Acorn (Watford) Ltd

Acorn House - Acorn Watford Limited

Inspection report

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Ratings

Overall rating for this service	Good
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?	Good

Overall summary

We inspected Acorn House on 15 December 2015. It provides accommodation and support for up to ten people. Accommodation is provided over three floors in a large semi-detached Edwardian building. The building is located within a residential area.

People living at Acorn House range in age from 54 to 81 years. The home provides care and support to people living with a range of learning disabilities and a variety of longer term healthcare needs such as dementia and diabetes. Several people had lived at the home for a number of years and were in a settled friendship group. There were the maximum permitted ten people living at the home.

We last inspected Acorn House on 15 April 2014 where we found it to be compliant with all areas inspected.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the

Summary of findings

requirements in the Health and Social Care Act and associated Regulations about how the service is run. The deputy manager had applied to be a second registered manager and the application was in process at the time of our inspection.

Potential risks to people's health, safety and well-being were not consistently well managed. A relative of the provider was lodging at the home. Suitable checks into the background of the individual to protect people were not carried out. The arrangement had implications for the provider's home insurance. We have identified this as an area of practice that requires improvement.

The maintenance of an area of the home had not been maintained to a high enough standard. People were exposed to an environment where cleanliness was not maintained across all areas, increasing risk from poor hygiene maintenance. We have identified this as an area of practice that requires improvement.

People appeared happy and relaxed with staff. It was clear staff and the management had spent considerable time with people, getting to know them, gaining an understanding of their personal history and building rapport with them. A relative said, "Staff are friendly and patient. It's like a family home. I have nothing but praise."

There were sufficient staff to support people. When staff were recruited, their employment history was checked, references obtained and an induction completed. Checks were also undertaken to ensure new staff were safe to work within the care sector. Staff were knowledgeable and trained in safeguarding and knew what action they should take if they suspected abuse was taking place. A range of specialist training was provided to ensure staff were confident to meet people's needs.

People were provided with a choice of healthy food and drink ensuring their nutritional needs were met.

People's needs had been assessed and detailed care plans developed. Care plans contained risk assessments for a wide range of daily living needs. For example, a person had a risk assessment around using public transport and this had changed as their needs evolved. People consistently received the care they required, and staff members were clear about people's individual needs. Care and support was provided with kindness and compassion. Staff members were responsive to people's changing needs.

People's health and wellbeing was continually monitored and the provider regularly liaised with healthcare professionals for advice and guidance. A healthcare professional told us, "My experience has been that the staff and management are good at seeking appropriate input with regards to individuals health needs, be that from specialist learning disability services or mainstream services."

Medicines were managed safely in accordance with current regulations and guidance. There were systems in place to ensure that medicines had been stored, administered, audited and reviewed appropriately.

The CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. We found that the deputy manager understood when an application should be made and how to submit one. Where people lacked the mental capacity to make specific decisions the home was guided by the principles of the Mental Capacity Act 2005 (MCA) to ensure any decisions were made in the person's best interests.

People were provided with opportunities to take part in activities 'in-house' and to regularly access the local and wider community. People were supported to take an active role in decision making regarding their own routines and the routines of their home. One relative said, "[My relative] has been in one previous home but here they really look after her. [The manager] brings her down her to visit me and I can see that they get on famously. I am very impressed."

Staff had a clear understanding of the vision and philosophy of the home and they spoke enthusiastically about working at the home and positively about the management of the home. The registered manager or their deputy undertook regular quality assurance reviews to monitor standards in the home and drive improvement.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

Acorn House was not consistently safe.

A lodging arrangement for a provider's relative to stay at the home meant potential risks to people's health, safety and well-being were not consistently well managed.

Arrangements for keeping the home clean and maintained to ensure people were protected from acquiring an infection were not in place across all areas of the home.

Staff were trained in how to protect people from abuse and knew what to do if they suspected it had taken place.

Staffing numbers were sufficient to ensure people received a safe level of care. Recruitment records demonstrated there were systems in place to ensure staff were suitable to work within the care sector.

Medicines were stored appropriately and associated records showed that medicines were ordered, administered and disposed of in line with regulations.

Is the service effective?

Good

Acorn House was effective.

Mental capacity assessments were undertaken for people if required and their freedom was not unlawfully restricted.

People were able to make decisions about what they wanted to eat and drink and were supported to stay healthy. They had access and were supported to health care professional appointments for regular check-ups as needed.

