Krinvest Limited

The Hamiltons 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?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

We carried out an unannounced inspection of The Hamiltons on 23 February 2015. We last inspected the service on 25 August 2013 when it was found to be meeting all standards inspected.

The Hamiltons Care Home provides accommodation and personal care for up to 18 people. At the time of our visit 14 people that lived at The Hamiltons were present. The home is situated close to Atherton town centre and other local amenities. Six rooms have en-suite facilities and all rooms have a hand wash basin. Toilets and bathrooms are in close proximity to bedrooms and communal areas. There is a small car park at the front of the home.

There was a registered manager at the time of our visit. They had been in post for around three years. 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.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponded to breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to requirements relating to fit and proper

Summary of findings

persons employed, staffing, need for consent and person-centred care. You can see what action we told the provider to take at the back of the full version of the report.

We saw there were enough staff to provide people with the support they required on the day of our inspection. People told us they felt safe and thought the staff were kind and caring. We saw staff took time to speak to people and took time in helping people make decisions, such as what they wanted to eat. We observed staff working in person centred ways to meet the needs and preferences of the people they were supporting.

Staff and relatives we spoke to told us the service was homely. They said as it was a small service their family members got to know the staff well. Relatives told us they had been involved in reviews of care for their family member. We saw people who were able to sign to agree their care plan had done so.

Some people felt there were not enough activities at the home, including trips out. The staff told us they would support activities including trips out of the home and one to one activities in the community whenever possible. However recent staff sickness had made this more difficult to do regularly.

We found that the service was not always following proper procedures to ensure only staff suitable to work with vulnerable adults were employed. Where staff had previously been employed in health or social care settings, services should seek evidence from their former employers to determine why their employment came to an end. We saw two staff files where the staff member had previously been employed in health or social care roles, but there was no evidence that references had been sought from their former employers.

Medicines were administered safely, however, not all medicines were being stored correctly. We saw two medicines that should have been kept in the fridge being kept in the medication trolley.

The service was not meeting the requirements of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). One person told us they would like to be able to go out alone, but didn't think they would be allowed to. Staff confirmed they would not allow this person to go out alone due to their vulnerability. The service had not made a DoLS application for this person or carried out an assessment of this person's capacity to take this decision.

People's weights records were not always completed consistently. We found this was due to keyworkers being responsible for recording weights, and there not being systems in place to ensure other staff picked up this duty when keyworkers were off work. This had also resulted in one individual who had lost weight not being referred to a health professional.

We saw there were gaps in training provision. Some staff had not completed training or it was out of date for a number of courses including safeguarding, infection control, health and safety and the Mental Capacity Act. None of the care staff had completed training in how to complete care plans. In one case this had resulted in a person's care plan not having been completed.

Staff, relatives and people living at the Hamiltons felt the registered manager and deputy manager were approachable. All the people we spoke to said they would feel comfortable raising a complaint if needed. We saw evidence that complaints and feedback gathered at residents meetings had been acted upon. Staff told us they were happy working for the service and felt supported in their roles. They told us the staff team worked well together.

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

Not all aspects of the service were safe.

The service had not always carried out checks required to determine why employees had left previous positions where they had worked with vulnerable children or adults.

Medicines were administered safely; however two medicines that should have been stored in the fridge were being kept in the trolley.

There were enough staff and people and their relatives felt they were safe. Staff understood procedures to report any concerns and were confident concerns would be acted upon.

Is the service effective?

Requires improvement

Not all aspects of the service were effective.

There were gaps in training including safeguarding and health and safety. The service was in the process of updating required training.

Keyworkers were responsible for completing care plans. However, no specific training or support had been provided to enable them to do this effectively. This had led to one person's care plan not being completed.

There were gaps in three people's weight records and no action had been taken in relation to one person losing weight.

The service had not always identified restrictive practice, or established people's capacity to make decisions about their care and support.

Is the service caring?

