Mrs Alyson Johnson and Mr John Johnson

Thornbury Residential Home

Inspection report

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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?	**Inadequate**

Overall summary

We inspected Thornbury Residential Home on 8 and 10 July 2015. Thornbury Residential Home provides accommodation, care and support for up to 19 people. On the day of our inspection 17 older people were living at the home aged between 77 and 97 years. The service provided care and support to people living with diabetes, sensory impairment, risk of falls and long term healthcare needs.

The home is located within close proximity to Uckfield town centre. Many people living at the home have lived there for many years. The provider had good retention of staff, with some staff members having worked there for over five years. Throughout the inspection, people and visitors spoke highly of the home. The service was last inspected in October 2014 where one area was identified as in breach of the regulations. This was related to record keeping. We found the provider had made some improvements however there remained areas that required improvement with record keeping. We also found new additional areas that breached regulations.

A registered manager was in post, who was also the provider/owner. A registered manager is a person who

Summary of findings

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 and associated Regulations about how the service is run.

People told us they felt safe living at Thornbury Residential Home however we found the provider had not ensured risks to people's safety and security had been adequately assessed. The front door to the service was left unlocked during daytime hours and the inspection team gained access to a person's room without staffs' knowledge.

Although there were appropriate systems in place for the safe receipt and disposal of medicines we found some concerns with the management of medicines. For example the provider had not sought appropriate professional guidance prior to one person's medicine being administered in a way that could alter its effectiveness.

Staffs recruitment files were well ordered and contained, identification, employment histories and references however we found one member of staff had not undergone appropriate checks to ensure they were suitable to work in a care setting. There were sufficient numbers of staff working to keep people safe.

People told us they found the home to be clean and tidy however we found areas more difficult to clean such as light fittings and ceiling fans were not clean. One toilet was found to be odorous. The service operated a reduced cleaning programme at the weekend.

The provider ran regular training and refreshers for staff to ensure they had the skills and confidence to support people. However we found one member of care staff whose training was not up-to-date. Staff were not having routine supervision with a senior member of staff from the service. Group and some one to one supervision had been undertaken by an external quality assurance company whom the provider had commissioned. Although the registered manager had oversight of the outputs from these meeting there was no evidence actions had been taken as a result of the issues staff had raised.

People told us staff were kind and we observed positive interactions between people and staff, however we found occasions where people's dignity had not been promoted. For example people's care notes and staff's language.

The service had a range of activities on offer provided by both internal and external providers; people told us they enjoyed these. However we observed people were left at some points during the day whilst staff were engaged with domestic tasks. The provider did not offer activities at the weekend; one person told us they could be bored during these times.

The provider had not routinely submitted statutory notifications to the Care Quality Commission, as required. Under the Health and Social Care Act 2008, providers are required by law to submit notifications of incident affecting people.

Staffing issues identified by an external quality assurance consultant related to staff cohesion and deployment had not been acted upon by the registered manager.

There were some quality assurance processes in place however this had not been effective at identifying the areas of concern we found or driving improvement in the quality of the service.

People's needs had been assessed and individual care plans were in place. Although care plans had inconsistencies in their layout this had not been identified as an issue by staff. The provider was in the process of introducing new care plans at the time of our inspection. A member of staff told us they were more logical and easier to follow.

Staff had an understanding of the procedures and their responsibilities to safeguard people from abuse. Staff understood their responsibility in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

People were complimentary about the food they received. People had access to a varied menu. If people did not like what was on offer alternatives were available. One person said, "I can always get something I fancy."

People were supported to maintain good health and had access to on-going healthcare support. People were able to see their GP whenever they needed to. Satisfaction surveys undertaken with health care professionals demonstrated the service liaised effectively with them.

Summary of findings

People told us they chose how they spent their time. We saw people freely moving round all areas of the home, relaxing and chatting in friendship groups, reading or watching television. One person told us, “I fill my days as I choose.”

People, staff and visitors were positive about the service and the registered manager. People knew how to raise complaints and concerns and told us they would feel happy to do so if required.

There were a number of breaches of the regulations. 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

Aspects of the service were not safe.

The provider had not adequately assessed the risks associated with people's safety and security.

We found areas related to the management of medicines which were not safe.

The provider had not taken steps to assure themselves that one member of staff was suitable to work within a care setting.