Staff had undertaken essential training as well as additional training specific to the needs of people.

Staff had regular supervisions with their manager.

Is the service caring?

Good

Acorn House was caring.

People were well cared for and were treated with dignity and respect by kind and friendly staff. They were encouraged to make decisions about their care and support.

Summary of findings

The staff knew the care needs of people well and provided individual personalised care.

Care records were safely maintained and people's information was kept confidential.

Is the service responsive?

Good

Acorn House was responsive.

Care plans were in place to ensure people received care which was personalised to meet their needs, wishes and aspirations.

People were supported to take part in a range of activities in the home and the community. They reflected peoples' interests and preferences.

Family members and friends continued to play an important role and relationships were maintained and nurtured.

People and their relatives were asked for their views about the home through questionnaires and surveys.

There were systems in place to respond to comments and complaints.

Is the service well-led?

Good

Acorn House was well led.

People were able to comment on the home to influence its delivery.

Staff felt supported by management. They said they were listened to and understood what was expected of them.

Systems were in place to ensure accidents and incidents were reported and acted upon. Quality assurance was measured and monitored to enable a high standard of service delivery.

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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. The inspection checked 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 home and to provide a rating for the home under the Care Act 2014.

The inspection was carried out on 15 December 2015 and was unannounced. It was carried out by two inspectors.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what they do well and improvements they plan to make. It included information about notifications. Notifications are changes, events or incidents that the home must inform us about. We contacted selected stakeholders including three health and social care professionals, the local authority and the local GP surgery to obtain their views about the care provided. They were happy for us to quote them in our report.

During the inspection we spent time with people who lived at the home. We focused on gaining the views of people, and spoke with all ten people who lived at Acorn House. We spoke with staff and observed how people were cared and supported. We spoke with three relatives of people. We spoke with the deputy manager, two care support workers, administrator and cleaner.

We observed the care people received. We spent time in the lounge and dining area and people's own rooms when we were invited to do so. We took time to observe how people and staff interacted.

We looked at three sets of personal records. They included individual care plans, risk assessments and health records. We examined other records including three staff files, quality monitoring, records of medicine administration and documents relating to the maintenance of the environment.

The last inspection was carried out on 15 April 2014 and no concerns were identified.

Requires improvement

Is the service safe?

Our findings

People told us they felt safe. We observed when people were feeling anxious they would approach staff for reassurance and support. Relatives told us they were confident the staff did everything possible to protect people from harm. They told us they could speak with the registered or deputy manager and staff if they were worried about anything and they were confident their concerns would be taken seriously and acted upon. The relative of one person described the multiple and complex needs of their relative and how they felt confident that their relative was safe and well looked after.

Potential risks to people's health, safety and well-being were not consistently well managed. We were told by the person in charge that an empty bedroom on the top floor of the home was used by a relative of the provider on a regular basis during the week. We saw the bedroom was next door to another person's room and shared a bathroom on that floor. Suitable checks into the background of the individual to protect people were not carried out. For example, procedures that included checks made with the Disclosure and Barring Service (DBS), a national agency that holds information about criminal records, were not followed. Risk assessments to identify and meet against any risks, for example from a person using the facilities within the home or living alongside people, were not present. The arrangement also required notification to the provider's home insurer to cover them for subletting or providing services to people outside of the regulated activity.

Due to the concerns with the arrangements in place which potentially place people at risk of harm, we have identified a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Standards of maintenance of most areas of the home were consistently adequate and improving. A relative told us, "It's not posh but the environment is clean and tidy and the staff are clean and tidy themselves." There was a maintenance programme in place that was worked to and included the replacement of a fire panel and renewal of flooring. However, maintenance to the ground floor bathroom required improvement. In this area, infection control measures were compromised by mould which could not be cleaned away adequately because of the condition of the sealant to the shower and tiles. The deputy manager was aware of the issue as it was pointed out and immediately accepted that remedial work was required to repair and make good the area. We have therefore identified this as an area of practice that needs improvement.

Staff understood different types of abuse and told us what actions they would take if they believed people were at risk. When an incident occurred staff reported it to the registered or deputy manager and were also responsible for referring to the local safeguarding authority. This meant staff knew how to report safeguarding concerns appropriately both within the company and to outside professionals.

