Bedale Grange (T F P) Limited

Bedale Grange Care Home

Inspection report

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Ratings

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

Overall summary

This inspection took place on 10 & 15 September 2015 and was unannounced.

Bedale Grange Care Home is registered to provide nursing and personal care for up to 20 older people. The service is situated in the market town of Bedale, located in a quiet residential area. The property is set over two floors and the first floor is accessed either by stairs or a stair lift, there is no passenger lift available. At the time of this inspection eleven people were living at the service, ten permanently and one receiving a temporary respite service.

The service had a registered manager, who had been registered with us since October 2010. 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. On the first day of our inspection the registered manager was on holiday, but the deputy manager was on duty. The registered manager was on duty for the second day of our inspection.

Summary of findings

People using the service, and their relatives, told us they felt safe at Bedale Grange. People had individual risk assessments in place which ensured staff were aware of the risks relevant to each person's care.

Staff knew how to report any concerns about people's safety or welfare and had confidence in the registered manager taking appropriate action.

Overall the service's premises and equipment were maintained in safe working order. We identified a potential safety issue with window restrictors during our visit, but we raised this with the registered provider and it was rectified during our inspection.

Staff were recruited safely and there were enough staff to provide the care people needed.

Medicines were safely managed and administered. However, we found that some improvements could be made to the records relating to medicines, to ensure that detailed information about the management of people's medicine and a full audit trail was available.

Staff were supported to have the skills and knowledge they needed through relevant training, although induction records for a new member of staff were not available when we asked to see them. Regular staff appraisals had taken place and a new system for regular supervision was about to be implemented.

The service was following the principles of the Mental Capacity Act 2005. At the time of the inspection no-one was subject to a DoLS authorisation, but the registered manager understood the Deprivation of Liberty safeguards (DoLS) and when they were needed.

People told us that the food was generally very good, with plenty of snacks and drinks available between meals if people wanted them. People's dietary needs were assessed and monitored, with support requested from relevant health care professionals where there were concerns about people's nutritional wellbeing.

We received positive feedback from health care professionals who told us the service worked well with them and provided a good standard of care to people.

People told us that they were well cared for and usually treated with dignity and respect. However, we received some negative feedback relating to the attitude of one member of staff and how this had made people feel uncomfortable. This was raised with the registered manager at the time of our inspection so that they could take action.

People had their needs assessed and had care plans which were individual to them. Care and nursing staff knew people well and were able to describe people's needs.

People had access to activities and were involved in their local community, with an activities coordinator working in the service two or three days each week. However, people felt that social stimulation and activities were sometimes lacking when the activities coordinator was not on duty.

A complaints procedure was in place and displayed in the reception area. The registered manager encouraged feedback from people who used the service and their relatives, inviting people to come and speak with them whenever they needed to. They had also recently sent surveys to the relatives of people who used the service asking for feedback. Feedback was taken seriously and acted on promptly.

The service had a long standing and experienced registered manager, who was open and honest throughout the inspection. There was a strong staff team, with many staff who had worked at the service for a long time. Staff were committed to providing good care and felt well supported by the registered manager.

The service was allocated two and a half designated management days a week. Management staff felt they struggled to implement full management systems in the time available.

We found that governance systems could be improved and were not always effective. For example, formal audit systems had not been fully implemented, and some aspects of maintenance and record keeping could be improved. Some of the management information provided to us during the inspection visit was not the most up to date version available.

We identified a breach of regulation. 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?
The service was safe.

People who used the service and their families told us they felt safe. People had individual risk assessments in place so staff knew how to manage risks to people.

Staff were recruited safely and knew how to safeguard people from avoidable harm.

Medicines were managed safely, although some improvements to records relating to medicines could be made.

Good

Is the service effective?
The service was effective.

The service followed the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Staff were provided with training relevant to their roles and felt supported by the registered manager. Staff had an annual appraisal and a new system of regular supervision was being implemented.

People's dietary needs were assessed and a varied menu of regular meals, snacks and drinks was provided.

The service appropriately sought advice and support from relevant health care professionals.

Good

Is the service caring?
The service was caring.

The majority of staff treated people with respect and maintained people's dignity. However, we received some negative feedback relating to the attitude of one member of staff.

People were able to maintain relationships, with visitors made welcome and people able to go out with relatives and friends if they wished.

