Mr Paul Nicholas Mould

Quarry Bank Residential Home

Inspection report

Woodfield Lane
Hessle
North Humberside
HU13 0ES

Tel: 01482648803

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 9 June 2016 and was unannounced. This meant the registered provider did not know we would be visiting. We previously visited the service in March 2014, when we found that the registered provider met the regulations we assessed.

The home is registered to provide accommodation and care for up to 23 older people, including people who are living with dementia. On the day of the inspection there were 22 people living at the home, including three people receiving respite care. The home is situated in the town of Hessle, in the East Riding of Yorkshire and it is also close to the city of Hull. There are two lounge areas, a dining room and an attached garden. The first and second floors of the home are accessed by a passenger lift.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager who was registered with the Care Quality Commission (CQC). 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 day of the inspection we saw that there were sufficient numbers of staff employed to meet people's individual needs. New staff had been employed using the home's recruitment and selection policies. This ensured only staff considered suitable to work with vulnerable people were employed at Quarry Bank.

The registered manager and care staff were trained in safeguarding adults from abuse and understood their responsibilities in respect of protecting people from the risk of harm. However, we noted that although staff appeared to deal effectively with people who displayed behaviours that challenged, they had not received appropriate training. This was a breach of Regulation 12 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Quality audits had been undertaken by the registered provider but these were minimal and did not monitor medication, infection control or accidents. Although the audits included recommendations, there was no information to record whether these recommendations had been being carried out. This was a breach of Regulation 17 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Commission had not been notified of some significant events as required by legislation. These included situations that had required a person to be restrained by staff and when Deprivation of Liberty Safeguard (DoLS) applications had been authorised. This was a breach of Regulation 18 of the Registration Regulations 2009.

We checked medication systems and saw that medicines were stored, administered and disposed of safely. Staff who had responsibility for the administration of medication had received appropriate training.

People who lived at the home and relatives told us that staff were caring and that they respected people's privacy and dignity. We saw that there were positive relationships between people who lived at the home, relatives and staff.

People told us that they were very happy with the food provided and we observed that people's individual food and drink requirements were met.

There had been no complaints made to the home during the previous twelve months but people told us that they were confident any concerns expressed or complaints made would be listened to and acted on. There were systems in place to record any complaints made. There were also systems in place to seek feedback from health and social care professionals, and family and friends.

Staff, relatives and a social care professional told us that the home was well managed. Staff told us that they were well supported by the registered provider and registered manager, and felt that they were valued.

You can see what action we told the provider to take at the back of the full version of the report.

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.

Staff had received training on safeguarding adults from abuse and understood their responsibility to report any incidents of abuse, but training in behaviours that challenge did not take place.

Staff adhered to the home's medication policies and procedures and this meant people who lived at the home received the right medication at the right time.

Staff had been recruited following the home's policies and procedures, and there were sufficient numbers of staff employed to ensure people received safe and effective support.

The premises were maintained in a safe condition.

Is the service effective?

Good

The service was effective.

Staff undertook training that gave them the skills and knowledge required to carry out their roles.

People's nutritional needs were assessed and people told us they liked the meals at the home. We saw that different meals were prepared to meet people's individual needs.

People's physical and mental health care needs were met. Health and social care professionals were consulted appropriately and their advice was followed by staff.

Is the service caring?

Good

The service was caring.

We observed positive relationships between people who lived at the home and staff.

People's individual care and support needs were understood by staff, and people were encouraged to be as independent as

possible, with support from staff.

We saw that people's privacy and dignity was respected.

Is the service responsive?

Good

The service was responsive to people's needs.

People's care plans recorded information about their support needs, their life history and the people who were important to them.

Activities were provided and were flexible to meet the needs of people who lived at the home.

There was a complaints procedure in place and people told us they were confident any complaints would be listened to.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was a registered manager in post, and people told us that the home was well managed. However, notifications were not being submitted to CQC as required by legislation.

Quality audits of care planning were being carried out but other important areas were not being monitored to check that staff were providing safe and effective care.

