Primrose (2013) Limited

Blackdown Nursing Home

Inspection report

Mary Tavy
Tavistock
Devon
PL19 9QB

Tel: 01822810249
Website: www.blackdownnursinghome.co.uk

Date of inspection visit:
15 December 2016
19 December 2016

Date of publication:
09 March 2017

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**

Summary of findings

Overall summary

The inspection took place on 15 and 19 December 2016 and was unannounced. Blackdown Nursing Home provides care and accommodation for up to 33 people who may require nursing care and for people who are living with dementia. On the day of the inspection 32 people lived in the home.

A registered manager was employed to manage the service. 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.

Our inspection in November 2015 found a breach of the regulations. People did not always give consent for care and treatment and the provider did not act in accordance with the Mental Capacity Act 2005. At this inspection we found staff told us they often made decisions in people's best interests and records showed best interests decisions had been made on behalf of people. However, mental capacity assessments were not always in place to identify why the person was deemed unable to make the decision themselves, the rationale for decisions made in people's best interests was not recorded and people's care plans did not always contain information to guide staff about people's preferences. Staff told us they sought consent from people but this was not always observed to be the case during the inspection.

People received their medicines on time from staff who were patient and understood their needs. However, people's medicines were not always stored or disposed of safely and there was no audit in place to help ensure medicines administration followed best practice. Following the inspection, the provider sent us details of a new medicines audit to be used in the home.

People were observed to have their healthcare needs met but risk assessments were not always clear or reflective of people's current needs; and actions taken to help mitigate any risks were not always recorded. Tools to monitor people's health needs were not always complete or up to date and action was not always taken in response to possible concerns, for example weight loss or regular falls.

A record was kept in people's rooms of their likes, dislikes and preferences but it was not clear that staff were using this information to provide meaningful activities for people. There was a programme of planned entertainment for people but outside of these times people were observed to have little to keep them cognitively active.

People and relatives described the service provided as being particularly caring and spoke highly of the staff and the support they provided. The provider had a clear philosophy that people should be treated as family members. This was reflected in the ways staff spoke about their work and comments received by relatives. Compliments received by the service stated, "I never ever saw anything but love for all the patients under your care" and "Thank you for the wonderful care and love you showed mum"
People were supported by staff who were knowledgeable about their needs and had regular training to

update their skills and knowledge. Staff told us they felt well supported by the provider and registered manager. One member of staff told us, "If there's something I'm unsure about, I can ask the manager or the owner for advice. I feel confident I can ask."

People told us they felt safe using the service. Staff had received training in how to recognise and report abuse and were confident any allegations would be taken seriously and investigated to help ensure people were protected.

People were kept safe by suitable staffing levels. Relatives told us there were enough staff on duty and we observed unhurried interactions between people and staff. This meant that people's needs were met in a timely manner. Recruitment practices were safe. Checks were carried out prior to staff commencing their employment to ensure they had the correct characteristics to work with vulnerable people.

Feedback received by the service was used to improve the quality of the service and complaints were taken seriously and acted upon. Relatives confirmed, "I can find no fault at all" and "Everything I've mentioned to staff, they've listened to."

The registered manager regularly audited care plans and risk assessments but this had not highlighted that some were not reflective of people's current needs. There were no audits of medicines, falls or incidents in place to help ensure all appropriate action had been taken or that improvements were made from any trends identified. The provider had not monitored the service effectively to identify areas for improvement. Following the inspection, the provider informed us of several new audits or procedures which would be put in place.

We found breaches of regulation. You can see what action we told the provider to take at the back of the full version of the report. We will also meet with the provider to discuss action they intend to take and carry out a further inspection in the near future.

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 always safe.

Medicines and medicines storage were not always appropriately maintained.

Risk assessments were not always up to date and did not always give clear guidance about the risks to people or reflect information in the care plan. Records did not always show that actions had been taken to mitigate the risks identified.

When people were at risk of being overweight or underweight, tools and records to assess and monitor this had not always been completed effectively; and actions had not always been taken when they highlighted a change to the person's health.

Information from incidents was not always acted upon to help reduce the risk of reoccurrence.

There were sufficient staff on duty to meet people's needs safely. Staff were recruited safely.

People were protected by staff who could identify abuse and who would act to protect people.

Is the service effective?

Requires Improvement

The service was not always effective.

People had mental capacity assessments in place but not in relation to all decisions they were deemed unable to make.

