Ms Diane Crowther

Maybury Court Residential Home

Inspection report

802-808 Holderness Road
Hull
Humberside
HU9 3LP
Tel: 01482 704629
Website: N/A

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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

Overall summary

We undertook this unannounced inspection on the 14 and 15 May 2015. The last full inspection took place on 4 July 2013 and the registered provider was compliant in all five of the areas we assessed.

Maybury Court is owned and managed by an individual and is registered to provide accommodation and personal care for up to 28 older people, some of whom who may be living with dementia. On the day of the inspection there were 25 people living in the home. The home consists of two adjacent houses connected on the ground floor by a corridor. There is a selection of shared bedrooms and those for single occupancy on both floors. There are several communal rooms on the ground floor and bathrooms and toilets located on both floors.

The registered provider is also the registered manager. A registered manager is a person who has registered with

Summary of findings

the Care Quality Commission [CQC] 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.

People who used the service were protected from the risk of harm and abuse by staff knowledge and safeguarding training. However, procedures had not been followed regarding informing the local safeguarding team of incidents between people who used the service. This would have provided them with the opportunity to check out how the incidents were managed and to provide advice. We found one person had unsafe bedrails on their bed, which were removed on the day of inspection. A risk assessment for the bedrails had not been updated.

We found people mostly received their medicines as prescribed although one person had not received the correct medicine for two days and the recording of some directions could be made clearer for staff. This was discussed with the person's GP during the inspection and the person had not experienced any ill effects.

We found there had been several occasions when CQC had not received notifications of incidents that affected the welfare of people who used the service and on one occasion an incident that had impacted on the running of the service. We had also not been notified when the registered provider/manager changed their email address. This had resulted in the registered provider/manager not receiving an important request to complete a Provider Information Return. It is important the registered provider/manager notifies us of incidents and changes so we can check how they are managed and have accurate and up to date information about the service.

There were some audits and checks completed, for example care files, people's nutritional status, accidents, medicines and the environment. Some of these were effective in highlighting gaps, however there was no environmental improvement plan to show when specific areas were to be addressed.

We found people's health and nutritional needs were met. We saw professional advice and treatment from community services was accessed when required. We found people received support in a person-centred way with care plans describing preferences for care and staff following this guidance.

We observed positive staff interactions with the people they cared for. Privacy and dignity was respected and staff supported people to be independent and to make their own choices. There was a range of activities and meaningful occupations for people to participate in. When people were assessed by staff as not having the capacity to make their own decisions, meetings were held with relevant others to discuss options and make decisions in the person's best interest.

We found staff were recruited in a safe way and in sufficient numbers to meet the current needs of people who used the service. Staff had access to induction, training, supervision and appraisal which helped them to feel skilled and confident when providing care to people.

We found there was a complaints procedure and people felt able to complain in the belief issues would be addressed.

We found the service was clean and tidy, did not have any malodours and equipment used was serviced in line with manufacturer's instructions.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not consistently safe.

Policies and procedures were in place to guide staff in how to safeguard people from abuse and staff had received training. However, procedures had not been followed and several incidents between people who used the service had not been reported to the local safeguarding team.

Some risk assessments were not sufficiently robust to help minimise risk.

People mostly received their medicines as prescribed although one person had not received the correct medicine for two days.

Staff were recruited safely and were employed in sufficient numbers in order to meet the needs of people who used the service.

Requires improvement

Is the service effective?
The service was effective.

People's health care needs were met and they were assisted to make choices about aspects of their lives.

When people were assessed as lacking capacity to make their own decisions, best interest meetings were held with relevant people to discuss options.

Staff had access to training, supervision and appraisal to enable them to feel confident in their role.

Good

Is the service caring?
The service was caring.

We observed care was provided to people in a kind and caring way.

People's privacy and dignity was respected and their independence promoted.

Staff provided people with information and explanations about the care they provided.

Good

Is the service responsive?
The service was responsive.

Care plans included people's preferences for how care should be carried out and gave staff guidance in how to support people in a person-centred way.

There were activities and meaningful occupations for people to participate in.

