AMS Care Wiltshire Limited

Bassett House

Inspection report

Cloately Crescent
Off Station Road
Wootton Bassett
SN4 7FJ
Tel: 01793 855415
Website: www.ams-care.co.uk

Date of inspection visit: 21 and 22 May 2015
Date of publication: 24/06/2015

Ratings

Overall rating for this service	**Requires Improvement**
Is the service safe?	**Good**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Good**

Overall summary

Bassett House provides accommodation, nursing and personal care for up to 63 people. At the time of our inspection there were 51 people living there. The rooms are arranged over three floors. There is a communal lounge and dining area on each floor with a central kitchen and laundry. The home is situated in a residential area on the outskirts of Wootton Bassett.

The inspection took place on 21 and 22 May 2015. This was unannounced inspection. We carried out this inspection as we had received a number of concerns relating to the care being provided to people living in the home and low staffing levels. During the inspection we investigated the concerns that has been raised with us about care and support and found no evidence to substantiate these concerns. During our last inspection in May 2014 and a follow up visit in November 2014 we found the provider satisfied the legal requirements in the areas that we looked at.

At the time of our inspection the home did not have a registered manager. The management of the service was being overseen by the director of care and development and the deputy manager. A new manager had recently

Summary of findings

been recruited and was due to commence employment in June 2015. 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.

The director of care and development and staff had knowledge of the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). Deprivation of Liberty Safeguards is where a person can be deprived of their liberties where it is deemed to be in their best interests or for their own safety. Where necessary Deprivation of Liberty Safeguards applications had been, or were in the process of being submitted by the provider. However, the requirements of the Mental Capacity Act were not always followed when assessing people's capacity to make decisions.

We looked at the care and support plans for eight people and found that guidance did not always reflect people's current needs and identify how care and support should be provided. This meant people were at risk of inconsistent care and/or not receiving the care and support they needed.

Systems were in place to protect people from abuse. Staff knew how to identify if people were at risk of abuse and what actions they needed to take to ensure people were protected. People and/or their relatives told us they or their relative felt safe living at Bassett House.

People's nursing and health care needs were met. Staff understood the needs of the people they were supporting. People were supported to maintain their physical health. Where necessary staff involved a range of other health and social care professionals to ensure people's needs were met.

People were supported to have a balanced diet which promoted healthy eating. There were arrangements for people to access specialist diets where required. People told us they could choose what they wanted to eat each mealtime. If they did not like what was on the menu then they could ask for an alternative. There were snacks and drinks available throughout the day.

There were clear policies and procedures for the safe handling and administration of medicines. These were followed by nursing staff and this meant people using the service received the correct medicines at the right time of day.

Staff were appropriately trained and understood their roles and responsibilities. Staff had completed training to ensure that the care and support provided to people was safe and effective to meet their needs. Staff received a comprehensive induction and training to support them to carry out their roles correctly.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

This service was safe.

People we spoke with consistently praised the care and support they received and said they felt safe.

People were protected from the risk of abuse because staff were knowledgeable about the procedures in place to recognise and respond to abuse. Safeguarding notifications had been raised appropriately.

Medicines were stored and administered safely.

Is the service effective?

Requires Improvement

This service was not always effective.

Whilst necessary Deprivation of Liberty Safeguards applications had been, or were in the process of being submitted by the provider the requirements of the Mental Capacity Act were not always followed when assessing people's capacity to make decisions.

People were supported to maintain their physical and emotional health. Appropriate referrals were made to other health care professionals.

People were supported to stay healthy and eat and drink enough.

Is the service caring?

Good

This service was caring.

People and their relatives spoke positively about the care they received. All commented that staff were helpful and friendly.

People were cared for in a dignified way. Staff were caring and we heard people being spoken to in a friendly manner.

Staff were knowledgeable about the care and support people required. People's choices were respected.

Is the service responsive?

Requires Improvement

This service was not always responsive.

Care plans did not always provide accurate instruction and information on how people wished to receive their care and support.

People benefitted from a range of activities.

People and their relatives told us they knew how to make a complaint. They felt confident that their concerns would be listened to and any actions required taken.

Summary of findings

Is the service well-led?

Good

This service was well led.

There were systems in place to monitor the quality of the service provided, where areas for improvement were required, actions to address these had been identified.

Staff were motivated, caring and received training appropriate to their role. Staff we spoke with were positive about the support they received from management and other colleagues.

