RS Care Homes Limited

Rose Farm

Inspection report

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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

This unannounced inspection took place on 24 November 2016. Rose Farm is run and managed by RS Care Homes Limited. The home provides accommodation and personal care for up to 54 older people and people with dementia. On the day of our inspection 38 people were accommodated at the home.

The home had a registered manager at the time of our inspection. 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.

At our inspection on 12 November 2015, we asked the provider to take action to ensure that people were cared for in a way that protected them from risk of harm but did not restrict their freedom and independence. Action had been taken by the provider to seek legal authorisation for restrictions placed on people.

Risks to people had been identified. However, risk assessments and safety plans did not always contain sufficient information and had not been updated to reflect changes.

Risks to people were not always sufficiently monitored. Checks on pressure relieving equipment were not documented and some areas of the home and equipment were not clean.

People were protected from the risk of abuse as management and staff understood their role in keeping people safe from harm. People were also supported by sufficient numbers of staff.

People received their medicines from trained staff and the storage and administration of medicines was safe.

People were supported by staff who had received training and were supported by the management team to ensure they could perform their roles and responsibilities effectively.

People were encouraged to make choices and decisions. If there was doubt as to whether people had the capacity to make decisions, a capacity assessment had been carried out and a best interest decision made. The registered manager had applied for authorisations to deprive people of their liberty if required.

People told us they found the food satisfactory and that people's dietary requirements were known and catered for. People received support to maintain their hydration, nutrition and healthcare.

People were treated with dignity and respect. We saw staff were kind and caring when supporting people and people were given information and choices.

We found that staff were knowledgeable about people's needs and preferences but that this information was not always recorded. People benefitted from a range of activities which they were supported to engage with as they wished.

People and their relatives felt able to approach the management team with any concerns they had although were not always aware of different feedback mechanisms within the home.

At our inspection on 12 November 2015, we asked the provider to take action to ensure they were monitoring service provision to identify where improvements were required. We found that management systems were in place and when issues were identified these had been addressed. However, systems were not always effective in identifying issues such as lack of information in care plans and cleanliness.

People told us that the management of the home were visible and approachable and staff felt supported and motivated. We observed that the staff worked well as a team.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risks to people were not always sufficiently monitored. Checks on pressure relieving equipment were not documented and some areas of the home and equipment were not clean.

People were protected from the risk of abuse as management and staff understood their role in keeping people safe from harm. People were also supported by sufficient numbers of staff.

People received their medicines from trained staff and the storage and administration of medicines was safe.

Is the service effective?

Good

The service was effective.

People were supported by staff who had received training and were supported by the management team to ensure they could perform their roles and responsibilities effectively.

People were encouraged to make choices and decisions. If there was doubt as to whether people had the capacity to make decisions, a capacity assessment had been carried out and a best interest decision made. The registered manager had applied for authorisations to deprive people of their liberty if required.

People told us they found the food satisfactory and that people's dietary requirements were known and catered for. People received support to maintain their hydration, nutrition and healthcare.

Is the service caring?

Good

The service was caring.

People's choices were respected and people were treated in a kind and caring manner.

People were treated with dignity and respect.

Is the service responsive?

Requires Improvement

The service was responsive.

We found that staff were knowledgeable about people's needs and preferences but that this information was not always recorded.

People benefitted from a range of activities which they were supported to engage with as they wished.

People and their relatives felt able to approach the management team with any concerns they had although were not always aware of different feedback mechanisms within the home.

Is the service well-led?

Requires Improvement

The service was not always well led.

Management systems were in place and when issues were identified they had been addressed. However, these systems were not always effective in identifying issues such as those associated with care plans and cleanliness.

People told us that the management of the home were visible and approachable and staff felt supported and motivated. We observed that the staff worked well as a team.

Rose Farm

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.