Good

The service was caring.

We observed staff took time to sit and talk with people. Staff took as much time as required to help people decide what meal option they would like.

People told us staff respected their privacy and dignity. Staff were able to tell us how they respected people's privacy and dignity and how they supported people to be as independent as possible.

We saw staff worked in person centred ways to meet people's preferences at that time. For example staff were flexible around the times meals and care were provided.

People told us the staff were kind and caring and they got on well with them. The relatives of people and staff both described the atmosphere as homely.

Is the service responsive?

Requires improvement

Not all aspects of the service were responsive.

Summary of findings

Whilst some people felt there was enough to do, others told us they would like more activities to be offered.

People and their relatives told us they would be confident in making a complaint to the service if needed.

Residents meetings were held regularly and were well attended. We saw input into the development of the service had been received from the people living there.

Care plans contained only limited information about medication, and this was not always up to date.

Is the service well-led?

Not all aspects of the service were well led.

Systems to monitor the quality of the service were not sufficiently robust to prevent the shortfalls we found in completion of care plans and weight monitoring. It was not always clear if actions identified in audits had been followed up.

Staff felt happy and supported in their roles and told us the registered manager was approachable. Staff felt they worked well together as a team.

The registered manager had completed a 'wish list' of improvements to the physical environment and we saw there had been progress on their completion.

Requires improvement

The Hamiltons 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.

The inspection took place on 23 February 2015 and was unannounced. The inspection team consisted of two adult social care inspectors and a specialist advisor who was a pharmacist. Before the inspection we reviewed information we held about the service. This included notifications that the service is required to send us about accidents, safeguarding and other important events. We contacted the local authority safeguarding and quality assurance teams as well as Wigan Healthwatch to get feedback on the service.

We reviewed the provider information return (PIR) sent to us by the service. A PIR 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.

During the inspection we looked at all areas of the home including the kitchen, bathrooms and communal areas such as the lounge. We observed the mid-day medication round and checked the stocks and storage of medicines including controlled drugs.

We spoke with eight people living at The Hamiltons and four relatives who were visiting at the time of our inspection. We also spoke to one health professional who was visiting at the time of our inspection.

As some people were unable to tell us about their experience of living at The Hamiltons we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care and support to help us understand the experience of people who could not talk with us.

We talked to seven staff including the registered manager, the deputy manager, three care staff, the cook and the maintenance worker. We looked at six people's care files and reviewed medication administration records (MARs) for all 14 people who were taking medicines at the time of our inspection. We reviewed five staff personnel files and other records related to the running of a care home. These included copies of policies and procedures, maintenance records, training records and minutes of meetings.

Requires improvement

Is the service safe?

Our findings

We looked at staff personnel files to check that procedures were in place to ensure only suitable and appropriately qualified staff had been recruited. Staff had Disclosure and Barring Service (DBS) checks. DBS checks involve checking police records and the DBS's own records to see if any safeguarding concerns relating to individuals have been notified to them. This would highlight if staff had any previous convictions or were barred from working with vulnerable adults. We saw staff had completed application forms and that two references had been obtained. However, we saw that two staff members had previously worked in care settings and there was no evidence that their former employers had been contacted for a reference as is a requirement. This was also contrary to the home's recruitment policy.

We found the service had not taken reasonably practicable steps to verify why employees' former work with vulnerable adults had ended. This was a breach of regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All the people we talked to told us they felt safe and thought their belongings were safe. One person said "Staff look after you, I feel safe here". The visitors we spoke to also felt their relatives were safe. One person told us "X feels safe here. It's like a little family".

On the day of the inspection we saw there were enough staff available to provide people with the support they required. Staff told us they had time to spend with people and we saw staff took time to sit and talk with people. All three relatives and one person living at The Hamiltons we asked about staff levels agreed there were enough staff. We confirmed staffing levels by looking at staff rotas.