Bassett House

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 21 and 22 May 2015 and was unannounced. Two inspectors carried out this inspection. We carried out this inspection as we had received a number of concerns relating to the care and support being provided to people living in the home and low staffing levels.

Before we visited we looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification. Before the inspection, we did not ask the provider to complete a Provider Information Return (PIR) as the inspection was carried out at short notice. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We used a number of different methods to help us understand the experiences of people who use the service. This included talking to people, looking at documents that related to people's care and support and the management of the service. We reviewed a range of records which included eight care and support plans, staff training records, staff duty rosters, staff personnel files, policies and procedures and quality monitoring documents. We looked around the premises and observed care practices throughout the day.

During our inspection we observed how staff supported and interacted with people who use the service. We spoke with nine people and four relatives about their views on the quality of the care and support being provided. During our inspection we spoke with the provider, the director of care and development, the deputy manager, five nurses, eight care workers, the senior activities co-ordinator, an activities co-ordinator, housekeeping staff, the chef and two kitchen assistants. We also spoke with a visiting health professional.

Good

Is the service safe?

Our findings

People and their relatives told us they or their relative felt safe and supported living at Bassett House. Comments included "I can speak with staff if I'm not happy", "I can chat about how I'm feeling. They are all very good" and "I feel safe. I have no concerns or worries." We saw that people had call bells in their bedrooms and these were mostly within people's reach. We observed that a few people did not have access to their call bells. Staff said they regularly checked on people who were unable to use their call bell. Records showed that people who remained in their rooms were checked either half hourly or hourly by staff.

We found that people who used the service were protected from the risk of abuse because reasonable steps had been taken to identify the possibility of abuse and prevent abuse from happening. Staff were knowledgeable of the provider's whistleblowing and safeguarding procedures. Staff described the actions they would need to take if they suspected abuse was happening. Staff said they would have no hesitation in reporting abuse and were confident the director of care and development and the deputy manager would act on their concerns.

We reviewed the provider's recent safeguarding referrals. We saw that the provider had followed the guidance set out by the local authority when raising a safeguarding alert. They had also notified the Care Quality Commission which is a requirement of the regulations. Records included information on why the alert was being made, any actions already taken by the provider and follow up actions required as a result of any investigations. We saw the provider worked in conjunction with the local authority in maintaining people's safety and wellbeing. The service followed clear disciplinary procedures when it identified that staff were not working within safe practices.

Care plans identified risks to people's health and welfare, for example falls prevention, risk of malnutrition and the use of bed rails. We looked at eight care plans and found that one falls risk assessment had not been completed. Risk assessments were used to identify what action was required to reduce a risk and were completed with the aim of keeping people safe

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place for the safe management of medicines. We observed the medicines round during our inspection. We saw three people having their diabetes monitored and their insulin administered. We saw that infection control procedures were followed as were clinical waste procedures. If people needed assistance to take their medicines they were helped. This was done in a calm manner and people were not rushed. The nurse ensured people had a drink to help with tablets and they checked tablets had been swallowed before they signed the medicine administration record (MAR) chart.

We looked at the MAR charts and where medicines had been omitted, or refused, the reasons were clearly documented. The administering of PRN (as required) medicines was recorded and the reasons why. The MAR charts had photographs of people at the front to help staff identify them correctly. However, some of the photographs we saw did not look like the person. One nurse told us they knew who was who and didn't really need to look at the photos. However, the agency nurse told us that sometimes the photographs did not reflect what the person looked like. When they were unsure, they told us they had to ask healthcare assistants to confirm people's identity. The same photographs were used on people's doors. It was not clear how often the photographs were updated.

Where people were receiving their medicines covertly, the provider's policy had been followed and the relevant documentation was in place. We saw that medicines were stored and destroyed safely. Nursing staff told us the deputy manager undertook medication audits regularly and that the results of these were shared with staff.

Before this inspection we had received concerns from an anonymous source about staffing. We looked at the homes duty rosters and found that the calculated levels of staff were met and any shortfalls were covered by agency staff. There was one agency nurse on duty during our inspection who was familiar with the service and had worked there on several occasions. They demonstrated through conversation with us that they were familiar with the needs of people. Some staff we spoke with felt that whilst there was enough staff to provide the care and support people needed, they were not always able to spend time chatting to people. Staff told us "It's busy in the mornings and we could do with another person on duty; Call bells sometimes take a long time to answer because we might be in the middle of personal care with a resident". Another member of staff told us "Some days there are enough staff

Good

Is the service safe?

and some days not". One staff member told us "The staff are amazing and everyone will get the care they need. There just isn't the time to sit and chat." We spoke with the provider and the director of care and development who explained how they monitored the response times of the call bells to ensure people were responded to quickly. Any queries with response times were discussed with staff to ascertain the reasons why.