There were opportunities for people's family and friends and health and social care professionals to express their views about the quality of the service provided.

Quarry Bank Residential 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 registered 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.

The inspection took place on 9 June 2016 and was unannounced. The inspection was carried out by one adult social care (ASC) inspector.

Before this inspection we reviewed the information we held about the home, such as information we had received from the local authorities who commissioned a service from the registered provider and notifications we had received from the registered provider. Notifications are documents that the registered provider submits to the Care Quality Commission (CQC) to inform us of important events that happen in the service. The registered provider was asked to submit a provider information return (PIR) before this inspection. The PIR 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. The PIR was submitted within the required timescale.

Prior to the inspection we received feedback from a social care professional. On the day of the inspection we spoke with one person who lived at the home, three relatives, two members of care staff, the deputy manager, the registered manager and the registered provider. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked around communal areas of the home and some bedrooms. We also spent time looking at records, which included the care records for two people who lived at the home, the recruitment and training records for two members of staff and other records relating to the management of the home, including

quality assurance, staff training, health and safety and medication.

Requires Improvement

Is the service safe?

Our findings

We observed that there were safe systems in place to manage medicines and that medication was appropriately ordered, received, recorded, administered and returned when not used. Medication was supplied by the pharmacy in blister packs. This is a monitored dosage system where tablets are stored in separate compartments for administration at a set time of day. Blister packs and medication supplied in boxes or bottles were stored in the medication trolley, and the medication trolley was locked and fastened to the wall in the registered manager's office when not in use. We saw that controlled drugs (CDs) were also stored securely. CDs are medicines that require specific storage and recording arrangements as they are liable to abuse. There was a suitable cabinet in place for the storage of CDs and a CD record book. We checked a sample of entries in the CD book and the corresponding medication and saw that the records and medication in the cupboard balanced.

There was a medication fridge available to hold medication that needed to be stored at a low temperature. However, this was currently not in use as none of the people who lived at the home had been prescribed this type of medication. The deputy manager assured us that these temperatures were recorded when medication was stored in the fridge. The packaging of eye drops and creams was dated when the medication started to be used, to ensure it was not used for longer than the recommended period of time. The deputy manager told us that they did not date bottles when they started to use the content, as a new supply of this medication was received from the pharmacy every month. We saw there were specific instructions for people who had been prescribed Warfarin. People who are prescribed Warfarin need to have a regular blood test and the results determine the amount of Warfarin to be prescribed and administered.

We looked at medication administration records (MARs) and we spoke with senior staff about the safe management of medicines. A MAR is a document showing the medicines a person has been prescribed and recording when they have been administered. We found that medication records were clear, complete and accurate, although we discussed that more care needed to be taken to ensure that hand written entries on MAR charts were signed by two people to reduce the risk of errors occurring. There was an audit trail to ensure that medication prescribed by the person's GP was the same as the medication provided by the pharmacy. There was a separate chart to record the administration of creams. We saw that one person's MAR chart recorded that they had run out of medication. The registered manager told us that the new supply of medicines had arrived that day so the situation would be remedied immediately.

Only senior staff had responsibility for the administration of medication and these staff had completed appropriate training. The registered manager told us that they were responsible for ordering new supplies of medication, checking that the correct medication had been received and checking the details on the new MAR chart.

The registered manager or registered provider had not carried out audits on the administration of medication. The home's pharmacy supplier had carried out a medication audit in October 2015. They had not identified any serious concerns but had made some recommendations. One of the recommendations was that the registered manager should carry out competency checks on staff that administered medication

to monitor their skill levels. The registered manager told us that they had carried out competency checks but acknowledged that these had not been recorded, although a member of staff confirmed that they had been observed by the registered manager.