There was a complaints policy and procedure. People were aware of how to make a complaint and told us any concerns would be dealt with.

Good

Summary of findings

Is the service well-led?

The service was not consistently well-led.

The Care Quality Commission had not been notified of specific incidents that affected the welfare of people who used the service and which also impacted on the running of the service.

Some quality audits took place but some checks of the environment had not identified shortfalls and a plan to address them had not been formulated with timescales for completion.

Surveys were carried out and there was an open culture to encourage people who used the service, their relatives and staff to seek out management and express their views.

Requires improvement

Maybury Court 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.

This inspection took place on 14 and 15 May 2015 and was unannounced. The inspection was completed by one adult social care inspector.

Before the inspection, the registered provider/manager was asked to complete a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We did not receive the completed PIR so checked out why during the inspection. We looked at notifications sent in to us by the registered provider, which gave us information about how incidents and accidents were managed.

Prior to the inspection we spoke with the local authority safeguarding team, and contracts and commissioning team about their views of the service.

We spoke with seven people who used the service and two of their relatives who were visiting during the inspection.

We observed how staff interacted with people who used the service and monitored how staff supported people during lunch. We spoke with a social worker and a community nurse who visited the service during the inspection and received information from a district nurse a few days after the inspection.

We spoke with the registered provider/manager, the deputy manager and four care workers of different grades, one of which also carried out some catering tasks.

We looked at five care files which belonged to people who used the service. We also looked at other important documentation relating to people who used the service such as incident and accident records and 10 medication administration records [MARs]. We looked at how the service used the Mental Capacity Act 2005 and Deprivation of Liberty code of practice to ensure that when people were deprived of their liberty or assessed as lacking capacity to make their own decisions, actions were taken in line with the legislation.

We looked at a selection of documentation relating to the management and running of the service. These included three staff recruitment files, the training record, the staff rotas, minutes of meetings with staff and people who used the service, quality assurance audits and maintenance of equipment records.

Requires improvement

Is the service safe?

Our findings

People told us they felt safe living at Maybury Court and staff treated them well. They said there was enough staff on duty and they answered call bells in a timely way. Comments included, "I like it very much here; the staff always check after us", "They look after us well", "Safe, yes I feel alright here", "The staff are smashing; they do talk to us in a nice way" and "I do like it here. Yes, I feel safe and secure; the staff look after me – they really do. I have never heard them shout at us; not one of them has raised their voice to me."

People also said they received their medicines on time. Comments included, "I come down in the morning for my tablets and find out who is doing them", "There are no problems with my tablets" and "I take Paracetamol for pain and when I ask for some they bring them straight away."

Visitors told us they were happy with care their relatives received. Comments included, "Yes, they look after him really well. I have no worries as I know he is safe here" and "I'm confident about the carers; yes, he's safe here."

The registered provider/manager had policies and procedures in place to guide staff in safeguarding people from abuse and we saw all staff had completed appropriate training. Staff recorded when incidents had occurred between people who used the service and they supported and reassured during these times. However, we found the registered provider/manager had not followed procedures and had not discussed several incidents with the local safeguarding team. This would have enabled the local safeguarding team to log the concerns and check how the staff managed the incidents. The records showed the people involved did not sustain any injuries. The registered provider/manager and deputy manager had both received training in the use of the local safeguarding risk matrix tool; they told us any future incidents will be graded against the tool and discussed with the safeguarding team straight away.

In discussions, staff knew the different types of abuse and the signs and symptoms that may alert them abuse had occurred. They all said they would report any concerns to the registered provider/manager straight away.

We found medicines were obtained, stored and disposed of appropriately. However, we found one person had not received the correct dose of their medicine for two days. The deputy manager spoke to the person's GP to inform them and to check if any action was required. The person had not experienced any ill effects from the error. We found there were times when the recording of medicines could be improved. For example, some people were prescribed medicines 'when required' to help relieve anxiety but there were no clear directions to guide staff in their administration. Staff recorded when they had been given to people but not whether they had alleviated the person's anxiety. There were also some occasions when staff had updated instructions on the medication administration records [MARs]. Staff told us this was following discussions with the person's GP but this had not been made clear on the MARs and had not been dated and signed. We found aero-chambers used to administer medicines prescribed for inhalation were not stored in line with good infection prevention and control practice. These points were mentioned to the registered provider/manager to address with staff who administered medicines.