Before the inspection we had received information from the local authority safeguarding team that the call bell system was old and required staff to enter the office to turn it off before responding to the call. This meant there was a risk staff could become distracted before attending to the person using the call bell. On the day of our inspection we saw call bells were being answered promptly by staff. We discussed the call bell system with the registered manager who told us they were looking into new systems that could be monitored and did not require staff to cancel the bell before attending the call.

Staff we spoke with were aware of how to recognise possible signs of abuse and of how to report any concerns they may have. Staff told us they would feel confident to both challenge and report any poor practice they may see. The registered manager was aware of local safeguarding procedures and how to raise an alert with the local authority. We saw the service's safeguarding policy was displayed on the noticeboard and included contact details for the local authority safeguarding team. This would help enable staff, people living at The Hamiltons and their visitors to report any concerns if they felt they could not discuss them with the manager.

We observed the mid-day medicines round. Medicines were administered to one person at a time following best practice guidance. Medication administration records (MARs) were accurately completed. We saw reasons for non-administration, doses given and time and reason for administration of 'when required' (PRN) medicines were recorded on the MARs.

Staff we spoke with were able to tell us when they would offer as required (PRN) medicines. Staff knew what the medicines were for and they told us they would ask people who were able to communicate their needs if they required the medicine. If someone was not able to communicate their needs verbally they said they would look for other signs such as behaviour that might indicate a medicine was required.

We saw staff take time to explain to people what 'when required' medicines were for and ask them if they needed it. However, there were no written records such as a PRN protocols to document when these medicines should be given. This meant there was a risk staff might not offer as required medicines consistently when it was needed. Any new or temporary staff might also be unaware when it was required.

We recommend that the service reviews guidance in relation to best practice for administration of 'when required' (PRN) medicines.

Controlled drugs are medicines that legally require additional measures to be put in place to ensure their safe administration and storage. We saw that the service was

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Is the service safe?

meeting these requirements by keeping controlled drugs in appropriate locked storage, keeping a register of controlled drugs and ensuring two people witnessed and signed the administration of controlled drugs. We also saw that an audit by the pharmacy had not found any issues in relation to controlled drugs.

Some improvements were required to ensure the safe keeping of other medications. During the tour of the home we saw creams had been left on the side in someone's bedroom. The staff member said they should not have been there and removed them immediately. We also saw two medicines that should have been kept in the fridge but were in the trolley. This was poor practice and would have shortened the shelf life of the medicines. However we received advice from a pharmacist that this was unlikely to have resulted in any harm occurring. We saw records of fridge temperatures were kept. The pharmacy had been contacted for advice on an occasion the maximum recommended temperature for storage of medicines in the fridge had been exceeded.

We looked to see if checks necessary to ensure a safe environment was maintained at The Hamiltons had been carried out. We saw that tests and maintenance of gas, electricity and care equipment such as hoists were carried out regularly and were in date. We saw there was an emergency contingency plan in place and the manager was able tell us the procedure that would be followed if an evacuation was required. People had personal emergency evacuation plans (PEEPs) in place that would allow staff to know how to support people in the event of a fire or other emergency.

We looked at records kept in the kitchen including food temperatures, fridge temperatures and cleaning schedules and saw these were completed and up to date. We saw all staff received fire training on induction and the service had recently invested in equipment that would assist in evacuating people with limited mobility in the event of an emergency.

The environment looked clean and tidy at the time of our visit. We saw that protective clothing (PPE) such as aprons and gloves were readily available in bathrooms and other areas where people may receive assistance with personal care. Two relatives and one person living at The Hamiltons remarked independently how clean the home was. One person said "The place is spotlessly clean".

Requires improvement

Is the service effective?

Our findings

We looked at the record of training undertaken by staff. It showed there were gaps where training identified by the service as mandatory had not been delivered to staff or was out of date. Of the 20 care staff, 35% (seven) had completed dementia awareness training and this was over three years old for five of those staff. Infection prevention and control training had been completed by 21% (five) of the 24 care, domestic and kitchen staff and this was over 18 months old.