We inspected the home on 24 November 2016. This was an unannounced inspection. The inspection team consisted of one inspector, a specialist advisor who was a nurse 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.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some information about the service, what the service does well and improvements they plan to make. We checked the information that we held about the home such as information we had received and statutory notifications. A notification is information about important events which the provider is required to send us by law. We contacted commissioners (who fund the care for some people) at the home and asked them for their views.

During the inspection we spoke with two people who lived at the home and four relatives. We also spoke with a senior care worker, two care workers, the chef, the activities co-ordinator, the deputy manager and the registered manager. We looked at the care records of seven people who lived at the home, the training and recruitment records of three members of staff, as well as a range of records relating to the running of the home. We observed care and support in communal areas of the home. Following our visit we spoke to a healthcare professional who visited the home and sought their views.

Requires Improvement

Is the service safe?

Our findings

At our last inspection on 12 November 2015, we asked the provider to take action to ensure that people were cared for in a way that protected them from risk of harm but did not restrict their freedom and independence.. This was because two people were cared for in their rooms which were locked due to the risk posed to them by other people living at the home. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection, we found that the provider was acting in accordance with legal authorisation.

People's care plans contained risk assessments in relation to different areas of care such as falls, moving and handling, personal care and behaviour. We reviewed the care records of three people who had fallen and sustained an injury. Their falls risk assessments had not been reviewed following their falls and their care plans and risk assessments stated there had been no changes at the monthly reviews. In addition, we found that some people had two risk assessments for the same area of care and the results of these were not always consistent. For example, a person's falls risk was recorded as low using a risk assessment tool and high in the care plan risk assessment. This meant there was a chance that changes in the level of risk posed to people and the measures required to keep people safe would not be identified in a timely manner.

We saw there was a monthly meeting where all falls were discussed and any themes identified. Recent falls had been discussed but there were no additional measures identified to reduce the risk of the people falling again. We talked with the registered manager about this and they told us two of the people were independently mobile and no additional measures were appropriate for them and the third person had become less mobile and was assisted by staff due to their increased need for support.

People had care plans to describe the support they needed to ensure their safety and wellbeing in the event of an emergency evacuation of the building. However, the amount of information in these was variable and they were not always up to date. For example, one person's plan stated they would not find the fire exit independently and would need directional guidance. However, their health had deteriorated; they remained in bed 24 hours a day and would need a hoist to transfer. We discussed this with the registered manager and we received confirmation following our inspection that all emergency evacuation plans had been reviewed and contained accurate information.

If people required regular repositioning in order to prevent a pressure ulcer developing, records were in place to evidence the person was being supported to change their position in line with their care plan. Where people required specialist equipment, such as a pressure relieving mattress, this was provided. However, some staff were unclear about the need to check pressure relieving mattresses regularly to ensure they were functioning correctly and we found one mattress pump stated the battery was low and that service was required. This had not been noticed by staff as the unit did not alarm audibly. When we raised this with the registered manager they contacted the supplier immediately to ask them to check the equipment.

The home did not have any record of the servicing of the pressure relieving mattresses and there was no

record of mattress checks. The mattresses were supplied by an external agency and the manager told us the agency carried out servicing and were responsible for ensuring that it was undertaken as required. However, the provider had a duty to ensure the equipment being used was functioning correctly. A mattress check form was introduced following our feedback. Records showed that other required safety checks, such as those on fire alarms and water temperatures were being carried out on a regular basis.

We observed that people were free to move around the home as they wished. One person moved around the home frequently and we saw that staff ensured the person remained safe by monitoring their whereabouts and providing redirection when required. We observed staff using equipment to support people to change position or move around the service. We saw that they used equipment competently and safely.

Although we saw that many areas of the home were clean during our visit and that measures were in place to reduce the risk and spread of infection, some areas of the kitchen were not clean even though cleaning schedules were in place. The manager accepted that the kitchen was not as clean as it should be and that they would check the cleaning schedules. We also checked the cleanliness of wheelchairs, a rotunda and stand aid, all of which required cleaning. Staff told us the night staff were expected to clean equipment such as hoists and wheelchairs although we were not provided with any cleaning schedules to evidence this. We received confirmation following our inspection that equipment had been added to the cleaning schedule.