Measures were in place to maintain standards of cleanliness and hygiene in the home. For example, there was a cleaning schedule which all housekeeping staff followed to ensure all areas of the home were appropriately cleaned. We found bedrooms and communal areas were clean and tidy. The service had adequate stocks of personal protective equipment such as gloves and aprons for staff to use to prevent the spread of infection. People we spoke with were happy with the standard of cleanliness in the home. One person told us "They come in every day and clean my room top to bottom." Another person said "The Cleaners are fabulous. They come in my room every day and the whole place smells lovely."

Requires Improvement

Is the service effective?

Our findings

CQC is required by law to monitor the application of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The Mental Capacity Act 2005 sets out what must be done to make sure that the rights of people who may lack mental capacity to make decisions are protected, including when balancing autonomy and protection in relation to consent or refusal of care or treatment. This includes decisions about depriving people of their liberty so that they get the care and treatment they need where there is no less restrictive way of achieving this. DoLS require providers to submit applications to a 'Supervisory Body', the appropriate local authority, for authority to do so.

During the inspection, the director of care and development told us they were in the process of making applications for DoLS authorisations. Applications had been submitted by the provider to the local authority. However the requirements of the Mental Capacity Act were not always followed by the provider when assessing people's capacity to make decisions. We looked at eight people's care records and found records of assessments of capacity were not appropriately completed for some people deemed to lack capacity to decide on their care and treatment. The assessments that were in place, did not meet the requirements of the MCA Code of Practice in terms of due process and the quality of recording. For example in one person's care plan it stated that they had capacity to consent to care and treatment. However underneath the statement it went on to say the person lacked capacity. Assessments did not identify where people were able to make day to day decisions with their daily living. For example where people could makes choices about the food they ate or the clothes they wanted to wear. We heard one person who was assessed as lacking capacity clearly making choices about their preferred meal choice.

Where people's care plans stated they lacked capacity to make decisions there was no evidence of how this assessment had been made or the processes gone through to check people's capacity. The assessments contained general statements as to why the person was deemed to lack capacity. For example 'Family spoken with' but no further information about the discussion which was held and how the conclusion was reached.

Care plans contained consent forms for the delivery of care and the use of photographs. However, these had not been completed or signed in one of the care plans we looked at. In another care plan the consent forms had been signed by a member of staff. This meant that people or their relatives had not signed to say that they agreed to the delivery of care or the use of photographs and therefore staff could be acting against their wishes.

We found the provider had not acted in accordance with the Mental Capacity Act 2005 when assessing people's capacity to consent to care and treatment. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff generally understood how to gain consent to care and treatment. Staff gave good examples of how they achieved this; for example one staff member told us "I always offer people choice and if they don't want a wash when I offer it, I'll go back later." Another said "I always ask what they would like to wear or if they want to come into the lounges or stay in their bedroom."

People had access to food and drink throughout the day and staff supported them when required. People told us they enjoyed the food provided by the home. Comments included, "The food is very good, I can ask for an omelette if I don't fancy what's on the menu" and "The food is really nice, they make me some lovely homemade milkshakes."

We spoke with the chef and two kitchen assistants who told us they received information from staff about people's dietary requirements. They would also go and chat with people and their relatives about their menu preferences. People had access to specialist diets such as pureed and soft food where required.

We observed the lunchtime on the different floors. Some people choose to eat in their rooms whilst others went to the communal dining areas. On the second floor there were fifteen people at one time in the dining room, which made the environment crowded. Some people were able to sit at the tables. Other people who used profiled chairs for their more complex seating needs were lined up side by side. There was not much room for staff to move around the room and on one occasion we observed staff asking someone to stop eating so the table they were sitting at could be moved. People were offered a choice of meal. However, the atmosphere was hurried and was not relaxed.

Requires Improvement

Is the service effective?

People who needed encouragement to eat were prompted as staff passed them, but there was not enough staff available to support people during the meal. We saw some people had drinks and some did not.

On the first floor most people were able to sit at the tables and choose where they wanted to sit. Whilst staff were pleasant there was not any social conversation going on between staff and people living in the home. People had their meals put down in front of them with no explanation as to what it was they were eating. Some staff at times did say "Here's your meal, enjoy your food". There were two people being supported to eat their meal. Staff did not explain to the person what food they were eating. People were mainly fed in silence.