The training matrix also showed 40% (eight)of the care staff had not completed training in safeguarding and that none of the staff had completed training in COSHH (control of substances hazardous to health), health and safety, tissue viability, nutrition, completion of care plans or deprivation of liberty safeguards (DoLS). We checked the staff training matrix against certificates in staff files and found the matrix to be accurate.

The gaps in training meant there was a risk staff would not have the skills required to care for people effectively. We found the care plan for one person had not been completed. The registered manager told us people's key workers were responsible for completing care plans. We spoke to the key worker who told us they had been asked to complete the care plan, but had not had any training and did not feel confident in completing such an important document. From looking at this person's daily records of care received we also saw they had behaviour that staff could find challenging. The key worker confirmed they had not received any training in handling challenging behaviour. This meant they might not be able to respond effectively when providing care and support to this person.

The service had not ensured staff had received the training required to enable them to deliver care to an appropriate standard. This was a breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke to the registered manager about the gaps in training. They told us they had found it difficult to arrange training courses, and also that some staff had completed training as part of other care qualifications, but certificates had not yet been brought in by staff. We saw that some of the staff were completing distance learning booklet training in a variety of courses including health and safety although there was no summary available of which staff were completing which courses.

The registered manager told us staff received supervision every three months as well as an annual appraisal of performance. We confirmed this by looking at copies of supervision records in staff files. Staff told us they received supervision and said they were able to discuss their support needs.

The Care Quality Commission has a duty to monitor activity under the Deprivation of Liberty Safeguards (DoLS). The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

The registered manager and deputy manager were aware of requirements in relation to DoLS. The registered manager told us two DoLS applications had been submitted to the local authority. They told us they would be submitting further applications as agreed with the local authority where it had been identified that people lacked capacity and restrictive practice was required in order to ensure people received the care and support they needed.

Before the inspection, we received information from Wigan Safeguarding. Some of this information related to concerns that the service had not assessed the capacity of a person to consent to care, and not having adequately monitored this person's health. Staff told us best interests meetings would be arranged for decisions such as determining if covert medicine was appropriate if a person repeatedly refused their medicine, or to determine if it was in a person's best interests to move to another home for example. However, we spoke with one person who told us they would like to go out of the home on their own, and felt they would be safe doing so. They told us they had not asked to go out alone, but they thought they would not be allowed as others had asked and been told "no".

We asked a member of staff and they confirmed they would not let this person out alone. They said they were unsure why they were not allowed out. We raised this with the registered manager who told us this person would not be allowed out alone due to their vulnerability. They told us staff would support this person to access the community

Is the service effective?

whenever possible, and that they did not think this person would want to go out alone if they were given the option. We highlighted that there was no capacity assessment or risk assessment in this persons care file that demonstrated the service had considered this person's ability to make a decision whether to go out alone. We confirmed after the inspection that an application for a DoLS authorisation that would have provided legal authorisation for not allowing this person out alone had not been submitted. The manager told us they would submit an urgent application for an authorised deprivation of liberty. The failure to identify this restrictive practice and assess this person's capacity in relation to making a decision about going out without staff supervision was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 .

We saw there had been some adaptations to the environment to make it more 'dementia friendly' and help people retain independence in their home. We saw there were pictorial signs to show which rooms were which. Bathrooms had contrasting coloured toilet seats that would stand out better to people with visual impairment. We saw there were 'memory boxes' outside people's bedrooms that would help them identify their room. However, only one of these had been completed at the time of our visit. The registered manager said they were in the process of working with families to put these in place for other people.

The registered manager told us they would be putting people's photos on their doors and this was planned to start on the day of our inspection. We saw from the pre inspection information provided that the service had identified other potential improvements they could carry out to make the environment more dementia friendly, such as the introduction of colour themed corridors.