The registered manager told us that most staff had attended training on safeguarding adults from abuse and this was confirmed on the staff training record. The local authority told us they were concerned that no alerts had been submitted by the home and we did not see any on the day of the inspection. The registered manager told us that people were closely supervised and that they had not had any serious incidents between people who lived at the home for over twelve months. The registered manager told us that, on occasions, they had telephoned the safeguarding adult's team to discuss minor incidents and it had been agreed that an alert did not need to be submitted. We reminded the registered manager that these discussions needed to be recorded on the safeguarding log to evidence that the circumstances of the incident had been considered. The registered manager told us that they had attended the safeguarding threshold training provided by the local authority and understood the home's responsibility to report safeguarding incidents. However, this was not recorded on the home's training record.

Although staff had not undertaken specific training on behaviours that could challenge the service, the feedback we received indicated that staff were skilled in managing these situations. A social care professional recorded in a survey, '[Staff] manage challenging behaviours very well'. Care plans included advice for staff on how to respond to people's behaviours and comments, so that there was a consistent approach. One care plan that we reviewed recorded, 'I refer to my mam and dad as still being alive and I am not to be told otherwise'.

One person who lived at the home displayed behaviours that challenged the service. We saw that detailed behaviour management charts had been completed by staff. Advice had been sought from health and social care professionals including psychologists, psychiatrists, social workers, community psychiatric nurses and GPs. The registered manager told us that there had been contact with the safeguarding adult's team, although there had been no investigations as the person concerned had capacity and was receiving appropriate support from care professionals. The behaviour management charts showed that the person concerned had been restrained at times to protect them from the risk of harm. This raised concerns as staff had not completed any training on the use of restraint.

This was a breach of Regulation 12 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked the recruitment records for two members of staff. These records evidenced that an application form had been completed, references had been obtained and checks had been made with the Disclosure and Barring Service (DBS). The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and helps to prevent unsuitable people from working with children and vulnerable adults. Staff who we spoke with confirmed that they were not allowed to start work until these recruitment checks were in place. These checks meant that only people who were considered safe to work with vulnerable adults had been employed at Quarry Bank.

We observed that there were sufficient numbers of staff on duty to enable people's needs to be met. We noted that there was always a staff presence in communal areas of the home and that people did not have to wait for attention. The registered manager told us that the standard staffing levels were three care staff on duty throughout the day and two care staff on duty overnight. We checked the staff rotas and saw that these staffing levels had been consistently maintained. The registered manager told us that they were on duty

during the day, Monday to Friday. We noted that this was not recorded on the staff rota and discussed how this would be helpful. They agreed that their name would be included in future. In addition to care staff, there was a cook on duty seven days a week and a domestic assistant on duty over five days a week. This meant that care staff were able to concentrate on supporting people who lived at the home.

Relatives told us that there appeared to be enough staff on duty when they visited. Staff told us that they were a strong staff team who were happy to cover staff absences; this meant that agency staff did not need to be used. One member of staff said, "Every day is different but staffing levels are fine – the manager helps out when we need it."

The registered provider, the registered manager or the deputy manager were 'on call' each weekend. This meant that staff always had someone to contact in the event of an emergency or if additional advice was needed.

Staff described to us how they kept people safe. One member of staff told us, "We make sure there are no trip hazards and no choking hazards. Our moving and handling training helps us to move people safely." Relatives told us their family members were safe at Quarry Bank. One relative told us that they had seen staff use safe methods when assisting people with moving and handling and another relative said, "I can relax knowing [my relative] is in good hands."

Risk assessments had been completed for any areas that were considered to be of concern. We saw risk assessments for skin integrity, aggression from others, bathing, medication, access to the kitchen, self-harm, eating / not eating, smoking and the risk of falls. We noted that the moving and handling assessment recorded the number of staff and any equipment that was needed to move people safely. Risk assessments had been reviewed on a regular basis to ensure they remained relevant and up to date.

We checked the accident records in place at the home. Eighteen accidents had been recorded since January 2016 and nine of these had resulted in injuries such as skin tears, cuts and bruises. There was no record on accident forms to indicate whether medical attention had been sought. One service user had several falls. These had been recorded in the accident book but there was no record of whether the falls team had been contacted. We discussed this with the registered manager and they told us that their first contact would be the GP so that the person's current health concerns and medication could be checked. Accidents had not been audited to assess whether any patterns were emerging or whether any further action needed to be taken.