We saw risk assessments had been completed for areas such as nutritional intake, skin integrity, mobility, potential falls and behaviour that could be challenging to staff and other people. These provided staff with information in how to reduce risks. We saw one person had recently rolled out of bed onto the floor whilst reaching for an item and sustained an injury. The person had capacity to make their own decisions and agreed to a bed rail to prevent this from happening again. However, we were told the person exited the bed whilst the rails were still up, which could potentially cause an injury, and we saw no risk assessment had been completed for the use of the bedrails. When we checked them we found the rails did not fit the bed properly. After discussion with the person, the registered provider/manager removed them and replaced them with a grab handle frame on the day of the inspection.

The registered provider/manager told us there had not been any new employees recruited for over a year as staff retention was very good. Recruitment documentation indicated application forms and references were in place and checks with the disclosure and barring service [DBS] had been completed. DBS checks helped to ensure only appropriately vetted people worked in care homes. The registered provider/manager told us potential staff were interviewed to establish their suitability to be care workers,

Requires improvement

Is the service safe?

however there were no records of the interviews. The registered provider/manager told us they would keep the interview record in the staff file for any future employee, which would help when auditing recruitment decisions.

Staff told us there were sufficient care workers to meet the current needs of people who used the service and they did not feel rushed when supporting people. This was confirmed in discussions with people who used the service and their relatives, and when we checked staff rotas. In addition to the registered provider/manager and deputy manager, there was a skill mix of staff employed in the service with a range of roles. For example, a newly developed role, 'carer and resident support worker', senior care workers and care workers. The carer and resident support worker was created to bridge a gap between senior care workers and the deputy manager and had a monitoring and oversight role; they also liaised with relatives. There were ancillary staff for catering, administration, domestic and maintenance tasks. The ancillary staff enabled care workers to focus on care tasks with people who used the service. The registered provider/manager told us they did not use agency staff as they preferred to have continuity of care workers and the core staff team covered for any short notice absences.

Comments from staff included, "We have some long term sickness at present but we can manage. There are plenty of staff and we can always ask the managers and cleaners for help." The registered provider/manager said, "We used to use the care staffing forum tool to calculate staffing numbers but now we consider people's needs; if service users are going through any crisis or troubling time then we would look at this and increase staffing hours. It's based on individual's day to day need."

Equipment used in the service was in working order and was checked and serviced in line with manufacturer's instructions. These included two passenger lifts, two chairlifts for the stairs, hoists, fire safety equipment, gas and electrical appliances, the nurse call system and hot water outlets. We saw that some windows, which opened quite wide, did not have restrictors in place, which could affect security. During the writing of this report the registered provider/manager confirmed these had been purchased and arrangements made for them to be fitted.

We found the service was clean and tidy with no malodours.

Good

Is the service effective?

Our findings

People told us they were able to see their GP or nurse when they needed to and also saw opticians, dentists and chiropodists. They said they enjoyed the meals provided and had plenty to eat and drink. Comments included, "Yes, I see my doctor when I need to and I go to my own optician and dentist up the road", "If I was ill, I'd see the girls [staff]", "The food is very good; two choices and plenty to eat and drink", "The food is smashing", "They plate the food nice" and "The food is lovely; there is a lot of choice and I've put weight on since being here."

Relatives told us they were happy with how the staff supported people's health care needs. They said, "He has a good diet here to help his diabetes", "They look after him well", "His GP has visited and the district nurse. He was really poorly before coming here but has rallied" and "Oh yes, he loves the food here and has a diary to fill in of what he eats for dinner."

A social worker spoken with during the inspection said, "He's happy with the food and has put weight on; he prefers gravy on the side and mentioned this at the review so they can sort it."