Not all areas of the service were found to be clean.

Is the service effective?

Requires Improvement

The service was not always effective.

Suitable training and refresher training was provided to staff however we found one member of staff who required updates in most areas.

Staff did not have regular supervision with senior staff from the service.

Staff had a basic understanding of the Mental Capacity Act 2005 and consent issues. Senior staff knew what they were required to do if someone lacked the capacity to understand a decision that needed to be made about their life.

Staff understood people's health needs and responded when those needs changed.

Is the service caring?

Requires Improvement

The service was not always seen to be caring.

Although we saw positive interaction between people and staff people's dignity and privacy was not consistently promoted.

Care plans contained limited information on people's preferences regarding their end of life decisions.

People's independence was promoted and they were able to make choices about all aspects of their daily living.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People told us they enjoy the activities provided, however there were no planned activities at weekends.

People were seen to be left at certain periods of the day whilst care staff undertook domestic tasks.

Summary of findings

A complaints policy was in place and people and relatives were regularly consulted about their opinions on the service.

Is the service well-led?

Inadequate

The service was not well-led.

Statutory notifications had not been submitted to the Care Quality Commission.

Care staff did not have clear lines of accountability whilst working on shift.

The registered manager had failed to take timely action in response to staff concerns regarding staff cohesion.

Systems for quality review were in place however had not identified all areas requiring improvement.

People spoke positively about the registered manager and staff told us they felt supported in their roles.

Thornbury 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 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 was an unannounced inspection on 8 and 10 July 2015. It was undertaken by one Inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

During the inspection we spoke with ten people who lived at the service. We spoke with two visitors, nine staff including the deputy manager and registered manager.

We observed care in communal areas to get a full view of care and support provided across all areas. We observed lunch in the dining room. The inspection team spent time sitting observing people in areas throughout the home and were able to see the interaction between people and staff. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people who were unable to talk to us.

We reviewed a variety of documents which included five care plans and risk assessments along with other relevant documentation to support our findings. We 'pathway tracked' people living at the home. This is when we looked at their care documentation in depth and obtained their views on their life at the home. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

We reviewed the records of the home. These included policies and procedures, audits, along with information in regards to the upkeep of the premises. We looked at three recruitment files and records of staff training and supervision. We read medicine records and looked at complaint records, accidents and incidents and quality assurance records.

We reviewed the information we held about the service. We considered information which had been shared with us by the local authority, members of the public, relatives and healthcare professionals including a social worker and community practice nurse. We requested information from a local GP practice and District Nurses. We spoke with a representative from the Local Authority's contracts and monitoring team. We reviewed notifications of incidents and safeguarding documentation that the provider had sent us since our last inspection. A notification is information about important events which the provider is required to tell us about by law.

On this occasion we did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This was because we were following up on an outstanding compliance action from a previous inspection.

Requires Improvement

Is the service safe?

Our findings

On arrival at the service there was no answer from the home's door bell. The front door was unlocked so we entered the service. We waited in the reception for several minutes; no staff were in the area to acknowledge our presence. We introduced ourselves to one person in the lounge and another person in their room. The person in their room was unable to verbally communicate and would have been unable to raise an alarm if required. An inspector went to the kitchen to locate a staff member to raise attention to our presence. Staff told us the front door was routinely left unlocked during the day and was unlocked when the morning staff arrived for their shifts and locked by night staff. The deputy manager told us the door bell was not working and that "Staff were normally around." We raised our concerns with the registered manager regarding people's safety and security. A risk assessment had not been completed and they were unable to identify what steps had been taken to ensure people were protected by adequate security measures. The registered manager told us they would adjust routines and keep the door locked whilst staff were not in the immediate vicinity.

People told us they felt safe and were well looked after whilst living at Thornbury. One person said, "I do feel safe, very much so." Another said, "I feel so safe I leave my door open at night and then I know staff can hear me if I need them". Although people and their relatives told us they felt safe we found the service was not consistently protecting people's safety.