We looked at service certificates to check that the premises were being maintained in a safe condition. There were current maintenance certificates in place for gas safety, the electrical installation, the passenger lift, mobility hoists, bath hoists, portable appliances, the fire alarm system, emergency lighting and fire extinguishers. In-house checks were carried out on the fire alarm, fire doors, emergency lighting, window opening restrictors and water temperatures. These measures helped to make sure that the premises remained safe for the people who lived and worked at the home.

There was a fire and environmental risk assessment stored in the 'fire' folder. This included the details of contractors who might need to be contacted in an emergency. We discussed how it would be helpful to include details of other emergency situations such as flood or utility failures, the details of people who lived at the home, staff and relatives and advice for staff on how to evacuate the premises safely in the event of an emergency. There were personal emergency evacuation plans (PEEPs) in place which recorded the support each person would need to evacuate the premises in an emergency.

There was an infection control folder at the home; this included the home's infection control policy. We saw that personal protective equipment (PPE) and hand cleaning gel was available throughout the home, including in the entrance hall. There were cleaning schedules in place that recorded the tasks completed each day and a weekly bed change rota. We walked around the building and saw that communal areas of the home, bedrooms, bathrooms and toilets were being maintained in a clean and hygienic condition. The home had achieved a rating of 5 following a food hygiene inspection undertaken by the local authority Environmental Health Department. The inspection checked hygiene standards and food safety in the home's kitchen. Five is the highest score available.

Good

Is the service effective?

Our findings

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 MCA requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager told us that she had submitted applications for authorisation for thirteen people and that one of these applications had been approved.

We saw that no formal mental capacity assessments had been carried out for people who lived at the home. However, care plans recorded people's ability to make decisions. One care plan we saw recorded, 'I am able to tell staff if I don't like an item of clothing'. Staff told us that they supported people to make day to day decisions such as what to wear, how to spend their day and what to eat and drink, and we observed this to be the case on the day of the inspection. Staff said that people's preferences were recorded in their care plan and this helped them to support people to make choices and decisions.

Staff asked people for consent before they assisted them with any aspect of their care, such as assisting them to transfer or assisting them with meals. People's care plans included forms that had been signed by them or their representative to care, treatment and photography where they had the capacity to do so.

There was no overall training record at the home to evidence staff achievements and staff training needs, although one was sent to us following the day of this inspection. This showed that staff had completed training that was considered to be essential by the registered provider, including food hygiene, health and safety, first aid, moving and handling and safeguarding adults from abuse. On the day of the inspection we saw training certificates that recorded six staff had attended moving and handling training on 16 January 2016 and nine staff had attended first aid training on 5 February 2016. Both of the staff who we spoke with confirmed that they had attended this training. However, staff had not completed training in behaviours that challenged the service or the use of restraint.

Staff we spoke with confirmed that they had completed induction training when they were new in post and that this had included shadowing experienced staff. One member of staff told us, "I was the fourth member of staff on shift for a couple of weeks." The registered manager told us that new staff were assigned a mentor and that, at the end of their induction period, they met with the registered manager to be asked a series of random questions to test their understanding of the induction training programme. The registered manager told us that, in future, new staff would undertake the Care Certificate instead of the existing induction programme. The Care Certificate is an identified set of standards that health and social care workers are

expected to adhere to in their daily working life.

Fourteen members of staff had achieved NVQ Level 2 in Care, one member of staff had achieved this award at Level 3 and a further three staff were working towards this award. The deputy manager had achieved NVQ Level 4 and the registered manager had completed the Manager's Award.

Staff told us that they were well supported by the registered manager. It was acknowledged that formal supervision meetings had fallen behind schedule but these had recently been reinstated. Two staff personnel records we checked included notes from a supervision meeting in March 2016. These records evidenced that the topics of training and any changes to policies and procedures were discussed. Staff were told about the importance of reading the policy and procedure file on a regular basis for updates. One member of staff said, "[The registered manager] is really approachable" and another told us, "I feel supported and listened to." We noted one person's supervision notes recorded, '[Name] is a valued member of staff' which showed that staff received feedback on their performance.