We saw records that indicated people had been referred to other health services when a need was identified. Carers told us they would contact a GP if someone was unwell. The registered manager said there was frequent involvement from nurses and told us they were able to do 'dip testing' for urinary tract infections (UTIs) in the home. We spoke to a visiting professional who told us staff followed the advice they gave and said "Staff know all the residents well. They contact us if they need any support. They don't leave things". One person told us they had visited the dentist that morning.

We saw the service monitored people's weights. However, we saw some people were not consistently weighed as regularly as required. We saw an audit in one person's files indicated they should be weighed weekly. In the ten week period from when the audit had identified a need for weekly weights, this person had been weighed six times.The average (mean) gap between weight records was 12 days. This person had gained weight however, and there was not a concern regarding their health. Another person had a nutritional risk assessment that indicated weekly weights were required. There was one recorded weight since the nutritional risk assessment had been completed approximately five months earlier. The recorded weights also showed this person had gained weight and there was no evidence of a detrimental impact on them.

One person had not been weighed for eight weeks, and another person's weight records showed they had lost 5kg in six weeks and there was no evidence of any action having been taken such as contacting this person's GP. The registered manager told us they were not aware of the weight loss and that this person's keyworker had been off work.They told us they would take immediate action to make sure this person was weighed and referred to a dietician if the weight loss had continued. Staff told us that keyworkers were responsible for weighing people. The registered manager told us other staff should pick up keyworkers' responsibilities if they were not in. However, staff were not aware of any systems being in place to ensure this happened.

The service had not taken adequate steps in the planning and delivery of care to ensure the safety and welfare of people. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they liked the food offered and said they were given a choice at mealtimes. Some of the comments included; "Meals are alright. If there's anything I don't like they find me something else. I enjoy my food"; "The food is

Requires improvement

Is the service effective?

very nice. We get cooked food. It's very nice and there is enough of it" and "The food looks and smells good". We saw the chef talking to people at the end of their meals and heard one person complementing the chef on the meal.

The chef told us food was fresh and locally sourced. We saw there was fresh fruit available in the communal areas that people could help themselves to. The chef told us people's preferences and dietary requirements were recorded on admission, and described how they had changed the menu to meet people's individual likes and dislikes.

Good

Is the service caring?

Our findings

We observed interactions between staff and people living at the Hamiltons to be respectful, warm and friendly. All the staff we asked told us they would be happy for a relative or loved one to live at The Hamilton's. It was also noted that some of the staff had previously had relatives who lived at the home.

We saw staff spend time sitting and talking with people or joining in with games such as dominoes. All the visitors and people we spoke to were complimentary about the staff and felt they were kind and caring. One person said "It's very nice here. If they can help me in any way they will do". Another person told us "It's absolutely gorgeous here. I was terribly ill last week. I was awful with staff but they were still kind to me". A relative told us "Staff care for each and every person. X has really benefitted from being here."

People told us that as The Hamiltons is a smaller home, they felt there was a close family atmosphere. One relative told us "Staff are fabulous. Because it's a smaller home, X knows every staff member by name". Two people commented that they felt they had a good relationship with staff and said they were able to 'have a joke' them. The registered manager told us they felt they had developed close relationships with people's families and said there were no restrictions on visiting times.

We observed the mid-day meal and saw people were served promptly and the atmosphere was relaxed. We observed staff took as much time as was needed to describe and present the food choices and wait for the person to make a decision. We saw one person who was asleep at the time the meal was being served. We heard staff discuss how they could rearrange this person's care needs to enable them to sleep a while longer. This showed staff were working in a person centred way to meet that individual's needs. We saw the staff returned later and woke this person gently and respectfully, made them comfortable and explained it was time for their medicine before the meal.

