HC-One Limited

Beauvale Care 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?	Requires improvement

Overall summary

We carried out an unannounced inspection of the service on 12 August 2015.

Beauvale Care Home provides nursing and residential care for up to 35 people. On the day of our inspection there were 33 people using the service.

Beauvale Care Home is required to have a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. At the time of the inspection a manager had been in post for six weeks. The manager told us that they were in the process of submitting their application for the registered manager position. We will monitor this situation.

At our last inspection in October 2013 we found the provider was in breach of one Regulation of the Health and Social Care Act 2008. This was in relation to consent to care and treatment. The provider sent us an action

Summary of findings

plan detailing what action they would take to become compliant with this regulation. At this inspection we found the provider had made the required improvements.

CQC is required by law to monitor the operation of the Mental capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. This is legislation that protects people who are unable to make specific decisions about their care and treatment. It ensures best interest decisions are made correctly and a person's liberty and freedom is not unlawfully restricted.

At this inspection some people raised concerns about the length of time they had to wait to have their requests for assistance met by staff. We found staff were not always available to respond to people's needs in a timely manner and that communal areas did not always have staff present to check on people's needs and safety. The staff roster showed that there were not always sufficient staff deployed appropriately to meet people's needs and keep them safe.

Individual plans of care and risk assessments were in place for people's that were regularly monitored and reviewed. Additionally, the environment and equipment had safety checks completed. However, personal evacuation plans in place for people in the event of emergency, lacked specific individual information.

Accidents and incidents were recorded and analysed for patterns and trends but it was not always clear what action had been taken to reduce risks. Staff were aware of safeguarding procedures and had received appropriate training. There was safe management and administration of medicines. Safe recruitment checks were in place that ensured people were cared for by suitable staff.

People's dietary and nutritional needs had been assessed and support plans and risk assessments were in place. However, the recording of people's food and fluid intake was not always accurately recorded or monitored.

Staff were appropriately supported, this consisted of formal and informal meetings to discuss and review their learning and development needs. Staff additionally received an induction and ongoing training. On the whole staff were positive about the leadership of the service and were clear about the vision and values.

Some people raised concerns about the care and approach of staff. We found on the whole staff were caring and compassionate and were knowledgeable about people's needs. People's preferences, routines and what was important to them had been assessed. However, specific details were sometimes missing affecting the person centred care being provided.

There was a complaint procedure available to people who used the service and visitors, including additional systems in place to enable people to share their opinions about the service. Some people told us they were not aware of how to make a complaint.

Staff provided daily activities and social opportunities for people to pursue their interests and hobbies and independence was promoted.

The provider had checks in place to monitor the quality and safety of the service. However, the audits in place had not identified all the shortfalls we found during this inspection. The provider had notified us of important events registered providers are required to do.

We found the provider was in breach of one regulation of the 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

The service was not consistently safe

Personal evacuation plans lacked important detailed information. Accidents and incidents were analysed but it was not always clear of the action taken to reduce further risks.

People were concerned about the length of time they sometimes had to wait for staff to support them. Recent staffing levels were less than expected and planned for.

The provider had a safe recruitment process to ensure suitable staff were employed. Staff had received safeguarding training and knew how to recognise and respond to abuse correctly.

Is the service effective?

Requires improvement

The service was not consistently effective

People's needs and risks associated with eating and drinking had been identified. However, effective monitoring was affected at times by a lack of record keeping.

Mental capacity assessments and deprivation of liberty assessments had been carried out.

Staff received an appropriate induction, support and training.

People were supported to access external healthcare professionals when needed.

Is the service caring?

Requires improvement

The service was not consistently caring

Some people raised concerns about the attitude and approach of staff.

People were supported to access an independent advocate if they wanted to.

There were no restrictions on friends and relatives visiting their family members.

Is the service responsive?

Requires improvement

The service was not consistently responsive

A complaints procedure was in place but some people were unaware of this and who to complain to.