We saw that there was a menu on display in the dining room. The cook told us that people were always asked early in the day what they would like for lunch; some people changed their minds by lunchtime and this was accommodated. The cook told us they were aware of any special nutritional needs and people's likes and dislikes, and described how people were provided with fortified, gluten free and low sugar diets. On the day of the inspection one person declined both meal choices on offer and the cook prepared them a sandwich and a drink of coffee, at their request.

When there were concerns about people's food and fluid intake, this was being recorded on food and fluid charts and monitored by staff. We saw that fluid intake was recorded in millilitres, which is good practice, although we discussed how it would be more helpful if the person's fluid intake was totalled each day. We noted that there were a small number of gaps in food and fluid charts and this meant that records were not always as effective as they should be. Staff told us that, if there were concerns about people's nutritional intake or ability to eat and drink, they would be referred to a dietician and any advice or information received would be added to the person's care plan. We saw evidence of this in people's care plans.

We recommend that charts are used consistently so that monitoring is effective and leads to improved care and support for people.

We observed the lunchtime experience. One person was provided with a plate guard so they were able to eat without assistance. Staff were constantly in and out of the dining room so that people were not left unaccompanied for long periods; we noted they were allowed to eat at their own pace and not hurried by staff.

We spoke with one person who visited the home twice a week to have lunch with their spouse. They told us, "The food is always lovely." They told us they appreciated the time that they were able to spend with their spouse.

We observed that people had no problems mobilising around the home. There was an easy flow from the dining room, to the 'quiet' lounge to the main lounge and there was signage to help people identify the dining room, the office and toilets. All of the bedrooms were on the first or second floors. The registered provider showed us plans that had been submitted to the planning department to add a ground floor extension that included two bedrooms and an updated bathroom.

Good

Is the service caring?

Our findings

During our short observational framework inspection (SOFI) we observed good interactions between people who lived at the home and staff, and that people received the level of attention that they required or desired. One person who we spoke with told us that the staff were caring and "Great". They told us that a member of staff had recently left the home to pursue a career elsewhere and that they really missed them. A relative told us, "There has been a vast improvement since [my relative] moved to Quarry Bank – staff handle them better." This showed us that people built up relationships with staff.

Relatives told us that they felt staff really cared about their family members. One relative told us, "I feel confident that [my family member] is receiving good care. Staff are easy going and this leads to a relaxed atmosphere at the home." Another relative said, "Staff are the right kind of people for the job – very patient. I have never heard them be unkind." Staff told us that they felt staff who worked at the home really cared about people. One member of staff said, "Staff genuinely care. If someone didn't, it would be picked up by other staff" and another told us, "Staff really care – it's more than just a job."

Although there was no dignity champion at the home, a social care professional told us, "I found all of the staff at Quarry Bank very caring and respectful. They were always cheery and happy to be at work which was reflected in their conduct and practice." We observed that staff referred to people by their preferred name and that they were discreet when asking people about their medication requirements and if they needed assistance with personal care. Relatives told us that they had observed staff were very careful to respect a person's privacy and dignity.

On the day of the inspection we saw staff were patient with people and took time to explain things to them clearly and in a way that they could understand. This varied from person to person to take account of their specific ways of communicating and level of understanding. Relatives told us they were kept informed of events concerning their family member. One relative told us that they and another relative attended a care review when their family member's condition was explained to them and this helped them understand their family member's behaviour and support needs.

Discussion with the staff revealed there were people living at the service with particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010 that applied to people living there; age, disability, gender, marital status, race, religion and sexual orientation. We were told that those diverse needs were adequately provided for within the service; the care records we saw evidenced this and the staff who we spoke with displayed empathy in respect of people's needs. We saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this.