All of the people and their relatives whom we spoke with felt that people were safe. People trusted the staff to look after them safely. One person told us, "We feel very safe here, it was one of the reasons we wanted to come and be looked after." People and their relatives felt comfortable to approach staff if they had any concerns about their safety. One person said, "If I was worried about anything I would speak to one of the seniors, she is very knowledgeable and helpful." During our visit, we observed that people appeared comfortable and relaxed with staff.

People could be assured that staff understood their responsibilities to respond to any incidents or allegations of abuse. Staff had received training in safeguarding adults and the staff members we spoke with told us about some of the different types and signs of possible abuse and the action they would take if they suspected abuse was happening. This included speaking to senior members of staff and reporting their concerns to outside agencies if required. One member of staff told us, "We have a policy (regarding safeguarding people). I haven't had to report anything. There is a phone number on the wall if we need to." Staff were confident that people at the service were kept safe from the risk of abuse and that the registered manager would take the required actions following any reports of suspected abuse. The registered manager was aware of their responsibilities to report concerns about possible abuse and had shared information with the local authority in the past as appropriate.

People felt that there were enough staff to meet their needs in a timely and safe way. One person told us, "They (staff) come in quite a reasonable length of time if we press the buzzer." Another person told us, "I think there is enough staff. I don't have to wait long; it has never been a problem." Most of the relatives we spoke with felt that there were enough staff to meet their relations needs.

Staff told us that there were enough staff to keep people safe and respond to their needs. We observed this to be the case during our visit. We observed that staff responded to people when they requested support in a timely and unhurried manner. Staff rotas reflected the number of staff identified by the registered manager to keep people safe. The registered manager told us that they had identified required staffing levels through observations of people's needs, seeking feedback from staff and discussion at management meetings.

We found that the provider had recruitment processes in place to protect people from the risk of receiving care from staff who may not be fit and safe to support them. We looked at the recruitment records of three members of staff and found that checks were carried out through the Disclosure and Barring Service (DBS) prior to a staff member commencing work at the service. The Disclosure and Barring Service (DBS) carry out a criminal record and barring check on individuals who intend to work with vulnerable adults. This helps employers make safer recruiting decisions. Staff had completed application forms and references were sought from previous employers to determine if staff were of good character and suitable for this kind of work.

People told us that they were supported to take their medicines safely at the time they required them. Some people required more support than others. One person told us, "The medication is on time. I have my own supply of paracetamol but staff will ask if I am comfortable. I usually remind them about my repeat prescription but they have normally done it anyway."

People's medicines were available when required as processes were in place for the timely ordering and supply of medicines. People received their medicines from staff who had received training and had been assessed as competent. We observed the administration of medicines and saw staff checked against the Medicines Administration Record (MAR) and stayed with the person until they had taken their medicines. The medicines trolleys were not always locked when staff were administering medicines to people, although the trolley remained near and within the eyesight of the person administering the medicine. Therefore staff were complying with medicines administration guidelines but there was a small risk of unauthorised access.

Each person's MAR had a photograph of the person to aid identification and a record of any allergies. A medicines plan for the person was kept with the MAR and this provided information on the person's preferences for taking their medicines. When medicines were handwritten on the MAR they were signed by two staff to indicate they had been checked for accuracy of information. We observed a person was prescribed medicines which must be administered at specific time intervals and we found this was highlighted on the MAR and recorded. When medicines had been prescribed to be given only as required rather than regularly, protocols to provide the additional information required to ensure they were given safely and consistently, were in place for most medicines.

Medicines were stored securely in locked trolleys, cupboards and a refrigerator within locked rooms. The temperature of the room used to store medicines and the refrigerators were checked and recorded daily and were within acceptable limits. Liquid medicines and topical creams were labelled with the date of opening. We checked the number of two controlled drugs and they corresponded with the number recorded in the controlled medicines record.

Good

Is the service effective?

