

Objectquest Limited

# Bethany House Care Home

## Inspection report

Village Close  
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County Durham  
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Tel: 01325300950

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### Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

**Requires Improvement** ●

Is the service effective?

**Requires Improvement** ●

Is the service caring?

**Requires Improvement** ●

Is the service responsive?

**Requires Improvement** ●

Is the service well-led?

**Requires Improvement** ●

# Summary of findings

## Overall summary

This inspection took place on 6 February 2018 and was unannounced.

Bethany House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. At the time of inspection the service was full with 31 people living there.

A registered manager was in post at the time of the inspection visit. They were registered with the Care Quality Commission in December 2011. 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 last inspection of the service was carried out in December 2015 and found that the service was meeting all the requirements of Health and Social Care Act 2008 and associated Regulations and rated them as good.

At this inspection we found that the standards at the service had deteriorated and required improvement.

We found concerns with the administration of medicines and the provider was following unsafe practice which was not within best practice guidelines.

Plans were not in place to minimise all risks to people who used the service. For example where a person self-administered their medicines or if a person was an insulin dependent diabetic.

People were at risk of harm from scalding due to high temperatures from the tap in their bedroom sink and due to windows opening wider than health and safety guidelines recommend.

Not all staff received a fire or full evacuation drill which meant at the time of an emergency people could be at risk.

Audits were not taking place for health and safety. The audits that were taking place were not effective in identifying the issues we found.

Due to these concerns we sent the provider an urgent action letter requesting them to take immediate action to address the concerns and keep people safe.

The majority of people enjoyed the food provided and were offered choice.

The premises were very plain without any contrasting colours and did not have any dementia friendly

adaptations. We have made a recommendation about this.

Staff had received all the training they needed to carry out their roles effectively. However, nurses had not received up to date percutaneous endoscopic gastrostomy (PEG) training. PEG feeding is a means of providing nutrition and hydration to people through a feeding tube inserted into the stomach. We were aware of one person with a PEG at the time of the inspection. Staff were fully supported from supervisions and a yearly appraisal.

People who lived at the service were safeguarded from abuse and potential abuse. People told us that they felt safe at the service and that they trusted staff. Safeguarding training was completed by staff and they had access to information about how to prevent abuse and how to respond to an allegation of abuse. Staff knew what was meant by abuse and said they would not hesitate to report any kind of abuse which they were told about, suspected or witnessed.

A number of recruitment checks were carried out before staff were employed to ensure they were suitable.

Staff had received Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS) training and demonstrated a basic understanding of the requirements of the Act. The registered manager understood their responsibilities in relation to the DoLS. Evidence of consent was sought.

Comments from people highlighted there were not enough staff on duty. Staff we spoke with said they felt staffing levels were difficult when they had sickness.

People said staff were kind and caring, however, many said they did not like to disturb them [staff]. People felt they were not receiving baths as often as they would like. We have made a recommendation about this.

Care plans provided information on people's wishes and preferences. However, there was no record of people's life histories. We have made a recommendation about this.

We saw evidence of activities that had taken place. People provided mixed responses about activities with many complaining they were bored.

The service had a complaints policy that was applied if and when issues arose. People and their relatives knew how to raise any issues they had. All complaints received had been investigated.

This is the first time the service has been rated Requires Improvement.

We identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was not making sure the premises were safe, risk assessments were in place or medicines were administered safely and the provider was not assessing, monitoring and improving the quality and safety of the service. You can see what action we told the registered 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.

Medicines were not always managed safely

Risks to people were not all assessed or plans put in place to minimise the risk.

Staff understood safeguarding issues and felt confident to raise any concerns they had.

The provider carried out pre-employment checks to minimise the risk of inappropriate staff being employed.

### Is the service effective?

**Requires Improvement** ●

The service was not always effective.

Staff received training to ensure that they could appropriately support people and were supported through supervisions and appraisals. Nurses had not received up to date PEG training.

Staff knew their responsibilities under the Mental Capacity Act. Evidence of consent was sought.

The majority of people were happy with the food and were offered choice.

The premises lacked colour and dementia friendly adaptations.

### Is the service caring?

**Requires Improvement** ●

The service was not always caring.