Our observations showed that staff knew the people they provided support to well and respected people's choices. For example, we noticed that one person had not come out of their room when most other people were having breakfast. We asked staff about this who told us they had checked with this person who had told them they wanted to stay in bed longer that morning. The staff said they had agreed to come back at a later time to support that person with their morning routine. We saw staff offered pain relief and other 'as required' medicines to people. Staff took time to explain what the offered medicine was for and supported people to make a decision as to if it were required or not.

People told us staff respected their privacy and dignity, such as by knocking on their door and waiting to be told it was okay to enter. One person told us the staff respected their privacy by "keeping away when you want them to". Staff told us they would respect people's privacy and dignity by asking them before providing any personal care, ensuring personal care was provided in a private environment and by talking through what they were doing when providing care. Staff said they would encourage people to be as independent as possible in personal care tasks. They told us they would look for signs such as facial expression to tell if people who had limited verbal communication were comfortable with the support being provided.

The registered manager told us some of the staff had received training in the 'six steps programme' for end of life care and they felt this had had a positive impact on care delivered. The six steps programme is a nationally recognised training programme on how to deliver good end of life care. We saw that eight staff had completed this training the previous year and the registered manager said they hoped more staff would be able to attend it.

Two of the care files we looked at had end of life care plans in them. We spoke to one of these staff who told us residents would be spoken to about their end of life wishes and ensure people were pain free. They also said people would have an end of life care plan. We saw most people had end of life care wishes documented in their care files. However, one person's advanced care planning document was completed with only limited detail. The registered manager was unaware of this and said they would ensure this was fully completed with the person and their family.

Requires improvement

Is the service responsive?

Our findings

We received a mixed response when we asked people if we thought they had enough to do at The Hamiltons. Whilst some people felt there was enough to do and enjoyed the activities on offer, others felt the range of activities was limited. Staff told us people would be supported on one to one activities such as going to the shops when possible. One person told us a staff member was taking them out that day. A different member of staff told us they were taking someone out the following day on their day off. They said “I don’t mind as it puts a smile on their face”.

One person who had lived in another home previously said they felt there was nothing to do other than play dominoes and said "I miss staff organising activities”. Another person said they would like to do wheel-chair exercises but this was not offered. People told us trips out had been arranged in the past, but they had not been on one for some time and the last one had been cancelled. They said this had been due to staff being off sick. A staff member also told us staff sickness had had an impact on the activities they were able to offer.

We reviewed the activities offered over the past nine days in the activity file. We saw there were four entries which were 'Dominoes'; 'music and exercise'; 'prize bingo'; 'massage, nails, pamper, haircuts’. Staff told us they also held events such as coffee mornings and a summer fete in the garden. On the day of our inspection we saw some people were completing crosswords and playing dominoes. The television was on in the lounge; however no one appeared to be watching it. We asked the registered manager if they had considered hiring an activity co-ordinator. They said they had, but that it had not been approved due to cost.

We asked people if they knew how to make a complaint and if they would feel confident in doing this. People told us they would speak to their keyworker, the manager or another member of staff if they had any complaints. One person told us they had raised a complaint with their keyworker and that the issue had been resolved quickly by them. Relatives also told us they would be confident in approaching staff to raise any concerns they might have.

The registered manager told us resident and relatives’ meetings were held every three months or as required. We viewed minutes from the last meeting, which covered areas such as food preferences, ideas for trips, decoration and complaints. We saw the meeting was well attended and it was evident that the service had sought the views and input of people living there.

The registered manager told us surveys were sent out annually to residents and families. We saw copies of completed surveys, which were generally positive. We spoke with the registered manager about two negative comments we saw and found that the issues raised had been resolved satisfactorily.

Other than the one care plan that had not been completed as discussed in the effective section of this report, we saw people’s care plans were complete and had been recently reviewed. Risk assessments, including nutritional risk assessments were in place and had been reviewed as required. There was some evidence of people’s preferences, likes and dislikes being recorded in care plans. However this information was often limited, and care plans were largely task based. It was noted that the format of the care plans meant there was only limited space to record relevant information.