People were not always offered choice about wearing a protective covering when eating. We observed one member of staff putting protective covers around people's necks without asking if they wanted one or informing them what they were doing. We saw that some people were given blue plastic aprons and some people were given material ones. One staff member told us "If there are no clean ones available we put plastic aprons on people to keep them clean". However, we also observed good practise during lunch. We observed one member of staff using serviettes to protect people's clothing. They told us "The serviettes look better than the bibs, and it's nicer for people, more dignified."

On the day of our inspection, there were fish and chips on the menu. There were no condiments available for people on the table. One person asked for "sauce" and was told "There is only brown sauce". People were not asked if they wanted condiments.

People had access to healthcare professionals such as GPs, chiropodists and opticians. We spoke with a visiting health care professional who told us that the home was "Proactive" in seeking advice and support to ensure people had their health needs met. They said that the nurses were knowledgeable of people's care and support needs and they followed treatment plans put in place to support the person. Details of any healthcare visits and outcomes were documented in each person's care plan. We saw in one person's records when they had been reviewed by the GP, or the Tissue Viability Nurse. One relative told us "They thought my relative might have had an infection, and they got a sample, informed the GP of the results, got a prescription and started them on antibiotics, all on the same day. I was really impressed."

Newly appointed care staff went through an induction period which included shadowing an experienced member of staff. All staff we spoke with and observed demonstrated they had the necessary knowledge and skills to meet the needs of the people using the service. They were able to describe people as individuals. Staff knew about people's likes, dislikes and preferences. People using the service spoke highly of staff. Comments included "The staff are lovely. I'm very independent so they leave me to do my own thing, but they're always very friendly." Relatives told us "I've seen the way new staff are mentored by the seniors. They certainly seem to be well trained." Most of the staff we spoke with confirmed they felt well supported by the manager and received regular meetings with their line manager were they good discuss training and their personal development.

Good

Is the service caring?

Our findings

People and their relatives told us they or their relative were treated in a caring and compassionate manner and that staff respected their privacy. Comments included "They are all very helpful", "I have no complaints at all, no problems here" and "I can't fault them. The carers are great and always listen to me."

People were supported to be independent and were encouraged to do as much for themselves as possible. Some people used equipment to maintain their independence. Staff ensured people had the equipment when they needed it. For example We observed one person who was receiving one to one support from staff at various times throughout the day. We were told the person was considered a high risk of falling and we saw that staff encouraged and reminded the person to use their walking aid. Staff spoke knowledgably to us about this person's needs.

Staff were respectful and caring in their approach to people. We observed staff treating people with kindness and compassion. Interactions were friendly and people were spoken to in a patient manner. Lunch time was the only time when interaction appeared more task led. People were supported with their personal care discretely and in ways which upheld and promoted their privacy and dignity.

Staff we spoke with discussed the people they had been caring for in a person centred way. They knew people's individual preferences and care needs. We observed care staff interacted with people, chatting and sharing jokes and involving them with whatever it was they were doing.

Staff knocked before entering people's rooms. We observed two staff members enter a person's room to check if the person was comfortable as they had slipped down the bed. They spoke with the person and explained they were going to reposition them. They asked the person's permission before assisting them, explained what they were doing and offered reassurance throughout the task.

One person, who was unable to use their call bell, was making loud vocal noises. Staff responded by checking on the person to ensure they were comfortable. As the person was moving around they had removed their covers. A staff member entered the room and asked the person if they were cold and did they want the covers back on. They checked the person and then placed the covers over them. The person then stopped being so vocal and when we went back a little while later the person was much more relaxed.

One person moved into Bassett House on the first day of our inspection. At breakfast staff reported that they were unable to ascertain what kind of food the person preferred, or even if they wanted tea or coffee to drink because it was not documented in the notes from the hospital. Another member of staff immediately rang the person's family to get the necessary information. We overheard them telling staff what the person would prefer to eat and drink. We then saw staff prepare the breakfast for them.

People's bedrooms were personalised and contained pictures, ornaments and the things each person wanted in their bedroom. People told us they could spend time in their room if they did not want to join other people in the communal areas. One person we spoke with was waiting to go to the lounge to join in the activity for that morning. They told us "I'm quite excited today. There's a cards competition." Another person said they enjoyed the activities, "It is my choice if I want to join in."