Although we saw kind interactions from staff to people who used the service, people told us they felt they could not 'bother' the staff.

People told us staff talked over them and a few people complained about not being supported to bathe as often as they would like.

Although we found the staff were caring throughout the inspection it was evident from the issues we found that the provider was not ensuring the service was caring overall.

### **Is the service responsive?**

The service was not always responsive.

The care plans contained no life histories.

People had end of life care plans documenting their wishes and preferences.

People were happy with the activities provided; however some people complained they were bored.

Complaints were recorded and acted upon.

**Requires Improvement** ●

### **Is the service well-led?**

The service was not always well-led.

Audits did not take place for health and safety or infection control. The quality assurance audits that did take place had not highlighted the concerns we raised.

The registered provider was not aware of the lack of safety in the service.

The service had made some links with the local community.

**Requires Improvement** ●

# Bethany House 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 6 February 2018 and was unannounced.

The inspection team consisted of one adult social care inspector, one specialist pharmacy advisor and one expert by experience. An expert by experience is someone who has experience of this type of service.

We reviewed information we held about the service, including the statutory notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we looked at four care plans, records, Medicine Administration Records (MARs) and daily records. We spoke with six members of care staff, the cook, the registered manager and a nurse. We spoke with nine people who used the service and one visiting relative.

# Is the service safe?

## Our findings

During this inspection we found some concerns with the safety of the premises. The provider was checking and recording water temperatures on a monthly basis. However, they had not done anything to make sure they were safe; water temperatures from the sinks in people's bedrooms had a temperature recorded of up to 65 degrees. Hot water temperature should be 44 degrees maximum recommended in the Health and Safety Executive (HSE) guidance Health and Safety in Care Homes (2014). We discussed this with the registered manager who said they had a risk assessment for this. However when they went to get the risk assessment there were none in place. The provider told us that contractors were coming to fit suitable valves on the 5 March 2018.

We checked if windows were restricted to open 100mm or less as per HSE guidance. The windows we checked were opening to 190mm and did not have tamper proof fittings. HSE guidance states, safety restricted hinges' that limit the initial opening of a window can be overridden without the use of any tools and are not suitable in health and social care premises where individuals are identified as being vulnerable to the risk of falls from windows. The provider told us that all windows had correct fittings fixed by 13 February 2018.

Risks to people's safety in the event of a fire had not been fully managed. No night staff members had practiced a full evacuation or even a fire drill. We did see evidence of fire alarm checks and fire equipment checks taking place. However, the fire risk assessment for Bethany House was not suitable or sufficient for a care home premise, it did not show the assessor understood how the service was compliant or where deficiencies were, it did not state whether fire safety arrangements were in place and there was no action plan to show the assessor had walked around the premises. We recommended that the provider refers to up to date guidance for fire drills and fire risk assessments.

Although on record it looked like medicines were administered safely, on speaking to care staff we found this was not the case. Care staff we spoke with said the nurses hand them the dispensed medicines and ask them to go to the person, who may be upstairs, and administer the medicine. Care staff explained they knew this was not a safe way to administer medicines and had highlighted this with the registered manager. However, their concerns were ignored. We discussed this with the registered manager who said they were not aware of this practice taking place but would speak to the nurses and stop it immediately.

People who self-administered their medicines had no risk assessments in place and no documentation in place to monitor this. One person who was on respite had all their medicines administered by the nursing staff. This person went home and it was found they could not cope at home, they returned to the care home two days later. However, this person now self-administered some of their own medicines. There had been no assessment undertaken to see if they could cope with this especially as two days prior to this they could not.

Due to all these concerns we sent an urgent action letter to the provider asking them to address them immediately for the safety of people living at Bethany House. The provider replied stating they would all be

addressed immediately or where work was needed by engineers it could be two or three weeks. We received an updated action plan to say all issues had been addressed and a contractor to fit valves for the water temperatures was due out Monday 5 March 2018.

We found medicines were stored safely and within the correct temperature guidelines. Where people required their medicines to be administered via the PEG tube there was no supporting documents from the pharmacy to authorise the crushing of the tablets or nothing documented on the process for medicines to be administered this way.