People's individual needs, routines and preferences were assessed but information sometimes lacked specific details. This impacted on the delivery of person centred care.

Summary of findings

Regular reviews of people's assessed needs were conducted to ensure staff responded appropriately.

Is the service well-led?

Requires improvement

The service was not consistently well-led

The provider's systems and processes that monitored the quality and safety of the service had not identified the shortfalls we identified at this inspection.

People, relatives and staff were encouraged to contribute to decisions to improve and develop the service.

Staff understood the values and aims of the service. The provider was aware of their regulatory responsibilities.

Beauvale Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 12 August 2015 and was unannounced.

Before the inspection, we asked 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. We reviewed information the provider had sent us including statutory notifications. These are made for serious incidents which the provider must inform us about. We also contacted the local authority, the GP, a community matron, a specialist home enteral feeding dietician and the care home quality lead with the clinical commissioning group for their feedback.

The inspection team consisted of two inspectors 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 14 people that used the service and two relatives for their feedback. We spoke with the manager, the provider's operational director and previous registered manager who were both visiting the service on the day of our visit. Additionally, we spoke with four care staff, a senior care staff, the deputy manager (who was also a nurse), a nurse and the cook. We looked at all or parts of the care records of four people that used the service along with other records relevant to the running of the service. This included policies and procedures and information about staff training. We also looked at the provider's quality assurance systems.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires improvement

Is the service safe?

Our findings

Some people that used the service raised concerns about the length of time they had to wait to have the needs met. One person said, "The care staff take ages to come back to you." Another person told us, "At night the care staff are different and do not answer the call bells." A relative said, "I think in my presence the bell is answered in time." A person told us, "No trouble at night, staff may be a bit late, but acceptable in answering sometimes."

Staff told us that when they were fully staffed they felt there were sufficient staff to meet people's needs and keep people safe. They said staff worked additional shifts to cover for sickness and holidays, and an agency was also used. However, they told us there had been times when staffing levels were less than expected and that this was a concern to them. The manager told us people's dependency needs were assessed and reviewed. The operations director told us that the staffing levels had recently been assessed to ensure it was sufficient to meet people's individual needs.

During the first day of our inspection, we saw people in the communal lounge were left for lengthy periods of time without staff being present. Whilst there was the facility for people to use a call bell, we did not see that any person had this to hand. We noted that if people needed attention other people that used the service tried to assist. On one occasion we saw how a person became concerned with another person who sat in a particular chair they liked. Staff were not present to intervene or offer reassurance. On several occasions the inspection team had to request staff assistance for people who were in their rooms. This was because they were either calling out for assistance or their call bell had not been answered. We noted from the analysis of falls that falls had sometimes occurred whilst people were in the lounge when staff were not present.

We looked at the staff roster for the last 14 days. Eight days showed staffing levels were below what was expected. Three of these days showed four care staff were on shift instead of six. The manager said that this was due to sickness where staff had reported their absence too late to arrange cover and annual leave. We were concerned that these staffing levels were unsafe.

This is a breach of Regulation 18 HSCA (RA) Regulations 2014.

There were processes in place that reduced the risk of people that used the service experiencing avoidable harm and abuse. People and their relatives told us that they felt staff cared for them safely. One person told us, "I am absolutely safe." A relative said, "Mother is safe here and I have no reservations about the care."

Staff demonstrated they understood the different kinds of abuse and how to protect people from avoidable harm. They said they had received training on how to protect people and that there was a safeguarding policy and procedure available. One staff member said, "We've had training and report any concerns to the manager."

We saw that there was information about how to protect people from abuse available on display around the service for both staff, people that used the service and visitors. The manager was aware of the safeguarding procedure and the action to take in the event of any allegations being received. Records confirmed staff had received appropriate training and the safeguarding policy and procedure was available and clear for staff to follow. From the sample of records we looked at we saw a person had reported a concern of a safeguarding nature in January 2015. Whilst the registered manager in post at the time had taken some action, they had not followed the safeguarding procedure. We discussed this with the operations director.