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

People commented they received their medicines on time. One person told us, "I always get help and my pills on time, no problems." However we identified areas that required improvement with the management of medicines. One person's care plan identified they lacked capacity regarding their medicines. Staff told us they may spit their medicine out if they did not like the texture. The service had consulted with this person's GP who had provided a letter stating their medicines could be crushed. However, one tablet this person took was a capsule, staff were opening the capsule and emptying its contents out and mixing it with honey. The deputy manager told us they had attempted to clarify with a pharmacist if this was acceptable however had not had a response. Crushing or removing medicines from their intended and original packaging may alter their effect. The provider had not gained appropriate advice regarding this person's medicine.

People's prescribed creams were not being consistently recorded. We found one person was having their creams recorded within their Medication Administration Records (MAR) held in the medicines room. However three other people's records identified recording was not being completed. Daily care records identified when cream had been applied by care staff but MAR charts were not being completed consistently. This meant it was not clear when people's creams had been applied. The deputy manager told us they had moved cream MAR charts from the medicine room to people's rooms in an attempt to encourage care staff to complete them more accurately. However, there had been no improvement in this area as a result of these changes.

One person's MAR had gaps where staff had not signed to state they had administered medicines; this meant the person may not have received their medicines correctly on the dates in question. Records and the deputy manager identified that this person had recently had their 'as required' medicines (PRN) changed by their GP to a routine prescription. However the deputy manager could not explain why there were gaps in this person's MAR. All other recordings were clear and accurate and confirmed the service had appropriate arrangements in place for the safe receipt and disposal of medicines.

Within the ground floor medicines room the fridge and room temperatures had not been recorded for the previous four days. Routine checks on temperatures ensure medicines are stored correctly One member of care staff told us they had not completed this as the documentation sign sheet had not been available. Although the fridge had no medicines stored within it on the day of our inspection, it is good practice to maintain clear records.

The issues related to the safe management of medicines are a Breach of the Health and Social Care Act 2008 Regulation 12 (Regulated Activities) Regulations 2014.

Although records demonstrated most staff were recruited in line with safe practice. For example, employment histories had been checked, suitable references obtained. We identified that one member of staff did not have a

Requires Improvement

Is the service safe?

Disclosure and Barring Service check (DBS) in place. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. The registered manager told us they had previously begun a DBS application for the staff member however had been unable to determine if it was necessary as the staff member did not provide care. There was no risk assessment in place to mitigate the risks of this staff member working in the premise unsupervised. This staff member had access to all areas of the service and therefore required a DBS. The registered manager informed us they would apply for a DBS for this staff member.

This meant adequate recruitment checks had not been undertaken and is a breach of the Health and Social Care Act 2008 Regulation 19 (Regulated Activities) Regulations 2014.

People told us their rooms were cleaned regularly. One person said, "Someone comes in everyday and has a clean-up." Although people told us they were happy with the standard of cleaning we found parts of the service were not clean. Areas such as people's wardrobe tops, lampshades, picture rails and ceiling fans had not been routinely cleaned. People's walking frames and wheelchairs had not been cleaned regularly. Records indicated this task had been undertaken daily until 15 January 2015 when it had stopped. A ground floor toilet close to the lounge, was seen to have frequent use during the day, had an unpleasant odour coming from the laminated flooring. There was no window or extraction fan mechanism in this toilet. Our inspection on 19 May 2014 identified the home had no sluice facility to wash commodes. Commode pans were cleaned in a bath with bleach. This meant areas where people washed were also being used to disinfect soiled equipment. We discussed cleaning routines with the deputy manager. The service employed two cleaners who worked two hours a day Monday to Friday. At the weekend one cleaner was employed to work three hours a day. The deputy manager was unable to clarify why the service was cleaned for less time at the weekend compared to week days. Once cleaning staff had completed an area they ticked a recording chart. This chart did not identify what specific cleaning tasks had been undertaken in a room or area, for example dusted or vacuumed. During the busy midday meal service we observed one member of staff filling a plastic watering can via the kitchen sink. The deputy manager addressed this issue immediately. The issues identified related to cleanliness and infection control requires improvement.

Care staff were able to identify their responsibilities to keep people safe from harm or abuse. They had a good understanding of the different types of abuse. Care workers told us they had confidence senior staff would take appropriate action if they raised concerns about abuse. One care worker told us "I know the manager would take any concerns I raised seriously." Care workers told us if they were not satisfied with the response from the office, they would escalate. One staff member was unable to identify who they would refer issues on to, for example the local authority; however they told us they would 'check online' and ensure people were safeguarded. The manager was aware of their responsibilities to report any concerns that a person may be at risk of abuse, to the local authority.