The service used a three month Kardex (medicine information) system for their Medicines Administration Records (MAR). These were all handwritten by the nursing staff. We recommend the provider refers to the latest medicines guidance. We saw a lot of gaps where staff should sign to say the medicines had been administered. No full medicines audits took place; the registered manager said they do a count each month which was correct. However other areas such gaps on MAR charts had not been acknowledged. Where one person received oxygen the service was not using British Standard signs to alert people to this.

Medicines that are liable to misuse, called controlled drugs, were stored appropriately. Additional records were kept of the usage of controlled drugs so as to readily detect any loss.

For people who had diabetes we found no documentation to show how the blood glucose levels were being monitored for these people. There were no risk assessments in place and nothing documented to show how staff were to support the person in the event of a hypoglycaemic or hyperglycaemic attack. This is when blood sugar levels are too low or too high.

In the care plans we reviewed we found that risk assessments were in place for falls, however more personal risk assessments were not in place. For example, where people had the need for soft or pureed diet or could experience anxiety, there were no risk assessments.

Many people were nursed in bed and were unable to summon assistance if needed. The risk assessment for this was for staff to do hourly or two hourly checks. We asked to see evidence of these checks. The registered manager said they had a new nurse call system that allowed staff to press it on entering the person's room and on leaving; they said this provided evidence of the checks. We asked to see this but the registered manager said staff were not using the system as they had only had it about a month and they were not used to it. We asked the registered manager to show us the report they can run off the computer to evidence these checks. The registered manager struggled to find this and agreed they needed training. Therefore we were provided with no evidence to show people, who could not summon assistance and were nursed in bed, were checked on.

People and staff we spoke with thought that more staff was needed. One person said, "They should have more staff for the amount of people with special needs, they sometimes take ages to come, ten to fifteen minutes." Staff we spoke with said, "We have had a bad run with the flu, we do have enough staff 90% of the time." We saw there was one nurse and 5 care workers on a morning and one nurse and three care workers on the afternoon. From our observations we saw many people were left alone in their rooms for most of the day.

These findings evidenced a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act (Regulated Activities) Regulations 2014

All the people who used the service said they felt safe with the staff that provided care. People we spoke with



said, "I am very safe, they help me with everything, before I came to live here I went through a bad time, they saved my life." Another person said, "I do feel safe here."

Required certificates in areas such as gas safety, electrical testing and hoist maintenance were in place. A Personal Emergency Evacuation Plan (PEEP) was in place.

A record was kept of accidents that occurred at the service, which included details of when and where they happened and any injuries sustained. The registered manager said they reviewed this for any trends, and would take any necessary remedial action needed. The accidents and incidents were too low to find any trends.

Recruitment procedures were in place to ensure suitable staff were employed. Applicants completed an application form in which they set out their experience, skills and employment history. Two references were sought and a Disclosure and Barring Service check was carried out before staff were employed. The Disclosure and Barring Service 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 minimise the risk from unsuitable people working with children and vulnerable adults. We saw evidence of checks on nurses PIN numbers.

Staff understood safeguarding issues and whistleblowing (telling someone) concerns and knew the procedures to follow if they had any concerns.

We saw the premises were clean and tidy, cleaning schedules were in place and records showed these had been followed. Staff told us that there was a plentiful supply of personal protective equipment such as aprons and gloves.

## Is the service effective?

### Our findings

We saw that staff training was up to date. We confirmed from our review of staff records and discussions that staff were suitably qualified and experienced to fulfil the basic requirements of their posts. Staff we spoke with told us they received which included safeguarding vulnerable adults, the Mental Capacity Act (MCA), Deprivation of Liberty Safeguards (DoLS), fire safety, food safety, equality and diversity and moving and handling. Staff who administered medicines also had competency observations once a year. However staff were not adhering to the medicine training they had received due to using another member of staff to administer medicines. We also had no evidence that the nursing staff had received PEG training and staff we spoke with thought they needed training in dementia and challenging behaviour. After the inspection the registered manager confirmed that they had booked in PEG training for all nursing staff. The registered manager sent evidence of PEG training after the inspection.

Staff we spoke with said, "We have a booklet about challenging behaviour and we are told to just walk away but most of the clients can't walk and the ones that kick off are chair bound." Another staff member said, "We need more training on aggression and dementia we've had some really aggressive clients who have done physical harm, you walk away." And another staff member said, "We are constantly training."