Our findings

People were supported by staff who were provided with training and support appropriate to their role. People and their relatives told us that they thought that staff were competent in their role. One person's relative told us, "The staff know what they are doing."

Staff told us that they had received an induction which prepared them adequately for their role. Records showed that staff completed an induction checklist when they commenced working at the service and staff told us they also undertook a period of shadowing experienced colleagues before providing care unsupervised. One member of staff told us, "Staff spent time going through everything with me thoroughly as we went along and it was really good." New staff were enrolled on The Care Certificate. The Care Certificate is a recently introduced nationally recognised qualification designed to provide health and social care staff with the knowledge and skills they need to provide safe, compassionate care.

Training records showed that the majority of staff had completed training courses appropriate to their role within the last two years. These courses included, health and safety, first aid, moving and handling and understanding dementia. One member of staff told us that a representative of the provider ensured that they kept up to date with the training they required and that the training was a mixture of practical sessions and e-learning. Staff told us that they felt able to approach the registered manager with any training requests they had. One member of staff said, "You can talk to the [registered] manager and she will always book you onto training if you ask."

Staff told us that they felt supported in their role. Most of the staff we spoke with confirmed that they received supervision from the registered manager and all of the staff felt able to request additional support and raise any concerns they may have. One member of staff told us that the registered manager and provider had been supportive when they had returned to work after a period of absence and had discussed any extra training or support they may require before commencing back at work.

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 told us that staff asked their permission before providing care and were given choices. Staff displayed an understanding of the principles of the MCA. They confirmed that they had received relevant training and that they acted in people's best interests if they lacked capacity. For example by referring to people's preferences and providing support which was least restrictive of their rights and freedoms.

If people's capacity was in doubt in relation to specific decisions such as dietary intake, medicines, personal care and medical interventions, mental capacity assessments had been carried out. These assessments showed that some consideration had been given to factors used to determine a person's best interests such

as the person's past wishes and the wishes of their family. However, some assessments lacked detail to show how the best interest decision had been made and that less restrictive options had been considered.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. 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. The registered manager told us that applications have been made for a number of people who lived at the service and records confirmed this to be the case. Some people had current authorisations in place and the registered manager was aware of conditions attached to the authorisations. The registered manager told us that one person had a paid relevant person's representative who visited the service to ensure conditions were met. A relevant person's representative is appointed to maintain contact with the person who is deprived of their liberty and provide support in relation to the safeguards.

People were protected from the use of avoidable restraint. People who sometimes communicated through their behaviour were supported by staff who recognised how to support the person and respond in a positive way. Records confirmed that staff had received training to support them to manage people's behaviour.

Some people had Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) forms in place which had been completed by the person's doctor. These had been completed appropriately.

People told us they were supported to maintain their nutrition and hydration and that the food looked appetising and was satisfactory to their needs. One person told us, "The food looks nice and staff always ask what I fancy." Another person said, "The meals are satisfactory. There is sufficient choice with two things at lunchtime. Tea can be a bit repetitive but you can ask for a sandwich although they tend to be the same. I suppose you could ask for a snack but I've never needed to as what I have is sufficient."

Staff ensured that people who required assistance to eat their meals were able to do so at the same time as others who were seated with them ate their meal. We observed that staff provided support in a kind, patient and helpful manner. For example, one person required support due to their limited eyesight. We observed a staff member explaining where items were positioned and checking that they had enough to eat before removing their plate. We observed that a lot of people required support to eat their meals and that staff were busy providing this support. This meant that people who did not require physical support to eat but may have benefited from additional prompting and encouragement to eat their meals may not have received as much prompting and encouragement as they required. We fed this back to the registered manager who told us that they monitored the meal time experience for people through audits and would continue to do so. They told us that the mealtime experience on the day of our visit was unusual due to the refurbishment taking place which meant one of the dining rooms could not be utilised as it normally would.