People told us there were always staff available to assist them. One said, "I prefer to stay in my room most of the time but you can see they are about all the time." During our inspection staffing levels matched what was planned on the staff rota. There were three care staff on duty between 8am and 8pm. An additional staff member worked between 7am and 10am to assist with setting up for breakfast and again between 6pm and 7pm to wash up after the evening meal. The deputy manager and registered manager predominately worked office hours in an administrative function and were based in the office. Staff told us they felt there were adequate numbers of staff to keep people safe. The staffing levels at this time were sufficient to meet people's needs.

Requires Improvement

Is the service effective?

Our findings

A training programme was in place which showed most staff received regular training and updates, this included moving and handling, food hygiene, first aid and mental capacity. One member of staff who was working on the day of our inspection had blank marks next to the majority of available training courses. The deputy manager told us although this staff member had worked at the service for a number of years they were currently working at the service intermittently. They were unable to explain why this staff members training was not up-to-date. The registered manager told us they would ensure this staff member refreshed their training in line with other care staff colleagues. This is an area that requires improvement.

Staff told us training helped them provide appropriate care and support for people. Training was undertaken either by classroom type sessions or via an online method. One staff member told us, "Training is regular and helps refresh my knowledge." Some care staff had completed training in other areas such as nutrition, person centred care and dementia. Administration of staff training was undertaken via a training matrix.

Care staff were not currently receiving one to one supervision with senior staff at the service. Records indicated a representative from an external quality assurance company, who had been commissioned by the provider, had undertaken someone to one supervision and wider group supervision. We reviewed recent meeting summaries from these meetings and they identified concerns in several areas such as staff cohesion and staff deployment. There was no evidence the provider had taken any actions as a result of this feedback. However, staff told us they felt supported in their roles and could approach the registered manager or deputy manager about any concerns they had. One staff member told us, "I know I can pop in the office to talk to them (senior staff) and they will make time for me."

When staff began work at the home they completed a period of induction. This included the day to day running of the home, health and safety and people's care records. They then spent time shadowing other staff before they worked on their own. Staff told us induction provided them with the knowledge and skills to look after people. They said they felt supported by and could always approach more experienced colleagues for help.

Staff understood the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) 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. However, one care plan identified a person did not have capacity for most daily decisions yet they had signed a consent form for their photograph to be used within their care plan. This demonstrated a lack of understanding in the application of the MCA. Information related to people's mental capacity assessments were recorded in their care plans. For example, one person's care plan reminded staff the person was able to make most of their own day to day decisions but may require support with larger decisions.

The Deprivation of Liberty Safeguards concern decisions about depriving people of their liberty, so people receive the care and treatment they need, where there is no less restrictive way of achieving this. The Care Quality Commission has a legal duty to monitor activity under DoLS. The legislation aims to protect people who lack capacity and ensure decisions taken on their behalf are made in the person's best interests and with the least restrictive option to rights and freedoms. 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. The registered manager understood the principles of DoLS. At the time of the inspection one DoLS application had been made. Staff demonstrated an understanding of consent and caring for people without imposing restrictions. Before offering support or care, staff were seen to ask people for consent to ensure they were happy with what was offered. For example, one staff member checked with a person each time they assisted them to move in their wheelchair.

Care plans identified people who had been assessed at risk of skin damage. One person used an air flow mattress to reduce the risk of developing skin pressure areas. The deputy manager told us staff regularly checked the pump unit was at the correct setting however there was no evidence this was being recorded. On the day of our inspection it was correctly set. This same person had been assessed at risk of not eating or drinking sufficient amounts. A 24 hour monitoring sheet was in their room. Staff were recording when they had assisted the person with personal care, when they ate and drank and the associated quantities. However staff had been provided

Requires Improvement

Is the service effective?

with no guidance as to what they were recording and as such there was inconsistency as to the information that was being recorded on this sheet and their daily record notes. This is an area that requires improvement.