The Care Quality Commission is required by law to monitor the use of Deprivation of Liberty Safeguards [DoLS]. DoLS are applied for when people who use the service lack capacity and the care they require to keep them safe amounts to continuous supervision and control. There were no people subject to a DoLS at the time of this inspection although the registered provider/manager told us they were having discussions with the local authority about one person who they felt met the criteria. The registered provider/manager is to keep us informed of the outcome.

We found the application of the Mental Capacity Act 2005 [MCA] in regards to the recording of assessments of capacity could be clearer. For example, although some best interest decisions were recorded, there was no documentation to show assessments had been completed to determine people lacked the capacity to make their own decisions. The registered provider/manager told us assessments had been made but not recorded or they were completed by health or social care professionals. We found this was in relation to people receiving flu vaccinations, moving bedrooms and sharing them and the use of lap straps in wheelchairs and in an armchair. The registered provider/manager and deputy manager had completed MCA and DoLS training. The registered provider/manager told us they would speak to the local authority to obtain the correct documentation for recording future MCA assessments and meetings to discuss decisions made in people's best interests.

Staff described how they gained consent from people when completing every day care tasks with them. They said, "We ask people and give explanations" and "We talk through everything we are going to do, ask if it's ok and reassure people." They described how consent could be given verbally, implied by allowing staff to assist them and also given using non-verbal means.

We found people's health care needs were met. The care files indicated that people who used the service had access to a range of health and social care professionals. These included GPs and consultants, district nurses and community psychiatric nurses, dieticians, social workers, chiropodists and opticians. Records were made of when the professionals visited and what treatment or advice they provided. In discussions, staff described how they recognised the first signs of pressure damage, chest infections and urine infections, and what action they took to ensure health professionals were made aware. A health professionals spoken with said, "The staff are really good and communicate well with us. The staff raised an issue for one patient so I could follow it up. They act quickly when they see problems and they follow instructions."

We found people's nutritional needs were met. The deputy manager used a recognised nutritional risk monitoring tool to determine if people had increased nutritional needs. This also gave them guidance about when to involve a dietician and appropriate intervals between monitoring people's weight. Care plans were in place to guide staff in how to support people's specific nutritional needs and in discussions it was clear they knew people's needs well. For example, they described who had special diets and who required thickeners in fluids to aid swallowing.

We found the dining room was nicely set out with individual tables and chairs and the lunchtime experience was calm and unhurried. We noticed that one person may require more assistance with their meals as they seemed to struggle at times and the choice of music at lunchtime could be discussed with people who used the service. We mentioned these points to the registered provider/

Good

Is the service effective?

manager to check out. One of the catering staff told us they had no concerns about the budget for food and confirmed there were always at least two choices for each meal. Menus were on display and indicated choices and alternatives for each meal.

Records indicated staff had completed a range of training considered essential by the registered provider/manager. Staff confirmed they completed training such as first aid, moving and handling, basic food hygiene, infection prevention and control, medication management, dementia awareness, safeguarding adults from abuse and fire safety. Some staff had also completed other training over the previous years such as end of life care, catheter care and diabetes. Most staff had a national vocational qualification [NVQ] in care and six care workers were awaiting registration for enrolment on the new care certificate. The registered provider/manager told us it was expected of all staff that they completed national training in care.

Staff told us they felt well supported by management and received supervision in meetings and via learning sets devised by the deputy manager. Records showed staff had six monthly reviews and annual appraisals. New staff received an induction that consisted of an orientation to the service and people who lived there, reading important policies and procedures, shadowing more experienced staff and having their competence checked when completing specific tasks.

The environment had some adaptations to meet people's current needs. There were grab rails, ramps and mobility aids. The doors to the toilets were a different colour to other doors and there was pictorial signage to assist people with memory impairment. The registered provider/manager told us they were aware that people who lived with dementia required bright lighting and memory aids. They said when the toilets were refurbished, this would be taken into consideration and good practice guidance regarding appropriate environments for people living with dementia would be used.

Good

Is the service caring?

Our findings

People told us the staff team were caring and treated them with dignity and respect. Comments included, "Yes, the staff are friendly and respectful", "I'm very happy here" and "They care for you."