Risks to people were identified and plans were put in place to manage the risk while protecting people's freedom and maintaining their independence. Person centred plans and risk assessments contained specific guidance about how staff should support people to keep them safe. These included information about how people may react to specific situations, for example out and about in the local community and what staff needed to do to support people to prevent them becoming anxious or distressed. Guidance enabled people to safely participate in their chosen activities as staff were able to support them appropriately. Risk assessments were reviewed and staff were able to tell us about risks to people and how they supported them to minimise the risks.

When an incident or accident occurred staff completed a form which described the incident. It included other information such as the person's demeanour and events leading up to the incident and how the incident was resolved. Within the form there was a section for a review of the incident and the actions taken to identify if alternative interventions should be considered. Staff told us it provided the opportunity to reflect on triggers that had not previously been identified and the effectiveness of interventions.

People required support throughout the day and there were enough staff on duty to ensure this was maintained. The deputy manager told us they had actively recruited staff and it was essential they employed the right staff. We were told, "We need staff who will be right for our residents, it's a concern that we recruit the right staff with the right

Requires improvement

Is the service safe?

outlook and skills." Staff told us they had worked extra shifts when required to ensure people received care from staff who knew them well. They confirmed they did not have to work extra hours if they chose not to.

Staff recruitment records contained the necessary information to help ensure the provider employed people who were suitable to work at the home. Staff files included a recent photograph, written references and a Disclosure and Barring System check, in addition to other required documentation. The provider required two references for staff commencing work.

Medicines were stored, administered, recorded and disposed of safely. We observed medicines being given at times people required them. People were supported, by their staff member for the shift to take their medicines. Where possible people were encouraged to be involved with their medicines. For example, one person was able to identify which medicines they needed. People relied on staff to ensure they received what they had been prescribed. Some people were prescribed 'as required' (PRN) medicines. People took these medicines only if they needed them, for example if they were experiencing pain or anxiety. When PRN medicine was given staff recorded when and why it had been given. Staff knew people well, they understood why these medicines were required and what actions to take if they were not effective.

Personal emergency evacuation plans were in place. These were detailed and contained information to ensure staff and emergency services were aware of people's individual needs and the assistance required in event of an emergency evacuation.

Good

Is the service effective?

Our findings

Staff knew people well, they had the knowledge and skills to look after them. People approached staff when they needed support or assistance and staff responded to them appropriately. One

person approached a staff member and expressed some anxiety. Staff used their knowledge and skills to support and reassure this person.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People 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.

We checked whether the home was working within the principles of the MCA. The procedures for this in care homes and hospitals is called the Deprivation of Liberty Safeguards (DoLS).Providers must make an application to the local authority when it is in a person's best interests to deprive them of their liberty in order to keep them safe from harm. There were DoLS applications pending for two people. Staff were able to tell us about what restrictions were placed on people and how this may constitute a deprivation of their liberty. For example, one person was assessed for, and used, a bed rail.

Staff understood the MCA and DoLS. They had received training and had an understanding of its principles and what may constitute a deprivation of liberty. The MCA aims to protect people who lack capacity, and maximise their ability to make decisions or participate in decision-making. Staff had a clear understanding of people's capacity. Staff asked people's consent before providing support. We saw within the care plans that consent had been discussed with people.

Staff received ongoing training and support. There was a training programme in place and we saw further training and updates were booked for mandatory training. In addition, staff received training to understand and support people with specific health needs, for example in diabetes.

The training provided by the local authority included safeguarding, infection control and food hygiene. However, we received feedback from the local authority that they had suspended the provider from accessing their training. It was not clear how the provider planned to address the training gap that would occur with the suspension in place.

There was a structured induction programme in place when staff started work at the home. This included an orientation during which they were introduced to the policies and procedures of the provider. Staff spent time at the home getting to know people, reading their care plans and risk assessments. Time was given to shadow other staff. In addition, the registered manager had introduced the care certificate, adapted to reflect the needs of the home and people's individual needs to support the induction process. The care certificate is a set of 15 standards that health and social care workers follow. The care certificate ensures staff who are new to working in care have appropriate introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. In addition to induction training, staff were required to complete further training, some of which was online and others taught. They were observed in practice by the registered or deputy manager and discussions were held to check their knowledge and understanding. Staff told us the induction programme provided them with a good understanding of the support people needed.