We spoke with the chef who was aware of people's dietary requirements, such as which people required a specialist diet due to a healthcare condition. We saw that people's weight was monitored and that advice had been sought from a healthcare professional when one person's weight had changed. We checked the fluid chart for a person who required this which evidenced that the person was receiving sufficient fluids.

People, and their relations, told us that the support of healthcare professionals was provided if needed. One person told us, "It's a lot quicker seeing the doctor here than at home. It is often the staff who suggest it might be necessary in case there is an infection." People's relatives also felt that medical support was sought when needed and that staff provided support to attend appointments if required. One person's relative said, "You can't fault them with the doctor. If [relation] needs one they ring and they (the doctor) are

here straight away. If ever [relation] has fallen or anything they (staff) always ring and let me know."

People's care records contained evidence of the involvement of external healthcare professionals when health concerns were identified, including the district nurse, community psychiatric nurse (CPN) and GP. For example, records showed that advice and support had been sought from a CPN and the GP when one person's mental and physical health had deteriorated. We saw that the home was visited by a chiropodist on a regular basis and that people had access to the optician if required. We spoke to a healthcare professional who told us that staff contacted them for support when required and acted upon advice given.

Good

Is the service caring?

Our findings

All of the people we spoke with felt that staff were kind and caring towards them. One person told us, "The staff are all very good, very nice. They try to do what they can for me. They are all very helpful." Another person said, "They (staff) are all very attentive and caring." Without exception, all of the relatives we spoke with praised the caring and respectful attitude of the staff. One person's relative said, "They (staff) have been a life line for me. They treat us all with respect and they are all very caring." Another relative told us, "The staff are pretty good, very caring."

The staff we spoke with talked about people who lived at the home warmly and with concern for maintaining their well-being. We observed warm and sociable interactions between staff and people living at the home during our visit. For example, we observed a member of staff complimenting a person on the necklace they were wearing and this started a conversation about the person who had given it to them and "happy times" as the person described them. We observed another person being supported by a member of staff to locate the bathroom. The staff member was patient and kind, stating, "Come this way. I'll show you where to go. Take your time, don't rush."

Staff we spoke with were knowledgeable about the people they supported. For example, one staff member clearly described the strategies they would use if someone was displaying agitation and what support the person required to eat well. They also showed awareness of the person's background and family relationships. People's care plans contained some information about people's preferences, for example what time they liked to get up and go to bed. One person's care plan contained detailed information about the order in which they like to be supported with aspects of personal care.

We found that staff were aware of people's preferences but still checked with people and gave them the opportunity to choose something different if they wished. One person said, "The staff always ask if I would like my hair washed whilst I am in the bath. I usually say no though as I like the hairdresser who comes to do it." Another person's relative told us, "They (staff) always ask [relation] if they are ready to get into bed and if we need anything."

Although people's care plans did not always contain information about people's lives and background, the activities co-ordinator was in the process of speaking to people and their families to gain this information. They told us, "I am still getting to know what people like and working with them and their families on their life stories." Likewise, the chef had information about what food people liked or disliked.

The registered manager told us that no one was using an advocate at the time of our visit. However, they were knowledgeable about the service provided by advocates and in what instances the support of an advocate would be sought. Advocates are trained professionals who support, enable and empower people to speak up. We did not see information about advocacy displayed in the home during our visit. The registered manager told us that information was previously been displayed but had been taken down during a change of the display. This information was put on display following our visit.

People we spoke with told us that staff treated them with dignity and respect. One person described how staff kept them warm with towels when they had a bath. People's relatives also described staff dealing with personal issues in a discreet and dignified way. One person's relative told us that if their relation required support with personal care staff would do so discreetly so that they would not be embarrassed in front of their relation. Another person's relative told us, "The staff are very discreet at looking after [relation] they make sure they treat [relation] with dignity."

The provider told us in their provider information return (PIR) that, "We do have 'Dignity Champions' within the home who promote dignity at all levels". The registered manager told us that they used their role of dignity champion to promote the principle of dignity during supervision with staff. Staff were able to describe the ways in which they protected people's privacy and dignity whilst providing personal care and by knocking on people's doors before entering. People told us that they were able to have as much privacy as they wished and could meet with their relations in their room or a quiet area of the home if they wished. Staff confirmed that some of the people who lived at the home opened their own mail had a key to their room to maintain their privacy and security.