People were supported to make decisions and choices about their day to day lives, such as daily routines, where they spent their time and what they ate and drank.

Good

Is the service responsive?
The service was responsive.

People had their needs assessed and had care plans which were individual to them.

Good

Summary of findings

People and their families, as well as staff at the service and other health and social care professionals were involved in the development and review of these.

People had access to activities and were involved in their local community, although people felt that care staff were often too busy to provide effective social stimulation when the activities coordinator was not on duty.

A complaints procedure was in place. The service encouraged feedback and comments were taken seriously and acted on promptly.

Is the service well-led?

Requires improvement

The service was not always well-led.

The service was allocated 2.5 designated management days a week. Management staff said they struggled to implement full management systems in the time available.

Governance systems were not always effective and records were not always available to evidence the work staff told us took place.

There was a long standing and strong staff team. Staff were committed to providing good care and felt well supported by the registered manager, who was open and honest throughout the inspection.

Bedale Grange Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 10 & 15 September 2015 and was unannounced. This meant that the registered manager and staff did not know that we would be visiting on the first day of the inspection. They did know that we were returning on the second day of the inspection, so that we could be sure that the registered manager would be available. The inspection team consisted of one inspector and an expert-by-experience.

Before the inspection we reviewed all of the information we held about the service. We looked for any notifications we had received from the service. Notifications are information about changes, events or incidents that the provider is legally obliged to send us within the required timescale. We asked the local authority (LA) commissioning team and clinical commissioning group (CCG) for feedback about the service. We also contacted Healthwatch. Healthwatch represents the views of local people in how their health and social care services are provided.

The registered provider completed a provider information return (PIR) and returned it to us within the expected timescales. This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with five people who used the service. Not everyone living at the service could talk with us, so we spent time observing the interactions between people and care staff. We also spoke with four relatives to get their views on the service. We looked at communal areas within the service, and we saw a selection of people's bedrooms, with their consent.

We spoke to the registered manager, the deputy manager, a nurse, two care staff and the cook. During the inspection we reviewed a range of records. This included three people's care records, including care planning documentation and medication records. We also looked at staff files, including staff recruitment and training records, records relating to the management of the home and a variety of policies and procedures developed and implemented by the provider.

During the inspection we spoke with a visiting healthcare professional. After the inspection we got feedback from another health care professional who worked with people living at the service.

Good

Is the service safe?

Our findings

The people who used the service told us that they felt happy and safe at the service. For example, one person told us “Oh yes, I do [feel safe here], there is no reason not to.” Another said “They are keeping me safe.” The relatives and visitors we spoke with also felt that people were safe and received the care they needed. For example, one relative said “We feel they [relative] are safe and cared for.” Another relative told us how they had “Peace of mind,” because they felt their relative was safe and well looked after at Bedale Grange.

We looked at the arrangements that were in place to ensure the service was safe and well maintained. This included looking at the service's approach to health and safety, including maintenance records and inspecting the premises. During our visit we found that three upstairs windows could be fully opened, due to ineffective or broken window restrictors. The upstairs of the service was only occupied by one person at the time of our visit and staff assured us that they were not considered to be at risk of falling out of a window. However, the windows were located in unlocked rooms and represented a potential risk. We brought this matter to the provider's attention and the windows were secured during our inspection.

We saw the service’s health and safety manual, which included an up to date health and safety policy and a health and safety audit completed in March 2015. The service had employed a specialist company to undertake their service specific risk assessments. During our visit the service specific risk assessments provided to us by the registered manager had been due for review in February 2015. However, the registered provider sent us copies of the up to date risk assessments, including the service's fire risk assessment, after our visit.

We saw that personal emergency evacuation plans were in place for the people who used the service. The registered manager described how they carried out ‘mock’ fire drills when the fire alarm was tested and discussed the fire procedure regularly with staff, to ensure that people knew what to do in the event of a fire. However, there were no records to evidence these discussions or which staff had taken part. The staff fire training records provided to us during the inspection showed that fire training was overdue for 21 staff, but the manager provided assurance to us that fire training was booked and would take place during October 2015. We also asked the registered manager if the service had a business continuity or emergency plan during our visit, but at the time they told us they were not aware of one being in place. However, after our inspection we were told that this had been a misunderstanding and a copy of the emergency plan was provided.