Staff received regular supervision which was booked in advance. They told us they were able to also speak informally with their supervisor if they required further support. This was possible because it was a small, intimate home where everybody regularly worked with each other. Prior to supervision they were provided with the opportunity to think about areas they may wish to discuss. They were also reminded supervision was also used a method of identifying staff training and development needs. Staff said supervision was useful and they were able to ask for support whenever they needed it. One member of staff said, "I would describe my supervision as productive, especially giving the chance to discuss people's behaviours and different approaches we can try."

People were involved in choosing and making their own meals and drinks. There were photographic menus from which people could choose meals to prepare. Menus were designed to meet the individual likes and dislikes of

Good

Is the service effective?

people. Staff understood people's individual skills and abilities and were able to support them with their choices. For example, one person liked to be involved in the whole meal preparation process. Staff supported this person with their choices to ensure they were able to participate and this promoted their independence. Meals were prepared with fresh ingredients and staff supported each person to ensure they were able to participate as much as possible to maintain their own independence.

Where a need was identified, staff monitored people's weight, fluid or food intake. This was done to ensure people were drinking enough or not eating too much. People enjoyed their food and when people wanted a snack they were encouraged to make 'healthy' choices. We heard one person talking to staff and telling them about a healthy food choice they had made. People were involved in choosing their own hot and cold drinks throughout the day.

Everybody had a health component to their care plan in place. These identified the health professionals involved in their care, for example the GP and chiropodist. They contained important information about the person should there be a need to go to hospital. These were clearly written and provided health care staff with information about supporting each person. A healthcare professional commented, "I have always found the service to be effective at meeting the needs of the people they support. My experience has been that the staff and management are good at seeking appropriate input with regards to individuals health needs, be that from specialist learning disability services or mainstream services. The service respond well to advice given and have always put my recommendations into action."

Good

Is the service caring?

Our findings

People were supported by staff who knew them well as individuals. They were able to tell us about people's needs, choices, personal histories and interests. We observed staff talking and communicating with people in a caring and professional manner and in a way people could understand. One relative said, "Staff are friendly and patient. It's like a family home. I have nothing but praise."

Friendships between people had blossomed while living at Acorn House. Throughout the inspection people were seen interacting together. We talked and spent time with two people who had the only shared room. They told us they preferred the arrangement as they enjoyed each other's company. They were obviously devoted to each other. One of them told us, "My name is [name of the person] and this is [their friend], we're friends and we always sit next to each other."

Staff spoke with people in a kind and respectful way. They demonstrated warmth and it was clear that all staff we spoke with were genuinely fond of the people they supported. Staff told us meeting people's individual needs was the most important thing they did each day. They told us they put people first to improve their lives and enable them to have more choices. We observed people enjoying themselves in the company of staff. People told us they were well looked after and happy living at the home. One person said, "The main good thing is the staff, who I like. Everyone is very friendly."

People had timetables of activities for each day, however they were supported and encouraged to make choices for each day. For example, people chose when they got up or when they went out. Staff knew how people liked to spend their time at the home. Some liked to stay in their bedrooms and others preferred to be in the communal areas and staff supported them in their choices. As Christmas approached, the home was decorated with a Christmas tree, tinsel and home-made decorations. People took obvious pleasure and pride in being involved in the decoration of the home. They told us they were involved in dressing the tree and making the colourful paper chain decorations. Some people had small Christmas trees and decorations within their bedrooms.

People were able to express their views and were involved in making decisions about their care and support and the running of the home. Resident's meetings were held on a regular basis. These provided people with the forum to discuss any concerns, queries or make any suggestions. Minutes from the last meeting confirmed people spoke about the upcoming holiday season, activities, menus and were given the opportunity to think about complaints.

People's privacy and dignity was respected. People were supported and encouraged to go to their bedroom, bathroom, or toilet whenever they needed to address aspects of personal care that was inappropriate in a communal area. This support, where it was required, was discreetly managed by care staff, so that people were treated in a dignified way in front of others. For example, we observed a staff member gently suggest to a person they may like to change their clothing. The person did this cheerfully and the staff member acknowledged this when they returned with clean clothes. Staff also made sure that doors were kept closed when they attended to people's personal support needs. Staff knocked on people's doors and waited for a response before they entered the room. Staff told us they maintained people's dignity by promoting their independence and involving them in decisions.

People's bedrooms were individually decorated and furnished with people's own items including their own pictures and artwork. One person, keen to keep-fit, had a rowing machine which they energetically used. We heard how staff supported people to choose how they would like their bedrooms decorated. Relatives told us people were supported to make choices.