Requires Improvement

Is the service responsive?

Our findings

People and their relatives told us that they thought staff were responsive to their needs. One person told us, "The staff have come to know us very well," whilst another person said, "The staff are all very good, very nice. They try to do what they can for me. They are all very helpful." One person's relative told us, "They (staff) know people well. I am not sure they could do anything better. We are very happy with the care here."

Not everyone we spoke with were aware that they had a plan of care or what was contained within it. However, people told us that they felt involved in decisions about their care. One person said, "I would say I am involved with my care because staff ask me but I don't know about the paperwork." The provider told us in their PIR that, "Resident's families/representatives are invited to attend regular reviews of the care plan." People's relatives were aware that care plans were devised when there relative first moved to the home but had limited awareness of subsequent reviews. We fed this back to the registered manager who showed us several examples of responses to a letter which was sent inviting input into care plans. We saw that some relatives had been involved and that some others had declined to be involved. The registered manager said that they would record on the care plan if no response to the invitation for involvement in care plans/reviews was received in future.

Each person had a range of care plans in place to provide information on their care and support needs. The amount of detail in these was variable and in most cases, contained standard statements which were not tailored to the needs of the individual. For example a person's skin and pressure ulcer prevention care plan stated, "Make position changes regularly; assess needs and allocate pressure relieving equipment." It did not state how often the person required re-positioning or the type of equipment provided for the person. Another person was identified as being at high risk of malnutrition and dehydration. The proposed action to reduce the risk stated that, "Risks should be discussed with the person and their family and staff should continue to offer assistance and dietary supplements". There was no guidance for staff with regards to how often the person's weight should be monitored and when advice should be sought from healthcare professionals.

Behavioural care plans for people with behaviours others may find challenging also contained little specific information and used standard phrases such as "Staff to be aware of triggers that can be disruptive to behaviours and try and avoid these situations. Use diversional techniques to distract. Use walk away policy." There was no information about the person's interests and specific things that were successful in diverting the person's attention or any specific triggers. Although care plans had been reviewed monthly in most cases, there appeared to have been very few changes over a period of over six months.

The staff we spoke with displayed a good knowledge of the people they supported. They were able to tell us about people, their backgrounds and preferences and how they tailored support to reflect people's individual needs and support their independence as much as possible. It was this information which was sometimes lacking from care plans and would help ensure a consistent approach from staff and ensure that newer members of staff had the same information as staff who had worked at the service for many years. We found that measures were in place to meet people's needs such as regular weight monitoring and

repositional changes and referrals had been made to health professionals as required.

People were provided with a range of activities at the home. One person's relative told us, "[Relation] sometimes joins in the activities and we will usually go down if there are singers. The minister comes once a month to give communion so we go to that."

The home had a dedicated activities co-ordinator. The member of staff fulfilling this role was relatively new in post and was passionate about developing their role. They told us, "I love my job, it is really new for me and I'm learning to use all my creative skills. I am still getting to know what people like and working with them and their families on their life stories. I am hoping in future I will be able to tailor what I do for people in a more individualised way."

Staff were complimentary of the activities available at the home. They told us that they felt people had plenty to do and that the activities co-ordinator spent time on a one to one basis with people who stayed in their rooms and those unable to join in group activities. We observed people being supported to join in activities throughout the day of our visit, including making Christmas decorations and participating in a physical activity. People were given support and encouragement by staff and were engaged and happy. One member of staff praised the efforts of a person taking part in the activity by saying, "These are fantastic you are very creative." We witnessed staff talking about local community events with people and much conversation and laughter. People told us that the home had organised trips into the community in the past and had arranged events at the home which relatives and visitors were able to attend. We saw that relatives were able to visit their relations unrestricted and were made to feel welcome by staff.