The home received maintenance support from the registered provider’s central maintenance department, which supported all of the registered provider’s homes. The home's fire equipment, electrical and gas installations, and manual handling equipment had all been serviced and inspected appropriately. Regular tests of the fire alarm and hot water temperatures were recorded. This showed that routine servicing and inspection of the home’s premises and equipment was taking place to help maintain people’s safety.

We looked at the arrangements that were in place for managing allegations or suspicions of abuse and managing concerns. Staff told us that they had been trained to identify and respond to suspicions or allegations of abuse and the training records we saw confirmed this. The staff we spoke with were able to describe the different types of abuse and how they would report any concerns. Staff said they would feel comfortable raising concerns with the manager and felt confident that concerns would be handled appropriately. The staff handbook included the service’s whistleblowing policy and the service had a safeguarding policy and procedure, which included information about how to alert the local safeguarding team. However, the copy of the service’s safeguarding policy that we were provided with contained some out of date information [regarding the Independent Safeguarding Authority and referring staff to the barred lists] that would benefit from updating. Overall we found that people were protected from abuse by staff who knew how to recognise and report any concerns.

We found that staff were recruited safely and people were protected from unsuitable staff. We spoke with the registered manager about staff recruitment processes and checked the recruitment records for one recently employed staff member. The service had a stable staff team, with very few new staff recruited recently. The records showed that a thorough recruitment process had been followed, including obtaining written references and a Disclosure and Barring Service (DBS) check. The DBS carry out a criminal

Good

Is the service safe?

record and barring check on individuals who intend to work with children and vulnerable adults, helping employers make safer recruiting decisions and minimising the risk of unsuitable people working with children and vulnerable adults. Copies of proof of identification, nursing qualifications and a check of professional registration with the Nursing and Midwifery Council (NMC) had also been obtained.

We looked at the arrangements that were in place to ensure safe staffing levels. Feedback from people who used the service and relatives was that staff were good and worked hard to meet people's needs, but that sometimes people felt that staff were rushed. For example, comments made to us included "They are keeping me safe, care is provided, I'm fed and watered, but it's the interaction that's lacking, but I think it's because they are rushed off their feet and don't get time to talk." Another person told us that staff usually responded quickly, but that "It depends if they are busy with someone else." Staff told us that there were enough staff to meet people's care needs and that people were not at risk because of inadequate staffing levels, although it could be very busy at times. For example, one staff member told us "It's sometimes a bit stressed if three people ring [the call bell] at once, but usually we can do what's needed." Another staff member said "I don't think we are short staffed, we can meet people's needs okay, and if it's quiet we can talk to people."

During our inspection we spoke with the registered manager about staffing levels and how they assessed what staffing levels were needed. The registered manager showed us how they used a staffing assessment tool to determine the home's staffing levels, based on occupancy levels and dependency. At the time of this inspection eleven people were living at the home, with three people receiving residential care and seven people receiving nursing care. Staffing levels at the time of this inspection were one nurse and two care staff between 8am and 8pm and one nurse and one carer between 8pm and 8am. Domestic staffing and management hours were provided in addition to these care and nursing staff.

The registered manager also explained how they were able to bring in additional staff if they thought it was necessary. For example, if they had someone on 'end of life' care who needed staff to stay with them or more people came to live at the service. Our observations during our visits showed that staff worked hard and at times were very busy, but that people received the basic care and support they needed. Staff we spoke with told us that the staff team was a close "family" and that they covered shifts between themselves when needed, meaning that agency staff were not currently used and people benefited from regular staff who were familiar with the service. Overall, we found that people were protected by safe staffing levels.

We looked at the arrangements that were in place to ensure the safe management, storage and administration of medicines. The service used a monitored dosage system (MDS). We spoke with the registered manager and the nurse administering medicines. Both confirmed that staff who administered medicines had received training and had their competency checked. They described how they administered medicines safely and answered queries about people's individual medication needs.

Medicines were stored safely, including arrangements for the storage of controlled drugs. We looked at a sample of three people's medicine administration records (MARs). Each person's medicine MAR included a photograph and relevant personal information, including allergies. People had a pain assessment, which included information about the management of any pain relief prescribed. The medicine administration records we looked at were up to date and showed that medicines had been administered in accordance with people's prescriptions.