Records confirmed that people who used the service and relatives had been involved in discussions and decisions about how risks were managed.

Staff told us that any risks to people and or the environment were assessed and planned for. They told us this information was available to them which provided guidance of the action required to manage and reduce known risks. During a staff handover we observed that risks to people were shared and discussed. This meant that people could be assured that staff were kept up to date of any risks associated to their needs.

Risks to people that used the service were assessed and planned for. These were reviewed monthly or earlier if required and plans of care and risk plans changed if required. Some people had specific needs that meant they required specialist equipment to keep them safe and protect them from harm. This included pressure relieving cushions and mattresses to protect skin damage. We observed where people had these assessed needs equipment was available and being used appropriately.

Requires improvement

Is the service safe?

The provider had plans in place to direct staff on the action to take in the event of any unexpected emergency that affected the delivery of the service, or put people at risk. This included personal evacuation plans to be used in the event of an emergency. However, we found these lacked information of what people's support needs were. For example, information did not include what level of support the person required. We discussed this with the manager and operations director. They agreed that these documents lacked specific important information. Records showed that regular checks on the equipment and environment were completed. External contractors were used when checks on equipment such as fire detectors or gas appliances were needed.

Staff were aware of the reporting process for any accidents and incidents. The manager told us they monitored and analysed accidents and incidents for themes and patterns. We saw how these were recorded and the manager gave examples of action that had been taken to reduce incidents from reoccurring. An example was given about a person who had experienced an increase in falls. The manager told us that a referral to the 'falls clinic' had been made for an assessment of the person's needs. However, from the person's care file we could not see recorded confirmation that this action had been completed. The deputy manager told us they had made the referral but said they had not recorded this. Without this information recorded stating what action was taken by whom and when, there was a risk that a delay may have occurred in the person having their needs appropriately assessed. We discussed this with the manager and action was taken to follow this up.

Safe recruitment procedures were followed. Staff employed at the service had relevant pre-employment checks before they commenced work to check on their suitably to work with people. This included checks on criminal records, references, employment history and proof of ID.

People did not raise any concerns about how they were supported with their medicines. We saw that arrangements for the management of people's medicines were safe. Staff that administered medicines had received training and had their competency assessed. There were policies in place that reflected best practice and guidance.

Requires improvement

Is the service effective?

Our findings

At our last inspection we found that the provider had not protected people against the risk of receiving care and treatment without consent. This was in breach of Regulation 18 of the

Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection people and their relatives did not raise any concerns about consent not being gained before care and treatment was provided. From the sample of care files we looked at we saw what action the provider had taken to improve the practice around consent that protected people's human rights. For example, the admission assessment form recorded if a person had lasting power of attorney that gave another person legal authorisation to act on a person's behalf about decisions relating to their care and welfare.

The Mental Capacity Act 2005 (MCA) which protects people who do not have mental capacity to make a specific decision themselves was adhered to. Where people lacked mental capacity to make specific decisions appropriate assessments and best interest decisions had been made and recorded. These showed how the decision was made, who was involved and that least restrictive practice had been considered.

The Deprivation of Liberty Safeguards (DoLS) are part of the MCA and aim to protect people where their liberty or freedom to undertake specific activities is restricted. The manager demonstrated an awareness of both MCA and DoLS and what their role and responsibility was in relation to this. Where concerns had been identified about a person's liberty, we saw the manager had taken correct action. For example applications to the supervisory body responsible for assessing and granting authorisations to restrict a person of their liberty had been made.

Staff told us they had received training on MCA and DoLS and demonstrated they had a limited awareness of the legation. However, they gave examples of how they gained consent from people on a day to day basis. During our observations of how staff supported people, we found that staff explained to people the support to be provided, gave people choices and respected people's decisions.

People and their relatives did not raise any concerns about the staff in relation to their competency in meeting their needs. The feedback we received from visiting health professionals was positive with regard to the nursing staff. This included their knowledge of people's needs and communication with them.