Staff treated people with compassion when they became distressed, talking to them privately and supporting them to identify why they were upset and helping them to resolve their concerns.

People had an allocated key worker. A key worker is a person who co-ordinates all aspects of a person's care and has responsibilities for working with them to develop a relationship to help and support them in their day to day lives. Key workers told us it was essential there was a bond and mutual respect between the person and their key worker to ensure people received the best possible care.

The management and staff followed the principals of privacy in relation to maintaining and storing records. There were arrangements in place to store people's support records, which included confidential information and medical histories. There were policies and procedures

Good

Is the service caring?

to protect people's confidentiality. Support records were stored securely on either the provider's computer system or in support files. Staff had a good understanding of privacy and confidentiality and had received training.

Good

Is the service responsive?

Our findings

People were involved in developing their own person centred plans. Relatives told us people were supported to be as independent as possible. One person said, "Staff have helped [My relative] to be more independent. They are happier now than they've been in a long time and they have lived in three homes." A visiting professional told us the home provided good person centred care.

A relative we spoke to said they felt fully involved in the care of their family member. They told us that they were updated with any changes or issues that affected care. People's care and support plans clearly identified their needs and reflected their individual preferences for all aspects of daily living. Care documentation contained a personal profile, including their family history. One staff member told us, "I found the support plans really helpful when I started to get an understanding of people's background and needs." Care plans demonstrated assessment of people's individual needs and clearly identified how these could be met. Areas included their independence, nutrition, personal hygiene and communication. Care plans contained sections that set out information for staff when they supported people who faced challenges to verbal communication. Likes and dislikes identified where people were able to makes choices and retain control in aspects of their daily routines such as clothing and meals. Care plans were regularly reviewed, followed by a more comprehensive review involving family and/or advocates, social workers and the person's key worker.

Staff had a good understanding of people's individual needs and said they were given time to ensure documentation, including daily notes were up-to-date. Support staff were familiar with people's day and night care needs and their routines they had developed around their day. We saw daily care records provided clear informative descriptors of people's activities, demeanour and behaviours. Staff told us these were useful to review if they had been off duty for a few days.

Routines were a crucial part of people's days, and person centred plans reinforced that these were important to ensure consistency. Some people benefitted from picture timetables to show what they had planned each day. People were encouraged to be responsible for cleaning and tidying their bedroom. People were provided with structured and spontaneous opportunities for people to take part in activities 'in-house' and to access the local area. A member of staff said, "Some people lost their day centre places but have had one-to-one funding in its place. They [named person] were becoming less happy there anyway. But one thing they loved was the arts and crafts work at the centre so we have put it in as a regular part of their week now." We saw photographs of people taking part in various activities at home and out and about in the community. One staff member identified the need for a person to maintain a balance between enjoying the company of others against their often expressed wish to retreat into their own personal space. Care documentation identified and supported this need.

People were involved in 'resident meetings' once a month. Meeting minutes from the last meeting on the 21/11/2015 showed this meeting had been well attended and provided people with the opportunity to have input into the running of the service. We saw that pictures and images were used to ensure people were able to be involved in decision making and so that the same questions could be used as prompts each time. The questions and topics included, 'What would you like to change in the home?' and 'What would you like to do at weekends?' The menu was a standing item for discussion and showed, for example, that the idea of salad wrap as a healthy lunch choice was put forward for people to try. Food choices were made for upcoming birthdays and other special occasions including Christmas. We saw a person chose to have fish & chips on Brighton pier for their birthday. We saw that one person had chosen not to attend a meeting and that staff had read and explained the agenda and discussion points to them following the meeting.

Staff had a handover between shifts. These provided staff with a clear summary of the routines of the home that day. It planned for the logistics related to staff allocation of duties. Individual updates on people featured prominently. Staff had the time and opportunity to ask each other questions and clarify their understanding on issues.

We looked at the completed satisfaction questionnaire surveys for 2014. People and their relatives were surveyed, though not all the relatives we spoke with had been included in the survey distribution. Feedback was seen to be positive. The information that was captured was collated and the results were shared with people. The deputy manager told us that if anything was raised that

Good

Is the service responsive?

required a response, they would undertake these themselves. Typical comments from the survey included, 'I am happy with staff', 'I like the manager' and 'I like to go to church and go every Sunday'.

The PIR identified that a complaints policy was available to people within the home. During our inspection we saw this was also available in a pictorial format for people. This was also a regular item for discussion at resident meetings. At the time of our visit the home had received no complaints and we saw previous complaints had been responded to appropriately.