Relatives told us, "They really look after him and really care for him. He says it's an extension of his own family", "He's the biggest promoter of the home", "They keep me informed and ring me if there is anything wrong; he fell once and they were straight on the phone" and "The staff are brilliant." Comments from a recent relatives survey were very positive and included, "I could not fault the care home or the way my mother is looked after", "Very respectful and always willing to help" and "He always speaks highly of everyone."

Visiting health and social care professionals said, "I have no issues with the staff; I've seen him bantering with staff" and "The staff are respectful to people."

We observed the atmosphere was calm and there were some positive interactions between staff and people who used the service. Staff had time to sit and chat to people and it was clear they knew their social histories and relative's names. They asked questions about how they were and whether they needed anything and we observed staff provide explanations to people before completing care tasks. We saw one person often entered the registered provider/manager's office to talk to them or just to explore the room; they were welcomed into the room and greeted politely. The approach from staff was kind and caring. Staff said, "We look after them as if they were our own mum and dad" and "One person was for TLC [tender loving care and meaning end of life care], we blended all their meals as they wouldn't eat them otherwise but now it's great, they've rallied." Staff greeted relatives in a friendly way when they visited and we were told there were no restrictions on visiting times. We observed visitors were offered refreshments.

We saw people's privacy and dignity was respected. Staff were seen to knock on doors and wait before entering, they called people by their preferred name and they observed privacy when people used the bathrooms. People looked well cared for, their clothes and nails were clean, their hair brushed and some people wore jewellery. When we checked people's bedrooms we saw their clothes and personal items were respected and put away tidily in wardrobes.

Staff told us how they promoted important values such as privacy and dignity. Comments included, "We keep people covered during personal care tasks, respect their privacy, knock on doors and use screens." Care plans prompted staff to think about privacy and dignity issues. For example, in one care plan it stated, "She is proud of her appearance."

We saw staff involved people in care plan reviews and 'residents meetings' each month. Minutes of these meetings showed us people who used the service were provided with information such as when the boiler broke down and when it was repaired. They were also asked their opinion about the menus and activities provided. There were notice boards in the entrance with information about the staff team and training, the policy on smoking in the service, the food safety certificate and how to complain. We saw menus were provided in written and pictorial format. We also saw there were leaflets about advocacy services on display although the registered provider/manager confirmed there was no-one currently using this service as people had relatives to support them.

There was a designated treatment room were GPs and district nurses could see people in private to deliver treatment or discuss confidential issues. A visiting health professional said, "Staff accompany me when I visit and I'm able to see patients in private."

Most people had bedrooms for single occupancy which offered privacy and there were several shared bedrooms in use. These had privacy screens for use when staff completed personal care tasks for people when both occupants were in the room. Bedroom doors did not have privacy locks and staff told us people were asked years ago if they wanted them but they declined. We noted that the privacy locks on two toilets doors did not work and the registered provider/manager told us they would address this straight away. The registered provider/manager told us they would install privacy locks to bedroom doors if people wanted them.

We saw staff kept people's personal information private and confidential. They told us telephone conversations with health and social care professionals or with relatives could be made in private in the staff office. Care records

Good

Is the service caring?

were held securely and computers were password protected. We saw that the registered provider/manager had registered with the Office of Information Governance [OIG]. This followed good practice guidance as the service held care records and personal details on the computer.

Good

Is the service responsive?

Our findings

We found the service was responsive to people's needs. People who used the service told us there were activities for them to participate in and they had choices about aspects of their lives. Comments included, "Yes, you can get up and go to bed when you want", "If I don't want to get up, I stay in bed", "I like to watch TV and be in my room", "There are activities every afternoon such as jigsaws, foot spas, memory games, bingo and the hairdresser comes on Mondays", "There are concerts and dominoes and six of us sit together at lunch", "I go out once a month to buy clothes; the staff take me" and "Visitors can come anytime they want; it's a home from home here",

People told us they felt able to complain in the belief it would be addressed and they named the registered manager or specific staff they would approach if they had concerns. Comments included, "Yes, I would definitely tell someone" and "I would tell anybody who is about; my daughter would also sort out problems." Relatives spoken with said, "I would see the manager or one of the girls if I had any concerns" and "I would tell the staff. I had an issue in the past but it was sorted out and I felt reassured. They were really approachable." Comments from a recent survey of relatives included, "She has settled so much better than we thought possible" and "They always have time to listen to your concerns."

