on a regular basis. Relatives told us they were offered refreshment when visiting. One relative told us, "I have had my lunch here; last week actually I had left my lunch behind." This was recorded in the care plans. Another relative said, "No restrictions on visiting." This ensured people could still

have contact with their own families and they in turn had information about their family member.

To further help people maintain contact with their families and friends a land line phone was available for people's use. One person also had their own personal telephone line. A lap top computer was available for people to use, if it was their preferred method of communicating with their families and friends.

All members of staff were involved in conversations with people and relatives. Each staff member always acknowledged people when walking around the building. Greeting each person with a smile and asking a person's well-being or engaging in lengthier conversations. Conversations were overheard about the weather, the gardens, the news and menus.

People were treated with dignity and respect at all times. This was performed in very subtle ways, such as ensuring people's clothing was not in disarray after using a bathroom and suggesting people wore the correct foot wear around the home. We heard one person says they did not like to see a person's bare feet, so staff gentle asked the person if they would not mind wearing some covering and the person put on their slippers.
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Staff gave us examples of how they would like to be looked after.They told us how they had helped people become what they termed, "part of the family", by introducing them to people who wanted to interact with others. They told us they respected people's wishes to remain in their bedrooms. We observed staff ensuring people in their bedrooms had everything they required, including a call bell. Staff did not leave each person until they were satisfied they were happy in their environment.

Staff told us that the registered manager lead by example in how to look after people. We saw the registered manager instructing staff and interacting with people throughout the day. They did this in a kind and compassionate manner. They ensured people were had everything they required before moving on to another person.

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. 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.

Good

Is the service responsive?

Our findings

The people we spoke with and relatives gave us positive views about the response times of staff to their needs. They told us staff responded to their needs quickly. One person said, "Really well." A relative said, "I do not worry when I leave here." People told us staff responded quickly when they used their call bell, day and night.

People told us staff had talked with them about their specific needs. This was in reviews about their care. They told us they were aware staff kept notes about them. People informed us they were involved in the care plan process, but if they could not read their notes staff would do this for them. A member of staff was given four hours of work each week to ensure the care plans were up to date, but other staff made amendments when necessary and passed those messages to others at the daily handover.

Staff received a verbal handover of each person's needs 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. There was also a handover book in use, which recorded and asked staff to complete tasks such as phoning a GP and to reinstate a person's diet regime after a health professional's visit.

People shared with us how they felt the skills and understanding of staff to look after them and how staff were aware of their social and cultural diversity, values and beliefs. People told us that staff knew them well. 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 been responsive in obtaining advice from people such as local GPs, district nurses and different people in the local hospital, which was recorded in people's care plans. Information leaflets were also on display about a variety of topics such as; local health care services and some leaflets on specific illnesses to ensure people had information to help them make decisions about their care needs as they arose.

People informed 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 required one. People shared with us the times they had visited other health and social care professionals such as GPs and community nurses. 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.

We were informed by the registered manager that all staff contributed to social activities. The social activities assessments in people's care plans stated people's general interests, past employment and preferred social activities. There was no weekly planner for activities displayed, but staff told us they liked to do whatever people wanted to do each day. This was recorded in the daily notes of people's care plans. We heard the staff arranging an outing to a local public house for a meal. People informed us of the types of visits they had been on such as visiting the local market and a garden centre. During our inspection a visiting facilitor was observed assisting people with some chair exercises to increase movement in people's limbs. Staff were also involved in the session.

We observed notices around the home to guide people who might have memory loss; either on their bedroom doors or to guide the way to other areas such as the dining room. We observed staff directing people to those areas.

People were actively encouraged to give their views and raise compliments, concerns or complaints. People informed us feedback was 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. Each person knew how to make a complaint. No-one we spoke with had made a formal complaint since their admission. People told us they felt any complaint would be thoroughly investigated and the records confirmed this. A relative told us they had raised a concern some time ago but the registered manager had listened to them and the problem had been resolved. We saw the complaints procedure on display. The complaints log detailed the formal complaints the manager had dealt with since our last visit. It recorded the details of the investigations and the outcomes for the complainant. Lessons learnt from the cases had been passed to staff at their meetings in 2015 and 2016.

The compliments book was very full and gave many positive comments about the care which had been delivered to individuals. Some thank you cards for care recently delivered were on display. We had been sent letters by three people who had been users of the home or had visited the home. They were all very complimentary about the services which had been provided.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post. People told us they could express their views to the registered manager and felt their opinions were valued in the running of the home. A relative said, "You are treated more like family, staff are so friendly."

Questionnaires about the quality of the service were only sent out by the registered manager on a regular basis. The last one was in 2015 for visitors and people who used the service. There was no analysis of the results. The last relatives meeting had been in December 2015. Some issues had been raised such as problems with hot water, which had only partially been dealt with at the time of our inspection.

The registered manager had put together a general action plan in July 2016 of items which required to be completed to test the quality of the services offered to people. These included audits on staff files, care plans and equipment checks. The action plan had begun to identify target areas, lines of responsibility of staff and progress checks, but was in the early stages of development. A further registered manager's report was split into sections such as health and safety, fire and infection control. Both had only just commenced and two staff members had been specifically identified to help the registered manager with the reports.

The registered manager and staff told us some staff had designated roles within the home. Such as infection control, fire and dementia. Staff told us it was the responsibility of those staff to gather information on their chosen topic and pass on learning to others. Staff had only just begun to develop those roles.

Staff told us they worked well as a team and felt supported by the registered manager and other staff. One staff member said, "I love to come to work." Another staff member said, "I like my job. I look after them as though they were my mum."

Staff informed 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 June 2016. The meetings had a variety of topics which staff had discussed, such as; requirements of staff of their conduct and specific kitchen issues. This ensured staff were kept up to date with events. Staff told us they felt included in the running of the home. The minutes of meetings showed staff were given time to express their views, with explanations given, if possible, or suggests for moving forward.

The registered manager was seen walking around the home. They knew the names of all the people, relatives and visitors. They gave support to staff when asked and checked on people's needs. The registered manager was visible throughout the day showing compassion and respect to people and assisting staff when they needed help.

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-agency groups.

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 Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider was failing to ensure the premises were being maintained to a suitable standard and there was no maintenance plan in place.