Staff told us they found the training opportunities to be sufficient and appropriate. One staff member said, "There is plenty of training available." They described the induction they received and said that this was useful in preparing them for their role and responsibilities. They also confirmed that they received opportunities to discuss and review their training and development needs with their line manager. One staff member told us, "I have supervision meetings where I can discuss anything that I'm concerned about. They're helpful." Nursing staff also received opportunities to continually develop their practice to meet their registration requirements with the Nursing and Midwifery Council.

The provider ensured staff received training and refresher training to keep their skills and knowledge up to date. Additionally, a healthcare professional told us that they had provided training presentations to all staff and this would be repeated later in the year. This included information on falls, catheter care, dehydration, pressure ulcers, urinary tract infections, and walking aids. They said the uptake in staff attendance was good.

We viewed a sample of staff development files and looked at the staff training matrix, supervision and appraisal plan. These records confirmed staff were appropriately trained and supported.

People were positive about the food choices and said they received sufficient to eat and drink. One person told us, "I am happy with the food." A relative said, "Mother likes the food, and it is fantastic."

We observed that cold drinks and fruit were readily available for people and staff offered a choice of drinks and snacks during the day. Some people required assistance from staff to eat and drink. Whilst we saw this was provided we also saw that some people struggled to eat independently and requested we asked staff to assist them. Where we did intervene staff responded and provided appropriate support.

On the first day of our inspection we observed some confusion amongst staff about a person's lunchtime meal.

Requires improvement

Is the service effective?

The result being that there was no hot meal left and the person was offered an alternative and chose a breakfast cereal. We were told that the person would be offered a hot meal in the evening. On the second day of our inspection we checked this person's food chart. They had been offered a sandwich for their evening meal which they had refused. Records showed over a 24 hour period that this person's food intake was a breakfast cereal. No explanation could be given why a hot meal was not offered. We were told the person would have been offered a supper but we had no evidence to confirm this to be correct. We were concerned that the nutritional needs of this person had not been met. We discussed this with the manager to follow up.

Specific dietary and nutritional needs in relation to people's healthcare needs or cultural or religious needs were assessed and included in people's plans of care. These needs were known by staff including kitchen staff. We found food stocks were appropriate for people's individual needs. Care files demonstrated how staff had worked with health professionals such as dieticians and speech and language therapists to meet people's needs. Where recommendations had been made these had been acted upon and included in the person's plan of care.

Where concerns were identified with people's nutrition or hydration their weight was monitored and their food and fluid intake recorded. We found examples that records did not always accurately show what people's intake had been. Additionally, fluid charts did not show what a person's optimum amount should be therefore making the monitoring of intake difficult.

People and their relatives told us they received support to maintain their healthcare needs and that they had access to healthcare professionals when required. One person said, "I'm visited by the chiropodist, GP and the nurse in the home." The information we received from healthcare professionals confirmed this.

Staff told us how they accompanied people to attend outpatient appointments or hospital if required. We observed a handover where concerns were raised about a change in a person's health. Staff made a note and said they would discuss this with the nurse. This meant people's healthcare needs were monitored and acted upon when concerns were identified.

From the sample of care files we looked at we found people living with specific health conditions such as diabetes had their needs regularly assessed. Where required referrals to external healthcare professionals were made.

Requires improvement

Is the service caring?

Our findings

Whilst some people were positive about the care and approach of staff others gave negative comments about their experience. For example, a person told us, "My room is cleaned daily; all staff respect me, are polite and maintain my dignity." Another person described staff as, 'nice'. Negative comments included, "One young carer [staff] snapped at me when I wanted to use a commode in the space of few minutes." and, "A female carer [staff] is very rude to me. She shouted at me saying turn the bloody TV down, at night." We informed the manager of these comments who agreed to follow these up.

Feedback from healthcare professionals described staff as caring and welcoming and supportive when healthcare professionals visited.