Care plans contained only limited information about medicines, and this had not always been updated following changes to medicines. We found that one person had had their medicine changed on the MAR sheet; however there was no information in the care plan and no prescription records to document this change. Another person’s medicine had changed on discharge from hospital. The MAR had been updated correctly; however, the information in the care plan had not been updated at the same time and was out of date.

Relatives we spoke to told us they had been involved in reviews of their family member’s care. Staff told us people were involved in developing their care plans and were asked to sign to say they agreed with the content if they were able to do so.

We asked the registered manager about the process followed when someone moved into the home. They told us they would complete an initial assessment of needs and preferences. They said people would then be given the opportunity to come and look round and join them for a meal before making a decision if they wanted to move in. Staff told us they would read the care plans of people

Requires improvement

Is the service responsive?

moving into the home and said they would have time to do this. They also told us important information, including any changes in people's care plans would be highlighted during staff handover.

Requires improvement

Is the service well-led?

Our findings

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered manager told us they worked shifts, including weekends to ensure they kept in touch with all staff. They told us the biggest achievement of the service was maintaining a safe and happy home for people.

The registered manager completed regular walk rounds with the maintenance worker, which they had used to draw up a 'wish list' of improvements to the home environment. We saw this list and that actions had been taken in some areas, such as redecorating certain rooms. The registered manager said it was planned to put in a second ramp into the garden leading from the conservatory to improve access for people with impaired mobility.

We saw that a variety of audits were undertaken in order to monitor the quality of service provision. The manager said they completed a weekly report for the provider and that someone from head office would visit on a weekly basis. We saw copies of audits completed including those covering infection control, environment and maintenance, accidents and incidents, and medication. The registered manager told us they carried out spot-checks on care and support being provided by care staff.

The registered manager told us care plan audits were completed every month. We saw evidence these audits had been completed, however it was not always clear whether identified actions had been followed up. It was discussed with the registered manager that the quality assurance system had not been sufficiently robust to ensure documents such as care plans had been completed consistently or in a timely manner. The registered manager told us they would go through how to complete care plans with staff.

We found that the system of keyworkers being responsible for weighing people and completing their care plans had led to gaps in these areas. The registered manager told us that staff would recognise when someone's keyworker was not in and would pick up these responsibilities, however staff were not aware of any particular system.

Staff told us they felt supported and happy in their roles. One staff member said "I feel confident in what I'm doing. There are always people to ask." They told us they would be confident in approaching the registered manager or deputy manager with any concerns, and they felt they would be taken seriously. Staff told us they worked well as a team. One staff member said "Staff are close as it's only a little home and we work well together".

We asked the registered manager what they felt the biggest challenge was in the service. They told us they thought this was staffing and covering shifts, particularly given that a number of staff were off work sick or on leave at the time of our visit. The registered manager told us they tried to minimise use of agency staff to ensure consistency of support to people. They said this was a challenge in ensuring staff were not overworked. Staff told us they tried to cover shifts within the team, but they felt free to turn down any overtime offered.

Staff told us they thought the service was well led and that the management were fair. Staff said they attended team meetings where they felt they were able to raise any issues they might have. We saw minutes from staff meetings and saw they were held around every other month. We saw various topics were discussed in these meetings including training, policies and procedures. This would enable the registered manager to keep staff up to date with their expectations.

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 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The provider had not taken adequate steps to ensure people employed were of good character through the seeking of evidence of conduct in previous employment in health and social care. Regulation 19 (2)(a)(3)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Arrangements were not in place to ensure people employed by the service had received the training required for them to deliver care to service users to an appropriate standard. Regulation 18 (2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People were not protected against the risks of unsafe care as the planning and delivery of care did not meet individual needs and ensure people's welfare and safety. Regulation 9(3)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Suitable arrangements were not in place to establish capacity to consent or establish best interests in line with section 4 of the Mental Capacity Act 2005. Regulation 11.