People felt they were able to say if anything was not right for them however not everyone was aware of how to make a formal complaint. One person told us, "I would tell [registered manager]. I expect she would sort it out." Another person's relative told us, "I would see [registered manager] if there was a problem. I think she would deal with it."

The home had a complaints procedure and information was available within the home about how to make a formal complaint. A comments and suggestions box was present in the main reception of the service which people could utilise to provide feedback on the quality of the service. Staff told us that they felt that complaints and suggestions were acted upon by the management team and gave us examples of a relatives comments having been acted upon. The home had not received any complaints in the 12 months prior to or visit. We saw that complaints made previous to this time period had been responded to appropriately.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection on 12 November 2015, we asked the provider to take action to ensure that they were monitoring service provision to identify where improvements were required. We identified they had not been doing this which was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection, we found that improvements had been made, however further action was needed to quality monitoring systems to ensure that areas requiring improvement were identified.

Internal systems were in place to monitor the quality of the service provided. We saw that audits of a number of areas such as medicines, care plans, catering and infection control were carried out on a regular basis. We found that the audits were effective in identifying some areas for improvement and action had been taken when issues were identified. For example, staff had received updated medicines training and were recording variable doses following a medicines audit. However audits had not picked up that care plans did not contain all of the information needed and had not been updated to reflect changes in people's care needs. Also infection control audits had not identified that equipment was not clean and had not been included on cleaning schedules.

In addition, not all of the areas that required improvement following our last inspection and the last quality monitoring audit carried out by commissioners in December 2015 had been acted upon. For example, information relating to the support people required in the event of an emergency evacuation did not always contain enough detail and had not been kept up to date when people's needs changed.

Although people's awareness of how they could give feedback about the service was not high, we saw that people's views were sought in developing the service. In their PIR the provider told us, "We seek to gain feedback from residents, family members and representatives via our annual satisfaction survey. Information gained from the surveys are collated and discussed during family/ representative meetings. An action plan is also devised to ensure an adequate response from comments is achieved." We saw that a survey had been sent out in February 2016 and the results of the survey had been collated and analysed. Records showed that the outcome of the survey was discussed at a subsequent meeting for people who lived at the service and their relatives. We informed the registered manager that not everyone was aware of actions resulting from people's feedback. However, we saw that specific aspects of care provision had been discussed with people who lived at the home, and people's views had been sought and acted upon in relation to the food, activities and the redecoration of some communal areas of the home.

People and their relatives felt that the home was run smoothly and that the registered manager was approachable and visible. One person told us, "It seems to be a well-run place. There are a lot of carers who have been here a long time. The [registered] manager pops in (to their room) from time to time to see how I am." Another person's relative told us, "If I want to get anything done or make a comment I speak to the deputy manager."

Staff told us they enjoyed working at the home and there was a pleasant atmosphere. Staff told us the

registered manager and deputy manager were approachable and they had staff meetings on a monthly basis and could raise issues and discuss them at the meeting. A relatively new member of staff said that when they had commenced work, the registered manager had told them they should come and talk to her if there was anything they were unhappy about or unsure about. Staff said they felt the manager listened to them and responded and they would be able to talk with the provider if they needed to. We observed that staff appeared motivated during our visit and worked well as a team to provide care and support to people.

At the time of our inspection, there was a registered manager in post. The registered manager was visible around the service and we observed relatives visiting the home approaching the registered manager. The registered manager displayed a good knowledge of the people residing at the service.

We found staff were aware of the organisation's whistleblowing and complaints procedures. They felt confident in initiating the procedures without fear of recrimination. We also found the management team were aware of their responsibility for reporting significant events to the Care Quality Commission (CQC). Our records showed we had been notified of incidents that had occurred within the service since our last inspection.

The manager told us that they felt well supported in their role by the provider and that resources were available to them to drive improvements at the home. Records showed that representatives from the provider visited the home regularly and records of meetings were kept at which aspects of care provision, such as accidents and incidents were discussed.