The care records we looked at included risk assessments, which had been completed to identify any risks associated with delivering each individual person's care. For example, risk assessment were in place to help identify individual risk factors, such as safe manual handling, falls, nutrition, and maintaining skin integrity. These had been reviewed regularly to identify any changes or new risks. This helped to provide staff with information on how to manage risks and provide people's care safely.

Accidents and incidents were recorded. These were reviewed by the registered manager each month, to ensure that appropriate actions had been taken and to identify any trends or further actions that were needed.

Good

Is the service effective?

Our findings

People received effective care. One person who used the service told us "I can't think of anything [to improve], I'm quite happy." Another person told us "I'm quite comfortable as I am." A relative of someone who uses the service told us, "We are quite happy with the care we've been getting." Another relative said "(name of person using service) is always clean and tidy and well presented."

All of the staff we spoke with told us they had completed the training they needed to do their jobs, including an introduction and induction to the service. The registered manager was aware of the new care certificate training for staff and told us that this would be implemented for new staff in the future. However, they had not had any new staff start work and go through this training at the time of our inspection. When we asked about previous induction arrangements the registered manager told us that new staff had been shown around the home, shown the fire safety, manual handling and medication procedures, introduced to the service's policies and procedures, and provided with a mentor and shadowing opportunities until they were familiar with their role. However, when we asked to see a record of this induction process being put into practice for the newest member of staff, the registered manager informed us that there was no formal record available.

Training records were available for each staff member and showed that staff had completed training in subjects such as manual handling, infection control, safeguarding adults, health and safety, food safety and nutrition, first aid, equality and diversity and dementia awareness. Nursing staff had also received training on tissue viability, venepuncture and wound care. The registered manager was able to show us how they monitored training using the service's computer system, which highlighted when training would be due or where it had expired. The registered manager had made arrangements to provide any training that was needed, with training dates booked for staff to attend. The manager also showed us how they encouraged staff learning through 'policy of the month.' Each month a policy was selected, with staff being encouraged to read the policy and any additional guidance information, before signing a record to show that they had done so. Overall we found that staff had the skills and knowledge required to support people who used the service.

Staff told us that they felt well supported by the registered manager and nursing staff. Staff said that they could get help when they needed it and that the registered manager and nursing staff oversaw their work on a day to day basis. However, staff also said that they did not receive regular, formal one to one supervision sessions, with staff supervision generally being of a more informal nature. Supervision is an opportunity for staff to discuss any training and development needs, any concerns they have about the people they support, and for their manager to give feedback on their practice. We spoke with the registered manager about the supervision and appraisal of staff. Staff had received annual appraisals and we saw records to evidence this. However, the registered manager acknowledged that formal supervisions had not taken place regularly in the past and this was something they were working to improve. They told us that a new supervision and appraisal system was in the process of being introduced and showed us evidence of the supervisions completed so far. They also showed us records of the regular competency observations of staff manual handling practice they undertook, to ensure staff were following safe manual handling procedures. Overall we found that staff were being supported and supervised on an informal, day to day basis, although the implementation of more formal supervision arrangements should continue as planned.

We saw staff consult people and seek their consent throughout the inspection. For example, we saw staff offer people choices and explanations, to support them to make their own decisions. We saw that staff gave choices of meals and drinks and that people spent their time in different places, depending on their own personal preferences.

The Mental Capacity Act (MCA) 2005 provides a legal framework for acting and making decisions on behalf of people who lack the ability to make specific decisions for themselves. The registered manager demonstrated an understanding of the principles of the MCA and explained how these were implemented. For example, through the use of a MCA capacity assessment and best interests decision making tool, and the involvement of other relevant professionals and relatives or supporters in relevant decisions. During our visit we saw evidence of these tools being used in the care records we looked at. The manager showed us that MCA and DoLS had been the 'policy of the month' during April/May 2015, with all staff

Good

Is the service effective?

being encouraged to read the policies and procedures. However, the care staff we spoke with could not demonstrate a detailed understanding of the MCA or DoLS and further training may be beneficial.

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards are in place to protect the rights of people who use services, by ensuring if there are any restrictions to their freedom and liberty. The registered manager had completed training on DoLS and had information available to help them ensure that people's legal rights were protected. For example, guidance information was available in the office, including information about the local authorities DoLS process and helpline. The registered manager confirmed that there were no DoLS authorisations in place at the time of our visit, but understood when they were needed and had completed DoLS applications for authorisation in the past.