We saw care was provided in a person centred way. People had assessments carried out prior to admission and care plans were developed to guide staff in how to support their needs. Each person had a 'one page profile', which detailed information such as what was important to the person, what people liked and admired about them and how best to support them. The care plans indicated what the person could do for themselves and what they required assistance with; this was important in ensuring people retained their current skills. The care plans also indicated preferences such as the jewellery people liked to wear each day, what day they saw the hairdresser and their preferred portion size for meals. A plan to support a person when they became anxious provided staff with guidance on how to speak to the person and what to say to help distract them and reassure them. We saw that some care plans to support other people to reduce their anxieties, and behaviours that were challenging to other people, could include more guidance to staff. This was mentioned to the registered provider/manager and deputy manager to address.

We saw care plans were updated when people's needs changed. The updates were in the form of additional sheets of paper and were signed and dated by staff. However, some people had several additional sheets which staff would have to trawl through to get to the most up to date pages. We saw some of the changes were not the most up to date information as the person's needs had changed again. The deputy manager told us they would collate this information into the actual care plan at certain intervals to prevent confusion. However, in discussions with staff they were fully aware of people's needs and the updates that had been made to care plans.

Staff told us how they provided person-centred care to people and gave us specific examples. These included one person who occasionally became anxious, but if staff approached them wearing ordinary clothes instead of a uniform during these times, it seemed to calm them. This showed us how staff tried to adapt their approach in response to people's individual needs. Staff described how observations completed every fifteen minutes were ineffective in supporting another person to reduce the number of falls they had. The issue was discussed with relatives, and sensor mats and an alternative bedroom closer to staff had proved successful in reducing the number of falls. One person became distressed when a ceiling track hoist was used to assist them into the bath. Staff told us the person now has bed baths instead and their anxieties have been reduced. One person had been assessed for a chair to suit their specific height requirements and some people had a rest on their beds in the afternoon to prevent damage to their fragile skin. There was a shelter in the garden for people who wished to smoke.

Records indicated people had reviews of the care provided to them. These included input from specific people involved in their care so that progress could be discussed and changes made to plans of care.

There were 'patient passports' in each person's care file. These provided information to hospital staff when people

Good

Is the service responsive?

were admitted for treatment. Some of the patient passports had not been updated with minor but relevant information. This was mentioned to the registered provider/manager to check out.

We saw people had access to activities each day. Staff told us they had time to sit and talk to people. Records showed people participated in memory card games, visiting entertainers each month, table top games, chair exercises, manicures, folding laundry, wiping dining tables, sorting clothes in drawers and wardrobes, looking at magazines, drawing and sing-a-longs. These activities and meaningful occupations helped to provide social stimulation for people who used the service.

We saw people who used the service could make choices such as what time to get up and retire to bed, where to sit during the day, what to have for their meals and where to eat them and what activities to participate it. The care files contained information about preferences for how people wished to be cared for. This helped to guide staff when they supported people to manage their needs. Staff told us they tried to ensure people retained as much independence and choice as possible. They said, “We try to encourage people all the time to do as much as they can for themselves.”

There was a complaints procedure on display in the entrance. The complaints policy and procedure informed people of who to speak with if they had any concerns and timescales for actioning complaints and responding to people. Staff were aware of the complaints procedure.

Requires improvement

Is the service well-led?

Our findings

People who used the service knew the registered provider/manager's name, which told us they got out and about the service and spoke to people. People named the registered provider/manager as one of the people they would go to if they had concerns. We observed the registered provider/manager noticed one person's leg was dry and itchy. We later saw they had spoken with staff and the person had received cream applied to their legs. This showed us the registered provider/manager knew people's needs. A community nurse said, "I have always found the management and carers helpful."