The staff we spoke with showed a good awareness of people's needs and spoke about people in a compassionate and caring manner. One staff member said, "I absolutely love my job." Another told us, "I spend more time here than I do at home, I'm passionate about providing the best care I can."

Our observations showed staff were caring and attentive to people's needs with one exception. We noted that at times staff struggled to meet people's needs in a timely manner, in particular for those people who had chosen to remain in their rooms. We saw examples where staff were warm, friendly and respectful. We observed positive, caring language and sensitive hair touching being used whilst a staff member was asking a person how they were feeling. The person responded positively to this approach. We saw how staff supported a person with their mobility needs and used good communication explaining to the person what was happening and gave reassurance. However, we observed a staff member support a person with their lunchtime meal that showed a lack of care and respect. Very limited interaction and communication was shown by the staff member towards the person they were supporting. The staff member on several occasions yawned and looked disinterested in what they were doing, showing a task centred approach rather than providing person centred care.

We found examples where dignity locks were either not working or were not in place in some of the toilets. We discussed this with the manager who arranged for the maintenance person to address this.

Information from the Provider Information Return told us evenings were arranged where relatives were invited into the home to have a meal cooked for them and their friend or relative. A relative confirmed they had been invited and photographs were available that showed people having an enjoyable social time with people important to them.

People were provided with opportunities to be involved in making decisions about their care. A relative said that their mother was involved in the assessment of their needs as they were, and that they were aware of the care that was provided.

We saw staff communicated effectively and knew what people liked to talk about and engaged people as much as possible in discussions and choices.

We saw examples of signed records in people's care files that showed they had or their relative had been involved and consulted in the development of their assessments and plans of care. Whilst people could not recall if they had been invited to participate in review meetings about their care, we saw examples that review meetings had occurred. The manager told us these were planned every six months.

People and their relatives gave examples that demonstrated their privacy and dignity were respected and promoted and that there were no restrictions about visiting. One person told us, "My privacy and dignity is maintained and carers [staff] do give respect." A relative said, "I am very satisfied and cannot fault the care."

Staff told us that people's independence was encouraged and respected. For example, some people accessed the community independently. Staff were able to give us examples of how they respected people's dignity and privacy and acted in accordance with people's wishes. The service had a dignity champion whose role was to promote dignity in care and to be a good role model for staff. Staff were able to tell us who this staff member was. Staff had also received training on privacy and dignity and the provider had a policy that promoted people's rights with regard to privacy and dignity.

Requires improvement

Is the service caring?

Information about independent advocacy support was available in the reception area. This meant should people required additional support or advice, the provider had made this information available to them.

Requires improvement

Is the service responsive?

Our findings

People and their relatives did not raise any issues or concerns about their needs not being known or understood by staff. Some people and relatives we spoke with confirmed they had participated in assessments of their care and treatment. From the sample of care files we looked at we found pre-assessments had taken place for people that lived at the service. This meant the provider had ensured people's needs could be met by the service. We also found there had been clear input from people, their relatives and health and social care professionals.

Staff told us that people's needs, routines and preferences were known and they described how people received person centred care. One staff member said, "We know people's preferences but we don't assume anything and ask people what they want." We observed a staff handover and found staff were well informed, knowledgeable and aware of people's needs. In addition to a handover meeting staff had written records where information was recorded and shared within the staff team. This showed the provider had processes in place to share information to ensure people received care personalised to them.

From the sample of support plans we looked we found a document referred to as 'Remembering Together – Your Life Story' that contained information about people's preferences, likes and dislikes. Additionally, people's social and family history, pastimes, hobbies and interests were included. On the day of our visit we saw a member of staff sit with a person completing this document. The person was seen to enjoy the opportunity to reminiscese. We saw a meeting dated July 2015 between the manager and the activity coordinators that showed there were plans to further develop activities and community links for people. This demonstrated there was a commitment to provide people with opportunities of different activities that were interesting, fulfilling, stimulating.