During our inspection we observed the lunch time meal and spoke to people who used the service about the food and drink provided. People said that they had a choice of meals and could ask for drinks and snacks at any time. People also told us the food was generally very good and that they did not go hungry. For example, one person told us "Quite good the food really, I've put on half a stone since I came here. I can ask all day for cups of tea and they'll always say do you want a biscuit." Another person said "The food is marvellous, really good, and she [the cook] always comes round to ask what you want." We spoke with the kitchen staff, who were able to describe people's dietary needs and how these were met. They confirmed that they had enough food supplies to provide people with a varied and nutritious diet. The service used the 'Appetito' meal system, where pre-prepared, nutritiously balanced meals are delivered and simply re-heated by the service. Generally people were happy with this arrangement, although we did receive some comments about certain dishes being overly dry and difficult to eat, such as the pastry. Throughout our visit we saw people being offered and provided with drinks. For example, the people we visited and spoke with all had cold drinks within reach and we saw people being offered hot drinks throughout the day. The food we saw being served looked appetising and appealing.

The care records we looked at included nutritional risk assessments and care plans. These assessments included regular weight monitoring and helped to identify anyone who was at risk due to poor nutrition or weight loss. The care plans we viewed included good information about people's individual needs and preferences, including their likes and dislikes, and any support or equipment they needed with eating and drinking. We also saw evidence of the involvement of the doctor, dietitian and speech and language therapy team where there was concern about a person's nutritional wellbeing. For example, during our inspection a speech and language therapist was visiting people who used the service, to complete reviews and reassessments. In August 2014 the home had received a visit from an environmental health officer and was awarded a 5 star rating (the best rating available) for food hygiene.

We saw evidence that the service liaised with relevant health professionals based on people's needs. For example, visits by doctors, nurses and other professionals were evident from people's care records. People who used the service and their relatives also confirmed that they had access to doctors and other health and social care professionals when needed. During our inspection a speech and language therapist was visiting people who used the service and provided positive feedback, saying that staff were always familiar with people's needs and preferences, involved them appropriately and followed their advice. We also sought feedback from two healthcare professionals who work regularly with the service and feedback was positive.

Good

Is the service caring?

Our findings

We looked at the arrangements in place to ensure that the approach of staff was caring and appropriate to the needs of the people using the service. People who lived at the service told us that they were cared for and that the majority of staff treated them very well. For example, one person told us, "They [care staff] know their job and they do it neat and tidy and quick and pleasant while they do it." Other comments used by people using the service to describe the approach of staff included, "Cheerful and efficient," and "The majority of staff are lovely." One person described how staff took special care because of their particular needs, saying "They are careful with me and they are very nice."

Relatives we spoke with also felt that staff were kind and caring. For example, one relative told us, "Everybody is very kind." Another regular visitor told us, "Most staff seem kind, considerate and lovely." Throughout the inspection we observed interactions between people who used the service and staff to be kind and caring. For example, we saw staff asking what people wanted, explaining what was happening and approaching people in a kind and courteous way.

However, we received feedback from two individual sources about the attitude of a particular staff member and how at times their approach and body language was not as respectful as it could be. This had made people feel uncomfortable at times. Neither person wanted to name the staff member concerned or raise a formal complaint about this, but agreed for us to feedback the information to the registered manager for their attention. The registered manager agreed to raise the issue with all staff and reiterate the importance of always treating people well and with respect.

Staff ensured people's dignity and privacy was respected. People described how staff assisted with personal care in private and tried to make people feel at ease and comfortable. One person told us, "If I'm in my room they [staff] always shut the doors and curtains, ask if they can wash certain bits and whatever." During our inspection we observed staff knocking on doors before entering and ensuring that care was carried out in private.

We looked at the arrangements in place to support people in maintaining relationships. Visitors told us that they were made welcome to the home and that visiting was not restricted. For example, one relative told us that staff were "friendly and welcoming". Another relative said, "We are made welcome and can visit any time." Several people told us how they could go out with their family and friends if they wished to. Staff training had included equality and diversity, to help staff understand and support different relationships.

We looked at the arrangements in place to ensure that people were involved in decisions about their day to day lives. We saw that people had their own routines and preferences respected. For example, some people spent time in the communal areas or in their own rooms according to their own preferences and needs. We also saw people being offered choices regarding their meals and drinks. Staff we spoke with knew people well and were able to describe how they involved people in decisions about their day to day lives. For example, by asking people what they would like to do or eat, giving people choices and helping people to pick their own clothes.