A social care professional described a situation where a member of staff had accompanied a person to hospital. The doctor tried to send the person home without seeing them due to their mental health needs. The care worker challenged the doctor and refused to leave the hospital until the person had been assessed like the other patients. They said, "I feel this took great courage and that this was an example of excellent practice."

We observed that people who lived at the home were supported to be as independent as possible. A member of staff said, "We encourage people to be as independent as possible, so that they keep the skills they have."

We saw that there were leaflets on display in the manager's office for an advocacy service. Advocacy seeks to ensure that people, particularly those who are most vulnerable in society, are able to have their voice heard on issues that are important to them.

Good

Is the service responsive?

Our findings

Records showed that people had an initial assessment prior to their admission to the home. This included details of the person's medical diagnosis, their current medication, a brief life history and the people who were important to them. Any risks identified during the assessment process were recorded in risk assessments that detailed the identified risk and the action that needed to be taken to minimise the risk. A social care professional described how a person was assessed prior to their admission to the home. They said, "I found staff non-judgemental and interested in listening to the client's history whilst at the same time acknowledging potential risk."

We saw that information recorded in initial assessments and risk assessments had been incorporated into a care plan. The areas covered in care plans included diet and nutrition, continence, medication, physical health, moving and handling, mental health, behaviour / aggression, skin integrity, independence, personal hygiene, relationships and sleep. All care plans included a long-term objective, the person's strengths and needs, the plan of care and the review dates. We saw evidence that care plans were reviewed and updated each month. More formal reviews had been organised by care managers to discuss whether the current care package was meeting the persons care needs.

Care plans were written in the first person, for example, "I respond to diversion techniques when I wish to leave the home" and "I like to wear perfume daily. All my toiletries are kept in my room."

It was clear that staff understood the needs of each person who lived at the home. They told us they got to know people by reading their care plan, and by talking to people, their family and their friends. A member of staff said that they asked relatives to provide information such as a person's hobbies, and that this gave them topics of conversation that they knew people would relate to. This led to people receiving person-centred care that met their individual lifestyle choices.

Comments from relatives included, "Staff are fantastic. They deal with everyone's different problems", "They treat people as individuals" and "Staff know [my relative]. They all seem to know what is going on." A health care professional recorded in a survey, 'The review was well conducted, in private, all staff know the clients and their needs well.'

Staff told us they had a verbal 'handover' from one shift to the next using information that was taken from each person's daily diary sheet. This meant that staff on shift were aware of the most recent information about each person who lived at the home. Any contact with health and social care professionals was recorded in a daily notes sheet, and this information was then transferred into individual care plans. Staff told us that they would not hesitate to contact a person's GP if they were concerned about their health. If this was urgent, they would contact the GP first and then inform the registered manager.

There was no activities coordinator employed at the home so activities were organised by care staff. Staff told us there were a variety of activities on offer, including ball games in the garden, a monthly external entertainer, singing and chatting to people. One member of staff told us it was difficult to engage some

people who lived at the home in activities due to their levels of concentration and some people responded better to undertaking tasks such as setting the tables at mealtimes. These activities were more meaningful for some people than taking part in social activities. On the day of the inspection we saw that staff engaged people in conversation and encouraged them to take part in activities. The registered manager told us that activities "Changed from day to day" and that favourite activities were singing and dancing.

Twiddle muffs had been provided for people who were living with dementia, which are hand muffs with items attached to them that provide people with stimulation and something to occupy their hands. We discussed with the registered manager that some people might also enjoy using rummage boxes. These are boxes of materials and objects that are another means of tapping into memories from the past, and can help people living with dementia to feel empowered and secure.

We saw there were numerous visitors during the day and they told us they were always made welcome. One relative told us, "I am made welcome and offered a drink." Relatives told us they knew the names of all of the staff who worked at the home as they saw the same staff on a day to day basis. They said that this made it easier for them to talk to staff about their family members.