Good

Is the service well-led?

Our findings

The provider had produced their vision and values and these ran through the homes policies and procedures. Staff confirmed they had read them. Staff were clear on the vision and philosophy that underpinned the service. The manager and staff we met on our inspection knew each person well. One staff member told us their saw their role as, "Helping people to have the best, most fulfilled life possible."

The provider was in the process of registering a second manager at the home. They told us this was because they wanted to have a registered manager available throughout the week, including weekends. The deputy manager was positive about the move and this was reflected by staff who spoke highly of both the registered manager and their deputy and the leadership they provided. One member of staff told us, "I know I can approach them about anything and they will make time for me." Staff demonstrated a clear understanding of their roles and the lines of accountability. One member of staff told us, "I would speak to the senior if I had a concern but I know I could always go to the manager." Another member of staff said, "I know I am listened to." The current (sole) registered manager was at the home between two or three days a week at the weekend and their deputy provided management cover during the week. All staff were aware of the 'on call' system in place when a manager was required out of hours. One staff member said, "You can always get to speak to a manager if you need one."

The home was small, with only ten people and most of these people had known each other for a number of years. People appeared to have a bond of friendship with each other. People, their relatives, management and staff reflected on the friendship that existed between people and made reference to the extended family feel of the service. One relative said, "Acorn House has a nice atmosphere and a homely feel." Another relative said, "[My relative] is very fond of [the manager] and their keyworker and is very happy about living there."

Staff meetings were held regularly. We looked at the minutes for the last meeting held on 28/10/2015. The minutes looked at the actions arising from the last meeting and whether these had been met. Staff who were unable to attend were able to read minutes of the meetings. The meetings provided an opportunity for staff to raise and discuss issues and for managers to remind the staff team about key issues in the running of the service. Staff told us they found these meetings useful and provided an opportunity to share ideas and provide each other with updates on individual people. For example, one person had a plan to visit London which had to be postponed. Alternatives for the person were discussed and planned for. One staff member said, "The communication here is very good, there are chances to share what we know."

Quality assurance systems were in place to monitor the running of the home and the effectiveness of systems in place. Audits were undertaken for a wide range of areas, these included medicines, care plans and health and safety. Audits were undertaken by the registered manager or their deputy. They provided a picture of the quality of the home and an action plan for each area looked at. For example, there was a section for the registered manager or deputy to indicate what actions they had taken in response to a prompt.

A walk through quality check of the home was undertaken monthly and done jointly with a manager and a person who lived at the home. The form used pictorial prompts for key questions such as, 'Are there enough gloves?' The deputy manager said, "It is helpful to have a fresh set of eyes to look at how the service runs." The managers also completed spot checks, whereby they made unannounced checks on staff.

The deputy manager told us they felt well supported by their line manager and that communication between them was effective. During our inspection we heard the deputy manager and administrator liaise over key tasks to be completed for that week. The deputy manager described the training they had been involved with and planned for the future. For example, the deputy manager knew that the Care Home In Reach Team provided additional support and advice for staff teams working with people living with dementia. The manager recognised the value of bringing in outside advice to inform the work they did and was committed to working alongside this valuable resource.

The registered manager had identified in their PIR that a focus for the home was to improve staff supervision and appraisal. During the inspection they identified one method they were using to achieve this was by accessing training for supervisors to become more skilled in this area and to inform practice. For example, we saw the registered manager and their deputy had worked with staff during

Good

Is the service well-led?

supervision to identify areas where they could take on additional responsibility. They said, “Focusing on staff morale is really important.” Staff we spoke with were positive about their roles and the people they supported.

The deputy manager was aware of the relatively new statutory Duty of Candour which aimed to ensure that providers are open, honest and transparent with people and others in relation to care and support. The Duty of Candour is to be open and honest when untoward events occurred. The deputy manager was able to describe unintentional and unexpected scenarios that may lead to a person experiencing harm and was confident about the steps to be taken, including producing a written notification. They were able to demonstrate the steps they would take including providing support, truthful information and an apology if things had gone wrong.

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	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment 13.—(1) Service users must be protected from abuse and improper treatment in accordance with this regulation. (2) Systems and processes must be established and operated effectively to prevent abuse of service users. How the regulation was not being met: People who use services and others were not protected against the risks associated with safeguarding people from suffering any form of abuse or improper treatment while receiving care and treatment.