One of the people we spoke with was aware of their care plan and that they would be involved in reviews to decide their future care needs. Other people were not aware of their care plan and said that they were not routinely involved in reviews of their needs. This is important so that people are in control of their lives and are fully involved in planning their care.

Good

Is the service responsive?

Our findings

We looked at the arrangements in place to ensure that people received person-centred care that had been appropriately assessed, planned and reviewed. Person-centred planning is a way of helping someone to plan their life and support, focusing on what's important to the individual person. During our visits we looked at the care plans and assessment records for three people. The care plans and assessments we looked at contained details about people's individual needs and preferences, including person centred information that was individual and detailed. Care plans and assessments had been reviewed regularly and provided good information about people's needs.

People who used the service told us that they received the individual help and support they needed with personal care. People also told us that staff tried to accommodate individual requests and preferences. One person told us "Once they get to know you and your routine they seem to know what you want." Another person said "On a day like today [it was sunny] if I asked to go out they'd put me in my wheelchair and make sure I had my buzzer with me." Two people told us how staff were supporting them with regular exercises to help them regain their mobility and confidence, because of their particular individual needs. All of the staff we spoke with knew people well and could answer any questions or queries we had about people's individual needs.

Health care professionals we spoke with were complimentary about the approach of the service's staff. The feedback we received was that staff knew people well and were responsive to people's needs. One healthcare professional said, "Staff always seem knowledgeable about people's likes, dislikes and interests." They also told us how, in their opinion, staff had responded really well to a change in someone's care needs in the past.

We looked at the arrangements in place to help people take part in activities, maintain their interests, encourage participation in the local community and prevent social isolation. The registered manager, staff and people using the service all told us how an activities coordinator worked at the home for two or three days each week. People who used the service spoke positively about the activities coordinator and the things they helped people to do. For example, one person told us how the activities coordinator took them out into the local community. They told us, "She asks if I want a run out in the wheelchair and takes me round Bedale. I see people who know me and have a chat." Another person told us how the activities coordinator assisted them to play scrabble and was going to take them out into town. However, we also received feedback that when the activity coordinator was not at the home there was not much going on, because care staff didn't have time. For example, one person said, "Apart from that lady [activities coordinator] nothing goes on." Another person told us, "Not very much going on in the home, but I'm not very sociable really." Staff told us that they tried to spend time with people and engage in chatting with them and activities when they had time between care tasks. For example, one staff member told us how they enjoyed helping someone with a game on their ipad and talking to another person. One staff member told us, "I like to go and talk to them and hear their stories." During our inspection the activities coordinator was not on duty. Care staff were busy throughout our visit and we did not see any activities taking place. People who were able entertained themselves, some people had visitors, others watched television, or chatted with staff while care was delivered.

We looked at the arrangements in place to manage complaints and concerns that were brought to the service's attention. Information about the complaints procedure was displayed clearly in the service's reception area. This included information about how people could raise complaints and how they would be dealt with. We discussed complaints with the registered manager, who told us they were open to suggestions and complaints and encouraged people to raise any concerns with them. None of the people living at the service or the relatives we spoke with had raised any formal complaints. However, all said that they would feel able to approach the manager or deputy if they needed to and that any minor issues had always been sorted out successfully at the time they occurred. For example, one relative told us, "I know the manager and could raise any concerns if I needed to." Another relative told us "Any issues have been dealt with at the time."

The service kept a record of complaints. However, when we looked at it we found it also contained many notes and cards of thanks, and was very full and disorganised. The only formal complaint recorded was from several years ago and had been dealt with by the registered provider, rather than the registered manager at the home. The manager

Good

Is the service responsive?

confirmed that they had not received any recent complaints, just little “niggles.” They dealt with these ‘niggles’ straight away and recorded them in the person’s individual care record, rather than recording these issues as formal complaints. Due to the small number of complaints recorded there had been no complaints analysis carried out.

Requires improvement

Is the service well-led?

Our findings

We looked at the arrangements in place for quality assurance and governance. Quality assurance and governance processes are systems that help providers to assess the safety and quality of their services, ensuring they provide people with a good service and meet appropriate legal obligations. The manager told us that they did have a quality assurance file, which included a schedule of audits, and support from the company's quality manager, but that implementing the full quality assurance system was difficult due to the management time available to them.