We saw that the complaints procedure was displayed in the entrance hall of the home. The registered manager told us there was a copy of the home's statement of purpose in each person's bedroom, and that this also included a copy of the home's complaints procedure. The registered manager said there had been no complaints made to the home during the previous twelve months.

Staff told us that, if they received any concerns or complaints from people who lived at the home, they would report these to the registered manager. They were confident that these complaints would be listened to and acted on. Relatives told us they were confident that any concerns or complaints they raised would be listened to by the registered manager and that she would improve the situation if she could. One relative said, "[Name of registered manager and registered provider] would listen – they would be receptive and try to sort out any problems."

Requires Improvement

Is the service well-led?

Our findings

The registered provider is required to have a registered manager as a condition of their registration. At the time of this inspection the manager was registered with the Care Quality Commission (CQC), meaning the registered provider was complying with the conditions of their registration.

Services that provide health and social care to people are required to inform the CQC of important events that happen in the service in the form of a 'notification'. The registered manager had not informed CQC of some significant events such as serious injuries, incidents when people had to be restrained and DoLS authorisations. This meant we could not always check that appropriate action had been taken.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We asked for a variety of records and documents during our inspection, including people's care plans and other documents relating to people's care and support. We found that most of these were well kept, easily accessible and stored securely. However, there were some gaps in food and fluid charts.

Care needs assessments and care plans had been audited and analysed in 2015. There were some recommendations for staff, such as 'Quality time should be incorporated into plans as a clearly identifiable need' and 'All staff should be encouraged to monitor care plans for any changes that may happen especially during their days off etc.' Another audit had been carried out on the personalisation of people's rooms. However, no audits had been carried out on the prevention and control of infection, accidents and medication. Without these audits being carried out, there was a lack of evidence that the systems in place at the home had been followed by staff to promote people's safety and well-being, and to improve the quality of the service provided.

This was a breach of Regulation 17 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, the registered provider sent us a list of planned audits for 2016. These included waste prevention, room personalisation, staff turnover / sickness / absenteeism, infection control and refurbishments. The document included a note recording that medication audits had been added to the list following a recommendation by CQC at this inspection.

A social care professional, relatives and staff told us that the home was well-managed. One member of staff said, "We are open – we can discuss things and are told about any changes" and another told us, "They are both [the registered manager and the registered provider] really approachable." A social care professional told us, "The home is well led throughout; the clients are well cared for and treated with the utmost respect." They added, "It helps when you have a manager who trusts and supports your decisions, which was the case here."

We saw the minutes of staff meetings that had been held in January and March 2016. Topics of discussion

included medication, entertainments, the 'niggles' folder, keyworker duties (including keeping care plan records up to date), bed making, shifts, staff incentives (for introducing new staff) and the home's training provider. A member of staff told us that they could raise issues at meetings; they said, "We can speak up and we all do." Staff told us that they would not hesitate to use the home's whistle blowing policy if they needed to. They were confident that any information shared under the whistle blowing policy would remain confidential by the registered persons.

We saw that satisfaction surveys had been distributed to health care professionals, and friends and relatives in April 2016. Four health care professionals returned the survey and the responses had been analysed. Comments included, "Warm, friendly staff who care about the residents." Ten surveys were returned by family and friends. Again, the responses had been analysed and we saw they were mainly positive, with a small number of comments stating that hair and nails required more attention.

Staff described the culture of the home as "Homely. No two days are the same. We would put things right if we could" and "Welcoming, homely and friendly." A relative told us the home was "Friendly, warm, caring and cosy with attentive staff."

We asked staff if any improvements had been made to the service as a result of learning from incidents or complaints. Staff told us that they could not recall specific incidents but they were certain that any issues would be discussed and that the staff group would learn from any complaints or incidents to reduce the risk of them reoccurring.

The registered provider told us that staff were paid above the minimum wage and this helped the home to retain staff and provide a consistent service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We 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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Staff had not received training to ensure that they provided safe care and treatment to people who lived at the home. Regulation 12 (2) (c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems had not been established to assess, monitor and improve the quality and safety of the services provided. Regulation 17 (2) (a).