However, we saw some examples that showed whilst person centred care had been considered it was not always fully met. For example, we saw information that asked what activities people liked or was important to them. One person had stated they enjoyed music. There was no further explanation of what this meant for the person. In this person's daily notes dated May 2015 we found an entry of a conversation with a staff member that had identified the person's favourite singer. However, we checked information contained in this person's care file to see if this important information had been shared with staff. There was no further recording. This meant there was a risk that staff did not know this information. In addition it was recorded that this person who remained largely in their room, enjoyed one to one activities such as having the paper read and having their hands massaged. There was no recording to confirm that staff provided this and we were unable to ask the person. In addition we saw conflicting information about the person's preference in relation to watching television. One record stated '[name] dislikes the TV.' Whilst in the night time support plan it stated staff were to leave the television on and encourage the person to watch it.

For another person, it was recorded the person enjoyed 'religious visits' but there was no explanation of what this meant. We were unable to ask the person about this information. We asked staff if this person was supported to visit a place of worship or if they received visits from a religious group. We were told they did not. We asked staff further about meeting people's religious and spiritual needs. One staff member said that people from the local church visited at specific times of the year such as Christmas and Easter. Another staff member said, "A priest used to visit a catholic person, who is no longer here." Another told us, "No one attends church but if this was requested we would be able to support them to attend."

Some people had specific healthcare needs. We saw examples where additional information was in people's care files that informed staff of important information that they needed to know. For example, information fact sheets on diabetes were present in some people's care files. However,

we saw examples where staff were not provided with information that advised them of a particular condition and how this affected the person. For example, some people had Parkinson's Disease, staff had not received training on this condition and the support plans did not clearly state how this affected the person.

We observed a person walking around for a while until staff intervened, with nothing on their feet and noted their nails appeared long. We discussed this with the deputy manager who told us that the person would not always allow staff to support them with their personal care needs. They gave an explanation of how the person became anxious and uncooperative. This person's care file did not include

Requires improvement

Is the service responsive?

information advising staff of this information. Nor did it include what the risks were of the person's refusal to cooperate at times and how this could impact on their health and wellbeing. Additionally, there was no information advising staff of the action to take if concerns were identified. We were concerned that this person's care was not responsive to their individual needs. We discussed this with the deputy and manager who agreed to review this person's care.

People told us that staff supported them to visit the weekly market in the village and that they enjoyed this. Many people had lived in the local area prior to moving to Beauvale Care Home and therefore may have developed links with market traders and visitors.

Staff told us about the activities that were provided internally and externally. One staff member said, "We have bingo, dominoes, one to one activity, pub lunches, Skegness trip, Rutland water trips, visits to market square, coffee shops visits and baking cakes." Another staff member told us, "We have resident meetings where we discuss what activities people would like. We are flexible in what we provide." An example was given of a visiting aromatherapy massage session that was provided once a month and entertainers such as singers.

We saw there was an activities board on display showing what activities were available each day. The provider employed activity coordinators who were responsible for arranging activities. They told us that activities were based on people's wishes and interests. On the day of our visit there was a visiting hairdresser. We saw how people were supported to have their hair done if they wished and saw it was a popular activity. We also saw the activity coordinator provided nail care and spent time chatting to people. Staff told us about a seaside trip that had been arranged for the end of the week and a Summer fete at the weekend. There was lots of talk with people about these activities.

We saw the provider had a complaints policy and procedure that was on display and visible for people. The complaints procedure was also available in large print. However, not all people said they knew how to make a compliant. One person said, "Don't know whom to complain to." A relative said, "I'm not aware of the complaint procedure." An additional person said, "I do not know who the manager is and do not know about any complaint procedure."

The provider had a system of recording all complaints which showed the action taken to resolve complaints. We saw there were three recorded complaints and these had all been resolved and responded to in a timely manner.

Requires improvement

Is the service well-led?