People told us they liked the food at the service. One person told us, "I look forward to my meals, very nice" another said, "Always a good breakfast, have what I want." We observed the lunch time meal service on both days of our inspection. Most people ate in the main dining room. The menu identified that there were two choices available for the lunch time meal. People who ate in the dining room mainly ate independently. People were chatting to each other prior to the meal being served, however the mealtimes themselves were quiet. Meals were well presented and appeared appetising and people ate well. People were offered breakfast, lunch, afternoon tea and a light supper. People were regularly offered drinks throughout the day; there was fresh fruit available in the dining room. People who were on a soft or pureed diet had their food presented in an appealing way; foods had been separated so as to retain flavours. People were able to have their breakfast when and where they chose. People's preferences and dietary requirements were seen to be accommodated.

People were supported to access healthcare services and maintain good health. Care records showed external healthcare professionals were involved in supporting people to maintain their health. This included GP, speech and language therapists, district nurses and chiropodist. One person told us, "The GP is very good; I can see them when I need." We reviewed the summary report from a recent satisfaction survey sent to health care professionals. The comments were positive and praised the service for their effective communication and calling GP's out to visit for appropriate reasons.

Requires Improvement

Is the service caring?

Our findings

Although people and their relatives spoke highly of the service we found the service was not consistently caring.

One person sustained a minor abrasion to their arm whilst they were being supported to move between rooms in their wheelchair. Staff reacted quickly to administer first aid however this was undertaken in full view of other people whilst they sat at the dining room table.

We saw in shared bathrooms people's toiletries were stored communally. It was not clear who these belonged to, although this did not present an infection control risk it did not promote people's dignity.

Language at the service both written and spoken did not consistently promote people's dignity for example one staff member routinely referred to people as 'darling'. It was not evident in people's care plans if this was their preference. One care plan stated, 'X is checked during the night but presents very little problem.' In the conservatory we saw one person was being assisted by two carers to readjust their seating position to a more comfortable one. Whilst assisting, one carer was heard to say, "Oh she is soaking." It was not clear if a drink had been spilt or if the person required assistance with their continence however their dignity had not been protected.

Care plans contained limited information on people's preferences or choices regarding their end of life decisions. Some care plans identified comments related to preferences regarding burial or cremation and who to contact however there was no evidence people or their families had been involved in gathering views and choices.

People's care plans were stored in a cupboard in a small staff room which was located off the main ground floor corridor. During our inspection both the staff room door and cupboard were unlocked. This meant the provider could not be assured people's confidential information was protected.

These issues related to dignity and privacy were a breach in Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us the staff were kind, friendly, and respectful. One person said, "The staff are very good, always happy to give me a helping hand." Another said, "I am well looked after here and have been for a long while." People told us they liked to live at Thornbury Residential Home. A visitor told us, "I am very pleased with the standard of care."

We also observed kind and positive interactions between staff and people. Staff knew people well and were observed chatting and laughing with people when providing assistance. Staff spoke fondly about the people they supported and demonstrated a commitment to providing good quality care and support. One staff member told us, "I just want people to be as happy as possible." It was clear staff had spent time building a rapport with people. Staff could tell us about individual personalities, likes and dislikes.

All bedrooms were single occupancy and they had been personalised with people's own belongings including furniture, photographs and ornaments. People were able to spend time in private in their rooms as they chose. Bedroom doors were kept closed when people received support from staff and we observed staff knocked at doors prior to entering. People told us, "I get privacy when they (staff) attend to me," and "They knock on my door even though I like it open."

Staff promoted people's independence and ensured they were able to make choices about all aspects of their daily living. People told us they were able to spend their day as they chose. One person told us they liked their own company, another told us they liked to spend a lot of their time reading and someone else told us they liked to go out every day and others told us they liked to spend time in the lounge with other people. We observed friendship groups had developed between people and they were supported by staff to maintain these. Visitors were welcomed at the home. One visitor told us they were able to visit whenever they chose and always felt welcome.

People were supported to maintain their personal and physical appearance in accordance with their own wishes. People were dressed in clothes they preferred and in the way they wanted. Women were seen wearing their jewellery and people's hair was neatly done. One person told us, "They (care staff) help me to choose what to wear, they are ever so good."

Requires Improvement

Is the service responsive?

Our findings

Although people told us they were happy with the care they received we found the service was not consistently responsive to people's needs.