New staff undertook an induction programme, covering the service's policies and procedures and using Care Certificate materials to provide basic training. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It sets out explicitly the learning outcomes, competences and standards of care that will be expected. New staff also completed shadow shifts until they and the registered manager felt they were competent to work alone.

Staff were supported through regular supervision and a yearly appraisal. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When people lack mental capacity to make particular decisions, any decisions 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 2005. The application procedures for this in care homes are called Deprivation of Liberty Safeguards (DoLS). We checked that the service was working within the principles of the MCA 2005 and found that they were. There were processes in place to protect the rights of people living at the service. Staff had undertaken training in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and they understood the main principles of the act in their day to day practice.

The management and staff understood their responsibilities and the process for making appropriate

applications if they considered a person was being deprived of their liberty. Applications for 4 people who lived at the service had been made to the relevant supervisory body, and authorised at the time of our inspection. We saw evidence of consent in people's care records.

We received mixed feedback about the food provided. One person said, "The food is not good, yesterday it was chicken casserole, when I make it its lovely but this didn't taste of anything." Another person said "The food is a bit rough, the mincemeat is rough, and you don't get a choice." And another person said, "The food here is very good, you can't walk away from the food." Another person did say that if they did not like the food on offer the staff would make them something different. A relative we spoke with said, "[Person's name] eats better here than before at home."

On the day of the inspection the main meal was shepherd's pie and vegetables with apricot crumble. The atmosphere was quite calm other than a wildlife television programme playing in the background. Where people needed assistance this was provided and staff were smiling and pleasant and did not rush them. We saw there was plenty of snacks and drinks available throughout the day. Snacks included sandwiches, cakes and biscuits.

The chef knew people's individual dietary requirements and these were documented. They said, "We receive updates from the nurse in charge after any assessments and the information is on the board in the kitchen." We were told no one required any special cultural or vegetarian diets. The chef said, "We try different food, sometimes lasagne, we are having a special St Patrick's day meal, we have fish and chips on a Friday and a roast dinner on a Sunday."

There was clear evidence of visits and contact with healthcare professionals when additional support was required for people. For example, social workers, dieticians and GP's were all noted in records as having supported individuals with their care.

There was very little signage for people living with dementia. The main communal areas which people with dementia regularly occupied, including lounge and the dining room lacked items of interaction or stimulus which could be used to support reminiscence such as pictures of the local areas and favourite pastimes of people who lived at the service.

There was not much use of colour; all areas were cream walls and white paint work. People's bedrooms did not display many personal items. People's bedroom doors were white with a white card which had their name on. There were no photos or memory boxes. Therefore a person with dementia may have difficulty distinguishing their own room. We recommend the provider looks into making the environment more dementia friendly.

## Is the service caring?

### Our findings

We received mixed reviews from people about the staff. Comments included, "They [staff] talk over my head, I don't like it", "I have nothing to do with staff I don't interfere with them", "They [staff] walk away from me when I'm talking to them, they haven't listened to me, some can be very rude" and "I love the staff here."

We observed staff to treat people with kindness. However, they were very busy getting on with tasks rather than sitting with people. People who were cared for in their own rooms were left alone for long periods of time with very little interaction.

We asked staff how they supported people's privacy and dignity. Staff explained how they always knock on people's door before entering and keep people covered as best as possible when providing personal care. One person who used the service said, "On yes they make sure I'm covered, and there are no men about, if not I would say something." However three people said, "When I first came here I didn't get a shower for four weeks, I've been waiting four days now for a bath." Another person said, "I like a bath but I'm still waiting." And another person said, "I can't walk, they help with bathing, depends how busy they are how long I have to wait." We recommend that the provider ensures people can have a bath when they want one.

Staff said they encouraged people to maintain their independence. Staff we spoke with said, "We always encourage them [people who used the service] to do what they can themselves, even if it just means washing their face." People we spoke with said, "They [staff] are not forceful people, they keep you involved in everything that's happening, they keep you going." Another person said, "They [staff] push you to do activities, you can do anything you want, they [staff] are all very keen people, so keen to get you going and keep you living." And another person said, "They [staff] don't really respect my wishes, we just do it ourselves, I don't bother with the staff, when they are busy with someone." Another person added, "Yes I have control it's down to myself, if I can't be bothered, they are so helpful to get you on your feet, I call them [staff] Boss, I find it difficult to remember names, they are more than helpful."