Our findings

People and their relatives gave limited feedback about their experience of the leadership of the service. A relative told us, "All information relating to the home was given to me and my mother was allowed to bring her own furniture. She has brought her pictures and they are on the wall. It has been a safe transition and I have no reservations." A person told us, "I was introduced to the manager but have not seen her again." This reflected similar comments made by others about contact with the manager.

Health professionals gave positive comments about the leadership and that the service had developed positive links and communication with them.

Staff made positive comments about the leadership style with one exception. Staff described the manager as approachable and supportive. Additionally they said, "She [manager] will get things done, she listens." A negative comment made was, "Management don't always know what good and safe practice looks like unless they come out of their office to look and see the bigger picture."

We observed the manager was visible to staff, people that used the service and visitors during the two days we visited. We saw they interacted and responded to people's requests for assistance and comfort needs well.

The provider had systems in place to monitor the quality of the service. These included weekly and monthly audit checks completed by the manager and area manager on a variety of issues such as the care people received the environment and equipment. Actions plans were developed from these audits where any shortfalls were identified. We discussed with the manager the shortfalls we identified during this inspection. This was with particular regard to the staffing levels, record keeping and information in people's care files. The manager told us that they reviewed care files on a regular basis to ensure information was detailed, correct and up to date. They also told us that they did a daily 'walk around' to check how the service was running. These systems to check on safety, quality and monitoring of people's needs had not identified the shortfalls we found during our inspection.

The manager had been at the service for six weeks at the time of our inspection. They told us that they were in the process of submitting their registered manager application to us. The provider had met their registration requirements by submitting notifications of serious incidents they are required to do.

Staff demonstrated they had an understanding of the provider's vision and values and described how they strived to provide the best possible care they could. This included promoting people's independence and respecting people's privacy and dignity.

The provider enabled people and their relatives to share their feedback about the service. This was facilitated in different ways. An electronic 'live' feedback system was in place whereby any person could share their views which went direct to the providers head office for analysis and action. Paper opinion surveys were also sent to people that used the service and relatives. We saw a report dated 2014 that showed the outcome from 13 people's feedback about the service they received. We saw positive feedback was received with regard to various topics such as staff and care, home and comforts, choice and having a say and quality of life. In addition, relatives had completed an opinion survey in March 2015. The manager told us that another survey had been sent out which they were waiting to have returned.

Relative and 'resident' meetings were arranged to enable people to share any issues, concerns or suggestions. They were also used as an opportunity for the manager to inform and consult with people about any developments within the service. We saw a meeting record dated July 2015 and noted the meeting was in the early evening and was hosted by the manager. We saw that the manager used this opportunity to introduce themselves, advised people about staff vacancies and recruitment and the activities planned for people over the Summer. People were informed of the next meeting in September 2015 where they were invited to part take in an Italian Buffett. We also saw records from meetings with people that used the service dated May, June and July 2015. People were asked about their opinions and choices relating to the food and activities. We saw people made positive comments on the trips they had participated in, these included, a pub lunch and a trip to Rufford park.

The provider supported the staff team to share their views and opinions about the service. Staff received opportunities to share their views via a questionnaire and by attending regular team meeting where they could raise

Requires improvement

Is the service well-led?

any issues, concerns or make suggestions. We viewed the staff survey response dated May 2015. Over 70 percent of staff said they felt valued in their job and that they felt they contributed to the success of the service provided in the home. Whilst over 76 percent of staff said they received opportunities to develop their skills.

We saw staff had available to them the dates of staff meetings where they were encouraged to attend to 'have your voice heard'. We also saw examples of staff meeting records where issues were discussed to further develop the service which detailed the action to be completed and by whom. This demonstrated the service regularly reviewed the service provided and strived to make further improvements.

Information from the Provider Information Return told us that staff had access to a confidential whistleblowing help line to report concerns confidentially. In addition staff had access to confidential employment assistance for counselling and support on work related matters. Staff confirmed this to be correct. Staff were also recognised for the care they provided in the way of a 'kindness in care award'.

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 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Staffing.** **Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the needs of the people using the service at all times.** Regulation 18 (1)