On the last day of our inspection we did over hear one member of staff speaking inappropriately to a person living in the home. We spoke with the provider who took immediate action to address the situation. This was the only time during our inspection we witnessed a member of staff not talking to people in a kind and caring manner.

Requires Improvement

Is the service responsive?

Our findings

During our inspection we looked at eight people's care and support plans and identified people's records were not always accurate and did not always contain information about how people wished to be supported. For example in one person's care plan it stated that for personal care they required two staff members to support. There was no detail of how the person wished to receive their care. It contained no information on whether the person liked a bath or shower, what the person could do independently and what they actually needed assistance with. It also stated that the person liked to have the television on when staff left the room. As the person was not able to communicate their preferences there was no information for such things on what kinds of programmes the person enjoyed and what kind of volume they liked their television to be left on.

When we spoke with staff about one person's dietary needs they told us the person was on a pureed diet. There was no mention of this in the person's nutritional plan. The plan did not include the person's food preferences. We could not see any referrals to speech and language regarding the need for this diet and it was not clear who had made the decision.

Another person had a section in their plan to support staff to help them manage their behaviour. The plan referred to staff using distraction techniques. The information did not detail what those distraction techniques might be.

Care plans were of an inconsistent quality. Not all sections had been fully completed, and although reviews had been documented there was little evidence that changes had been made to the plan of care. The plans were not easy to use and at times it was difficult for us to find the information we were looking for. For example, we looked at the tissue viability plan for one person. Although there were photographs in place and evidence of reviews by the tissue viability nurse, it was not clear how often the dressing needed to be changed. The pain relief plan stated the person was on regular analgesia, but did not indicate why or where the pain was. No pain score had been completed.

Each care plan contained 'This is Me' booklets, which had generally been fully completed. However, because the care staff told us they did not have time to read the care plans, it meant that the information held within these documents was not being used to promote person centred care. For example, we looked at the 'This is Me document' for one person. It stated that they had lived abroad for several years. We spoke to them in the language of the country and they answered us in the same language. Staff expressed surprise and one told us "I didn't know they used to live there". A member of staff told us "Some staff have never read the care plans; there's a risk of incorrect care being given".

Care staff completed a daily record of the care people received and details about how people had spent their day. We looked at six people's records and found they did not give a clear and descriptive reference to the emotional well-being of the person and the actions staff had taken.

For example one person's records stated that they had been screaming and shouting. This was noted several times throughout the days recording. There was no explanation as to why the person may have been shouting out or what actions had been taken to comfort and support the person. A lack of recording which describes behaviours or actions taken may prevent staff sharing important information about the person's emotional well-being and what was done to support them. In the absence of this information people were at risk of not receiving timely and appropriate support. Daily recording charts for repositioning and food and fluid intake had also not been consistently completed. This meant it was difficult to know if care identified on these charts had been given.

People also had daily diaries of what activities they had joined in with. Again there was a lack detail about what the activity had involved and whether the person had engaged with the activity and enjoyed it. Therefore it was difficult to ascertain if the activity had been of benefit to the person and whether it should be continued in the future.

We reviewed four people's DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) and found that these had not been completed correctly. One person's DNACPR, whilst in their support plan, had not been signed by the GP. Another person had a resuscitation plan in place but also had an unsigned DNACPR in place which was confusing. We have asked the provider to take immediate action to review people's DNACPR.

The manager told us the care plan documentation was being reviewed. Staff told us the "paperwork is being changed". One care assistant told us they had been

Requires Improvement

Is the service responsive?

involved in reviewing one care plan. Other care assistants told us that although they provided a large part of the care for people using the service, they were not involved in the care planning process.

We found that the registered person had not designed care and treatment plans to include people's preferences and accurate information to ensure their needs were met. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The director of care and support showed us their accident and incident records. We saw accident and incident forms which described the incident and actions taken. For example after a recent incident the person's sleeping position had been discussed with staff and actions put in place. These forms were audited by the director of care and support to identify any trends and to ensure appropriate action had been taken. However we observed the handover from night staff to day staff. The night staff reported that one person had gone into another person's room during the night and that staff had needed to assist them back to their own room. We checked the person's care plan to see what had been documented in relation to this incident. We asked staff where in the plan it would be recorded and we were told it would be in the behaviour section. However, when we looked, we could see no record of the incident. We looked at the provider's policy folder, but could not see an incident policy identifying how things should be recorded.