We asked people if staff talked to them with respect. One person said, "Yes they do but they are not used to people talking back to them." Another person said, "There is a lack of communication." And another person said, "Yes they very much speak to me respectfully." And "Most of them [staff] have cold; I worry when they come in and bring in all the germs."

The relative we spoke with said, "Yes the staff are respectful, we are all first names basis, my [relative] has a positive relationship with the staff, I don't have any hard evidence of staff promoting independence though."

The service had equality and diversity policy in place and staff had received training in this. We asked staff how they embed equality and diversity into their caring role. Staff we spoke with said, "Everyone is the same, we have someone with a specialist need and they are treat the same, they go to a specialist group every Wednesday." Another staff member said, "It's equal opportunities, everyone is special but not different, it's about individual needs, but all are treated the same."

Most people using the service had a similar ethnic background and religious beliefs and there was nobody with an obviously diverse need. We were told that local churches come in to see people who required this. They [staff and people] were very involved with the church next door and we were told a group of people from this church visit the home regularly.

Nobody at the service was using an advocate. Advocates help to ensure that people's views and preferences are heard. We saw there was information available to people about advocates if they wanted it.

## Is the service responsive?

### Our findings

The care plans were all stored on the computer. There was a summary tab which documented at a glance people's specific needs such as personal care needs, medicines and mobility needs. There was information recorded for people's normal morning, afternoon and evening routine. However, the care plans did contain information about people's histories. Having information on people's life histories and key people in their lives helps gain an understanding of what is important to them. We recommend the provider updates the care plans with this information.

The care plans did contain information on people's preferences such as leaving the en suite light on at night or enjoys carrying certain objects that comfort the person. We saw there was good information on how staff were to communicate with people if they sensory loss.

We asked people and their relatives if they were involved in the planning of their care, we received a mixed response. People we spoke with said, "I know my care plan, there were a lot of things, from the previous home, not right, like I had certain conditions when I didn't. I told them to change it, which they did." Another person said, "I have not had a review meeting regarding my care plan." The relative we spoke with said, "I am not familiar with my [relatives] care plan."

Staff we spoke with said, "Everyone has an individual care plan." Another staff member said, "We ensure the care plans are up to date I know everyone's needs I spend time with them I know what they like."

We saw evidence of end of life care plans in place which documented people's wishes and preferences at this time.

We asked people if they were happy with the activities on offer, again we received a mixed response. Comments included, "I like the Bingo and, I do the chair exercises, I like the quizzes and crosswords, I get on well with [person who used the service]", "I paddle on, sometimes I'm lonely", "I can't play games I don't do anything but sit", "My daughter takes me out regularly, but I'm just bored here", "It's a waste of time here, you get to do nothing, I'm bored stiff, the days are too long" and "I liked gardening, I want to help but I don't think I could interfere, It's kept private and I've never had the chance."

One staff member said, "I don't see the activities very often, I work afternoons, more needs to be done it's boring for them on an afternoon."

Everyone acknowledged that the activity coordinator was very busy and tried their hardest. They only worked mornings therefore people were left alone from about 2pm onwards.

There was an activity board which highlighted regular activities such as bingo Monday and Friday, hairdressing Tuesday, Wrinkles and Dimples Wednesday, quiz Wednesday, chair exercises Thursday, meeting for people who used the service last Thursday of the month. Wrinkles and Dimples was when a few people went and joined in the play group at the village hall next door, we received good feedback about this

and people enjoyed it immensely.

One the day of inspection the activity was hairdressing, we questioned whether this was really personal care but the activity person assured us that they make it a social occasion and a few people at a time go down to the hairdressers and share a pot of tea and have a chat. It was snowing on the day of inspection and the activity person went outside and made a snowman on a board and brought it inside for people to look at and touch. This was a nice gesture and people responded well to show they enjoyed this.