The registered provider/manager is required to send the Care Quality Commission [CQC] notifications of incidents which affected the safety and wellbeing of people who used the service and which affected the running of the service. We found there had been several incidents in the last year which required a notification to CQC but our records indicated we did not receive them. Notifying the CQC of incidents which affected the health and welfare of people who used the service enabled us to check with the registered manager how these were being dealt with. We have written to the registered provider/manager advising them of the need to notify CQC as required by regulation.

We spoke with the registered provider/manager as to why they had not returned the Provider Information Return requested prior to the inspection. They told us they had not received a request for one. When we checked this out, we found the registered provider/manager had changed their email address but had not notified CQC. It was important the registered provider/manager informed CQC of any changes to their registration including email addresses so we have up to date and accurate information. The registered provider/manager told us they would formally notify CQC of the change so our records could be updated.

We spoke with the registered provider/manager about the culture of the service and their management style. They told us it was important to have a management structure but the aim was to work as a team and to support staff with an open-door policy so they could discuss concerns. They also said their focus was the people who used the service. They said, "Staff do come forward and misunderstandings between staff are sorted out and resolved amicably" and "Communication and being caring is important, so is stepping in and helping out; I expect staff to tell me what's going on and the door is always open so I can hear what goes on." We observed the registered provider/manager knew the people who used the service and their relatives. The registered provider/manager greeted people on her arrival in the service and went round to check if people who used the service and staff were ok.

We found the team worked well together in practice. Staff spoken with were complimentary about the registered provider/manager's style and said they felt very supported. Comments included, "It is a good place to work; there is a lovely caring atmosphere", "Management are very approachable and will bend over backwards to help you" and "I enjoy it here; we are a good team, have good routines and get on well together."

We spoke with the deputy manager about the quality monitoring system, as they had lead responsibility. We saw there was a yearly planner for them which detailed month by month what tasks were required. These included updating records, care plan reviews, accident analysis, staff supervisions/reviews, medicines audits, a check on training, ensuring people were weighed and checking nutritional risk assessments were in place. Each month, the deputy manager indicated which staff had received their reviews, who had completed training and which people who used the service had received a care plan review.

We saw some audits were completed, for example a monthly medicines audit. Records showed this was effective in identifying gaps in recording and commented on areas such as stock control, cleanliness of the trolleys and temperature of the stored medicines. We saw the amount of recording gaps had been reduced between audits completed in February and March 2015, showing they were effective. Care plan audits identified the number of updates that had been completed but had not captured some out of date information included in the care files.

Environmental checks had been completed and they identified when repairs were required. There had been major updates to the heating system in recent months and a repair to one of the passenger lifts. However, there was no environmental improvement plan to show when specific areas were to be addressed. For example, the linen room was not fit for purpose and window restrictors were required to improve security and safety. The registered provider/manager told us they were aware the hallway and

Requires improvement

Is the service well-led?

stair carpets needed replacement and toilets required refurbishing. Following the inspection, we received a refurbishment and redecoration plan giving timescales for these areas.

The deputy manager also told us they analysed any accidents which occurred in the service. We found recording of accidents took place but analysis could be improved. We found the documentation did not include the accidents which were of a minor nature but when taken into consideration could inform the larger picture and enable lessons to be learned to minimise accidents.

The registered provider/manager described the mechanisms in place to ensure people who used the service, their relatives and staff could express their views about how it was run. We saw these included daily chats with people who used the service, meetings, surveys, care plan reviews and the complaints process. There had been surveys for people who used the service, their relatives and staff in January 2015. Comments from surveys had been analysed and an action plan to address suggestions had been produced. We discussed with the registered provider/ manager how the results of the surveys and the action taken could be displayed on the notice board so people who completed them could see their views had been listened to. The minutes of meetings showed people could make suggestions and they were provided with relevant information.

The deputy manager had a good system of ensuring that important information was cascaded to staff. They showed us information training sheets that were disseminated to staff who signed to say they had read and understood them. These included among others, information about fire safety, special diets, medication updates and a poem about a person's experience of living with dementia.