The home had four activity co-ordinators who organised group activities throughout the week including weekends. They also offered people activities on an individual basis. People from the local community also volunteered to provide activities for people. On the second day of our inspection we saw that some volunteers had organised a sherry morning. People could choose to have a glass of sherry or other drink. It was a social occasion with people chatting and sharing stories. People told us their relatives and friends were able to visit them at any time. During our inspection days we saw family and friends of the people living in the home visiting at various times throughout the day.

Whilst the building was light and airy and purpose built it was not responsive to people living with dementia. There were large lounge areas for people and the outside space was pleasant. However, there were few signs for people with dementia to use to help them navigate around the building. Toilet signs were very discreet and might not be clear to people with poor eyesight. The corridors were neutral in colour and could make it more difficult for people with dementia to remember their way back to their room. There were no memory boxes, or anything similar to help people know where they were. Some staff told us that some independent residents could become disorientated and frequently asked for support to return to their room. We observed one person walking the corridor who then approached us to help him find his room. Whilst people had photos on their doors this were quite small and not easy to see. We spoke with the provider about the décor. They said they were currently reviewing the environment.

There was a procedure in place which outlined how the provider would respond to complaints. People were given this information in their service user guide when they first arrived at the home. People and their relatives told us that whilst they had not needed to make a complaint they knew what to do if they were unhappy with any aspects of care they were receiving. They said they felt comfortable speaking with the manager or a member of staff. We looked at the complaints file and saw that all complaints had been dealt with in line with the provider's procedure.

Good

Is the service well-led?

Our findings

At the time of our inspection the home did not have a registered manager. The management of the service was being overseen by the recently appointed director of care and development and the deputy manager. A new manager had recently been recruited and was due to commence employment in June 2015. 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.

The director of care and development demonstrated strong leadership skills and had a clear understanding of the changes and improvements needed within the home. Some staff told us they had seen positive changes that had improved the care received by people living at the home since the director of care had been appointed and that they felt involved and supported. One staff member said that they felt the "bar had been raised" around staff's working practices with the new management. Another said "There have been great improvements since the acting manager came here. I do feel like we are providing good care and that the changes have had a positive impact on us." Staff said they felt confident to raise any concerns they might have about poor practice. They said action had been taken by the director of care and development to deal with concerns raised about staff performance and where necessary disciplinary action had been taken.

One of the relatives we spoke with told us "I know my relative is well looked after here. The manager is very visible and is always asking if everything is ok."

People who used the service, their relatives and staff were asked for their views about the service. The home held regular resident and relatives meetings where they could discuss topics such as the environment, staffing and the care received by their relative. We saw the notes from a meeting held in October 2014. We saw that concerns raised were discussed and actions to be taken noted. A satisfaction survey was sent to people who use the service and their relatives. The most recent survey was completed in October 2014. The survey asked people such things as, did they know how to raise a complaint, were people happy with the meals and about how staff supported their relative. Overall the comments were positive. The provider told us that they had also sent a survey to staff but as yet they had little response. They said they would be following up to find out the reasons why.

The provider had a system in place to regularly assess and monitor the quality of service that people received. This included audits carried out periodically throughout the year. The audits covered areas such as training, care plans, management of medicines, infection control and staffing. Areas where they could improve further had been identified and an action plan was in place. Additionally the home had a 'resident of the day' which they used to monitor people's care and support. This involved choosing a resident from each floor every day and reviewing the care and support they received. This included people's care plans, nutrition, activities and their bedroom. Each person was looked at every month and relatives were invited to be a part of this review.

Staff members' training was monitored by the director of care and development to make sure their knowledge and skills were up to date. There was a training record of when staff had received training and when they should receive refresher training. Staff told us they received the correct training to assist them to carry out their roles.

Staff were aware of the organisation's visions and values. Staff we spoke with felt that knowing the people they supported ensured people were treated with dignity and respect. Staff told us they were there to offer people support but also to promote and encourage people to maintain their independence.

The director of care and development attended the local provider's forum. This gave them the opportunity to meet with other providers to share best practice and discuss challenges they may be facing with service delivery. They were also in regular contact with the local authority's quality assurance representative and were exploring ways of sharing best practice with other homes.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent We found that the registered person had not acted in accordance with the Mental Capacity Act 2005 when assessing people's capacity to consent to care and treatment. (1) (3) (4)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care We found that the registered person had not designed care and treatment plans to include people's preferences and accurate information to ensure their needs were met. (3) (b) (C)