The activities on offer over a three month period were communicated via a flyer that was posted on notice boards and a copy had been placed in people's rooms. There was also a white board in the dining room that identified what was planned to take place that week. Activities were either provided by an in-house activities co-ordinator or from a variety of external providers. Activities included sessions such as musical entertainers and fitness sessions. People told us they enjoyed the activities. One person told us, "I have my favourites but I like to go along to as much as possible."

On the first day of our inspection the in-house activities session was cancelled due to staff availability. However care staff were seen to engage some people in a crossword activity in the lounge. In the afternoon we saw an activities staff member hold a 'nostalgia' session with five people in the conservatory. People were enjoying the discussion and freely contributing. Although people generally spoke positively about the range of activities some people and staff told us weekends could be 'quiet'. There were no planned activities over weekends. The deputy manager told us this was often a busier time for families and friends to visit. However one person told us they were, 'often bored' at weekends and would like more activities.

We observed during parts of the day whilst there was no activities staff on duty people were left for periods of time in lounges while care staff were undertaking other duties. For example, care staff were responsible for all the laundering of people's clothes, preparing the afternoon meal and some domestic tasks such as cleaning commodes. Staff told us the completion of domestic tasks could prevent them from spending time with people. One said, "Doing the laundry can take up a chunk of your shift." This is an area that requires improvement.

We saw evidence that people, and where appropriate their representatives were involved with the development and review of care plans. There was evidence in care plans that people's choice and independence was encouraged. They contained information about what the person could do and where they may require prompting or supporting.

Information was available on people's daily routines and care requirements. This included their likes and dislikes and what remained important to them. Although people's care files contained a clear front index which enabled staff to locate sections easily, care plans reviewed lacked continuity. Care plans were in different formats and contained different sub headings. The deputy manager told us this was dependant on when the plan was initially created. For example one care plan contained information which related to a specific health incident which was in a person's 'suppertime routine.' Another care plan contained specific instructions from a health care professional on how to set up a wheelchair however this information was within the person's daily notes. This meant there was a risk information was not easily accessible to care staff. Staff told us they knew where information was held when they required it from care plans however one told us when they started work at the service it took them sometime to familiarise themselves with the different layouts. The deputy manager showed us a new care plan format which was in the process of being introduced. This document contained sections which related to people's specific care needs and was presented in a clear and logical format. The issues identified relating to care plans require improvement.

People told us they received care and support that met their needs and was tailored to their individual choices. They said they were able to choose how they spent their day. One person told us, "I like to stay in my room except for meals but I have the choice."

People were seen freely moving round the service and spending time in various parts of the home. One told us, "I like sitting here, such a lovely breeze." People spent time in the conservatory reading and looking at photographs. There was a relaxed atmosphere where people were easy in each other's company. Two people spent most of the afternoon watching television and others chose to remain in their rooms. One relative we told us, "I am very pleased with how my mum is cared for, they do they their best to encourage her to stay mobile."

People were encouraged to share their views on the service. Residents meetings were held on a regular basis and satisfaction surveys had been completed with people and their families in January 2015. The results of these were positive. We saw an external quality assurance consultant had analysed the findings and made

Requires Improvement

Is the service responsive?

recommendations for actions. For example to collate a 'pre-admission pack' for people, this had been actioned. The registered manager told us they maintained regular contact with people and their relatives to facilitate communication and feedback. People told us they didn't have any complaints. One person said, "I've never complained but if I was unhappy about something, I'd tell them," and "I've never complained, but I would." Visitors we spoke with told us they were updated about any changes to their relative's needs.

Inadequate

Is the service well-led?

Our findings

Despite people's positive comments we found the provider was not consistently notifying the Care Quality Commission of incidents where injury, harm or abuse had occurred to people. Under the Health and Social Care Act 2008, providers are required by law to submit statutory notifications. A notification is information about important events which the provider is required to tell us about. We identified incidents which had not been notified to us. The provider had submitted some notifications to the CQC however had not done this consistently. They acknowledged the need to submit notification following future incidents.

This inconsistent notifying to the CQC of notifiable events is a breach in Regulation 18 of the Health and Social Care Act 2008 (Registration Regulations 2009).