The activity person had a lot of planned events coming up such as afternoon tea and Pimms for the upcoming royal wedding; they had also ordered fascinators for the ladies and button holes for the men. They had plans for Valentine's day, St Patrick's day and pancake day. They worked closely with the village hall and arranged a beach day in the summer with Punch and Judy, fish and chips and ice cream. The activity person also arranged for day trips to take place, they had recently been to the Locomotion to see the space capsule and often go to the Excel Church for high tea.

The activity coordinator was very passionate about their job and said, "As long as there is movement I am happy."

We asked people if they had ever made a complaint and if they knew how to make a complaint. We saw evidence of complaints documented with a full investigation. People we spoke with said they knew how to complain and comments included, "There is no bother here, I have no complaints at all." Another person said, "I have no complaints about the staff or my bedroom." And another person said, "I complained but nothing happened." A further person said, "They [staff] will say to you, you shouldn't complain too much."

## Is the service well-led?

### Our findings

The registered manager carried out only a small number of quality assurance checks to monitor the standards at the home. 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 quality standards and legal obligations. The registered manager did a monthly 'physical standards' audit where they checked areas such as bedrooms, kitchen, and reception area and staff attire. Although they tested and recorded water temperature they had not acknowledged or done anything about the temperatures being up to 20 degrees hotter than they should safely be. We found these audits had not highlighted the concerns we raised.

The provider completed an audit visit every two months. During this audit we saw they spoke to people and staff, inspected the premises, looked at falls and complaints and highlighted any areas for improvement. Although we saw these audits highlighted more concerns such as clutter in stairwells, they still had not highlighted the concerns we raised. For example, lack of fire drills, water temperatures too high, windows opening too wide, the fire risk assessment not being suitable, lack of risk assessments and some people who used the service not being happy with the care provided.

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

We asked people and their relatives what they thought of the management provision. People we spoke with said, "The manager is always approachable and available like a mother," Another person said, "I've only met the manager two or three times but I see the assistant manager every day and the girls. The nurse is twenty-four hours a day." The relative we spoke with said, "Yes there's no sign of a crisis, the atmosphere is positive, the manager's fine."

We asked staff if they felt supported by the management. Staff we spoke with said, "I feel confident to speak with the manager if I have any issues." Another staff member said, "The manager is approachable, if she's not working as a nurse she's in the office most days." And another staff member said, "I am supported in most things." A further staff member said, "I think I give a very good service, I get clear messages from the management."

Feedback was sought from people who used the service and their relatives. This was done via a questionnaire that was sent out. The last one was done in June 2017 and people were mostly happy with the service. The registered manager said they were looking at different ways of getting people's feedback as they felt the yes or no survey did nothing to support their learning.

Staff we spoke with were happy working at the service and really enjoyed their job. One staff member said, "I enjoy working here, it is a nice and friendly place to work." Another staff member said, "It's a very pleasant place to come here to do my job I enjoy every bit of time with each resident."



Staff meetings were taking place regularly and staff said they find them very useful. One staff member said, "I have raised issues in meetings and been listened to, if not acted on quickly if I mention it again things are sorted out." Topics discussed at staff meetings were shifts, training, safeguarding, information, appropriate uniform and people who used the service.

We observed a handover from the morning staff to the afternoon staff. Two nurses sat at a desk with the nurse receiving the handover and had their back to the three care workers. The two nurses were involved in the handover but the care workers were merely observing and were not asked for their input at any point.

Meetings for people who used the service and relatives took place every month. Topics discussed were food and menus, activities, laundry and cleanliness of the home. An action plan was drawn up at the end of each meeting and this was addressed at the beginning of the next meeting. One person we spoke with said, "We all mention the food at the meetings, I think there is no variety, no choice and there is not taste."

We saw some evidence that the service worked with the local community such as the nearby church and village hall.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC) of important events that happen in the service. The registered manager of the service had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.

This section is primarily information for the provider

## Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Diagnostic and screening procedures	The provider was not assessing the risk for the health and safety of service users, or doing all that is reasonably practicable to mitigate risks by ensuring the premises were safe, risk assessments were in place and medicines were administered safely. Reg 12 (2) (a) (b) (d) (g)
Treatment of disease, disorder or injury	

  

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Diagnostic and screening procedures	The provider was not assessing, monitoring and improving the quality and safety of the service. Reg 17 (2)
Treatment of disease, disorder or injury	