The manager showed us the monthly accident and incident analysis and regular audits for medicines they completed. They also described the less formal checks they completed on a day to day basis. For example, observations around the home, looking at records and talking to staff and people who used the service. These informal checks were not recorded. There was no evidence of audits of maintenance or other health and safety issues, care documentation, records, infection control procedures or other aspects of service provision.

We found areas for improvement during the inspection that evidenced that the current governance systems were not always effective. The issues we identified regarding window restrictors should have been identified and rectified independently by the registered manager and provider. Staff told us that although basic safety issues were usually dealt with promptly, other less serious maintenance issues took longer to resolve. We saw that some parts of the service's premises and grounds were in need of maintenance work. For example, floor coverings in the home were marked and worn, and paintwork and wallpaper was damaged in some areas. At the time of our visit the garden was badly overgrown and the garden furniture was peeling and in need of painting.

We also found some areas for improvement relating to record keeping. For example, the quantities of medicines carried over from one monthly cycle to the next were not always recorded and staff were not consistently recording the amount of medication given where a variable dose was prescribed. This made effective auditing of the MARs and medicine stock difficult. Detailed individual guidance on medicines prescribed on an 'as required' or variable dose basis was not available to guide staff.

The registered manager and staff were able to describe checks and work that took place, but recorded evidence of this was not always available. For example, there were no records to evidence the regular fire scenarios and discussions staff told us they completed. The induction records of the most recent staff member were not available when we asked to see them. The registered manager was able to describe how they informally monitored and supported staff and that a formal supervision system was about to be implemented, but there was no record of regular staff supervision at the time of our visit. When we discussed the available records with the registered manager they agreed that they could be better at recording and evidencing some of the good work they did.

There were also some issues accessing the most up to date management information at the time of our inspection visit. For example, some information we were provided with during our visit [such as the fire risk assessment] were not the most up to date versions. The registered provider provided the most up to date versions to us after receiving the draft report.

These findings evidenced a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014: Good governance.

We looked at the arrangements in place for the management and leadership of the service. At the time of our inspection visit, the home had a registered manager in place who had worked at the service for a long time. A registered manager is a person who has registered with CQC to manage the service. During the inspection we received feedback from people who used the service, visitors and staff that the registered manager was approachable and that people felt able to go to them to discuss issues or concerns.

The registered manager explained that they currently had two days a week as designated [time set aside for a particular purpose] management hours. The deputy manager had half a day each week as designated management time. When not on designated management time both the registered manager and deputy worked as nurses in the home. However, both staff told us that they often covered additional nursing shifts when needed, which impacted on the actual management time available. The registered manager told us that it could be difficult to effectively undertake all of the necessary management and administration responsibilities within the management

Requires improvement

Is the service well-led?

time available to them. In April 2015 a new computer system had been installed by the registered provider to help their staff cope with increased management and administration tasks. The registered provider also assured us that additional administration support was available at head office.

We found the registered manager to be open and honest during the inspection. They had worked at the service for a long time and knew the people who lived there and the staff team well. Discussions with staff and observations made during our visits showed that the staff team worked well together and there were many very long standing members of staff. For example, one staff member told us that the staff team was "More like a family really." Care staff told us that the registered manager, deputy and nursing staff were approachable and supportive. Staff expressed commitment to their role and providing people with good quality care. For example, one staff member said "I like to think we can give people good care and do as well as we can." Another said "I love it [their job]."

The registered manager told us they did not currently have formal meetings with people who used the service and their relatives, due to the small number of people currently living at the service and lack of attendance at such meetings in the past. Instead they told us how they made themselves available to meet individually with anyone who wished to discuss anything and resolved issues as they came up. They had also recently sent out questionnaires to relatives of people who used the service. Two of these questionnaires had been returned at the time of our inspection. Both were positive and raised no issues or concerns about people's care.

The manager told us that formal staff meetings took place twice a year, but that informal meetings between staff took place "almost daily." We looked at the meeting record from the last formal staff meeting, which had taken place in April 2015. We saw there had discussion about the needs of people who used the service and best practice issues. There had also been a manager's meeting in July 2015, involving the registered manager, deputy and company's quality manager.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The registered person did not have effective systems to assess, monitor and improve the quality and safety of the service. Regulation 17 (2) (a).**