Issues identified through the inspection indicated there were not clear lines of accountability amongst care staff. Staff told us they felt confident they could raise concerns with the deputy or registered manager, however whilst care staff worked their shift there was no effective leadership evident. This resulted in care staffs approach to their duties being at times unplanned and reactive. The provider employed two senior carers one of which worked nights; this meant the majority of shifts did not have a senior carer leading the shift. One member of staff told us, "Generally there's no carer in charge on shift, which is not always ideal. You assume things are done, like paperwork." We saw this impacted on the effectiveness of care staff. For example, in the afternoon on our second day of inspection we saw two care staff having their lunch together, this left one member of care staff available to support and interact with people. We spoke to the registered manager regarding this issue, they told us they had previously considered having a senior on each shift but had not implemented this.

Staff told us there had been ongoing issues related to staff cohesion. One staff member told us, "Some staff are treated differently and this has caused resentment and a bit unsettling." We saw within the group supervision meeting minutes from June 2015 staff had raised this issue with the external quality assurance consultant. There was no evidence the registered manager had taken steps to address these concerns. At a previous staff supervision meeting with the external quality assurance consultant in April 2015 care staff identified the requirement for additional domestic staff to assist with the evening meal and laundry. There was no evidence the registered manager had formally responded to staffs concerns. The registered manager did not currently have a system of staff meetings. This meant that staff did not have a platform to raise concerns in a formal setting with senior staff from the service.

There were some quality assurance processes in place for example audits for medicines and infection control. However these had not been effective at identifying the areas we found requiring improvement during our inspection. The deputy manager used a system for tracking key monthly information. This was referred to as a 'clinical governance monthly check', it recorded information such as the number on people on antibiotics, incidents and accidents and admissions to hospital. We found occasions where this information was incorrect. For example in May 2015 a person had been admitted to hospital with a suspected health condition, however as no accident or incident form had been completed, this information had been missed off the monthly check sheet. When an accident had occurred a staff member completed an accident form and this was left out for senior staff to review. This form was then placed into individual care files; detail was picked up and transferred into people's individual risk assessment. However information from these incidents had not been analysed to identify potential patterns, trends or for future staff learning.

The above issues and the concerns identified through the inspection process directly relate to the service's leadership. For example gaps in a staff members training, not assessing the security risks associated with the front door and a member of staff not having adequate recruitment checks. These are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However staff told us they generally felt supported by senior staff and the deputy and registered manager were available if required. One member of care staff who worked nights told us, "I would have no hesitation calling the manager during the night; I know they would respond immediately." Another staff member said, "They (registered manager) are very kind and will go out of their way for residents and staff." People told us they felt the home was well run and their comments and suggestions were listened to. One person said, "This is a good home and a

Inadequate

Is the service well-led?

very nice place to live." People also said the registered manager was approachable and available. We were told, "The manager pops round to see me," and "The manager is very nice." Visitors told us they were always able to speak to or contact a senior staff member if they had any concerns. One visitor said, "The manager knows the residents well and genuinely cares." The provider had ensured there were systems in place for people to raise formal complaints and concerns. The service's complaints procedure was clearly sign posted around the home and within admission packs. There had been no recent complaints received.

The provider had established aims and objectives and a philosophy of care for the service, these were published on the services website. Although staff were not directly familiar with these the recurring theme from people, staff and visitors was the service provided a 'homely' atmosphere. One person told us, "It's the next best thing to living at home." Another said, "It has a family feel to the place."

The registered manager told us the work they had undertaken as a result of using the external quality assurance consultancy service had been very productive and helpful. The deputy manager said, "It has been really supportive having a fresh set of eyes look at how things run." It was evident that improvements with records had been made as a result of the suggestions however there were additional recommendations that had yet to be actioned by the registered manager.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered provider had not ensured people's safety and welfare had been protected by adequately assessing risk. 12(2)(a)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **The registered provider had not established effective recruitment procedures which ensured persons employed were of good character. 19(1)(a)2**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **The registered provider had not ensured suitable arrangements were in place to maintain people's privacy and dignity. 10(1)(2)(a)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **The registered provider had not fulfilled their statutory obligations to the CQC with regard to notifications.** 18 (2)b(ii) 2e

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered provider had not protected people against the risks associated with the unsafe use and management of medicines. 12(2)(g)

The enforcement action we took:
Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered provider did not have an effective system to regularly assess and monitor the quality of service that people receive. 17(2)(a)(b)(c)(e)

The enforcement action we took:
Warning Notice.