Best interests meetings had been held for people but no rationale for the decisions made had been recorded to show people's rights were protected. Information was not always recorded in people's care plans to advise staff how to make best interest decisions for people.

People received support from staff who knew them well and had the knowledge and skills to meet their needs.

Staff were well supported and felt confident contacting senior

staff to raise concerns or ask advice.

Is the service caring?

Good

The service was caring.

People were looked after by staff who treated them with kindness and respect. People and visitors spoke highly of staff.

Staff spoke about the people they were looking after with fondness.

Staff described how they protected people's privacy and dignity. People's end of life wishes were discussed with them where possible and respected by staff.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care plans did not always contain information about how people liked their care to be delivered.

Staff were knowledgeable about people's likes and dislikes but there was no evidence staff used this information to provide meaningful cognitive stimulation for people outside of planned activities.

Staff used handover time to keep up to date with people's needs.

People knew how to make a complaint and raise any concerns. The service took these issues seriously and acted on them in a timely and appropriate manner.

Is the service well-led?

Requires Improvement

The service was not always well led.

Records did not always give a full picture of what care had been delivered to people.

Audits had not been used effectively to identify areas for improvement. Following the inspection, the provider shared details of new audits and procedures that would be put in place.

There was a positive, caring culture in the service.

The provider had clear values about wanting people to feel cared for. These values were understood and shared with the staff

team.

People's feedback about the service was sought and their views were valued and acted upon.

Blackdown Nursing 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 15 and 19 December 2016 and was unannounced. The inspection was carried out by one inspector and a specialist nurse advisor.

Prior to the inspection we reviewed the records held on the service. This included notifications and the Provider Information Return (PIR). Notifications are specific events registered people have to tell us about by law. The 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 spoke with two people, three relatives and an occupational therapist who was providing support to someone living at the home. Some people living at Blackdown Nursing Home were not able to verbally express their views so 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.

We reviewed four people's records in detail. We also spoke with the clinical lead nurse, a nurse, five healthcare assistants and the cook and looked at four personnel records and the training records for all staff. Other records we reviewed included the records held within the service to show how the registered manager reviewed the quality of the service. This included a range of audits, questionnaires to people who live at the service, minutes of meetings and policies and procedures. We were supported during the inspection by the providers and the registered manager.

Requires Improvement

Is the service safe?

Our findings

People were weighed regularly to help ensure staff were aware of any weight loss concerns. However, one person had lost eight kilograms over a three month period. This had not been identified as a concern and no referral had been made for professional advice. The person had seen the GP for a routine review but the level of weight loss had not been discussed. This meant any related healthcare concerns may not have been identified. Following the inspection, we were informed the person had been referred to the dietician to help ensure their needs were being met.

Where people were at risk of being overweight or underweight, the PIR stated, "We do MUST (Malnutrition Universal Screening Tool) risk assessments and anyone seen to be at risk is referred to dieticians." However, these were not always in place for people assessed as at risk; and where they were in place, they were not always up to date. This meant they could not be relied on to identify if someone needed to be referred to an external healthcare professional.

People had risk assessments in place to guide staff how to reduce any risks to people due to their health or social care needs. However, they did not always contain clear information which was consistent with the person's care plan. For example, one person's care plan described them as being at a 'high risk of falls', however a general risk assessment of their needs described them as being at a 'low risk of falls'. Another risk assessment, specifically concerning falls, scored the risk of them falling as 'nine', but did not indicate if this signified a high or a low risk, or what action staff should take as a result. People's risk assessments had not always been reviewed regularly to help ensure they were still up to date with people's needs. This meant staff did not always have clear, up to date guidance regarding the level of risk to people and how to keep them safe.

Staff were aware of the reporting procedures for any accidents or incidents that occurred. Staff reported incidents, however action was not always taken as a result. For example, one person had experienced three falls in one month but had not been referred to any healthcare professional to establish if there were any changes that could be made to help mitigate the risk. Neither the person's care plan nor risk assessments had been reviewed since the falls. This meant staff may not have had up to date information about the person's needs or risks. Following the inspection, the provider informed us that a 'Post Fall Investigation Report' had been developed by the registered manager to help ensure appropriate action had been taken and recorded for each fall.

Medicines were given to people as prescribed and staff gave people the time they needed to take their medicines. One person told us, "They're very meticulous about getting them right." However, not all medicines were stored securely. Some medicines were stored on an unlockable shelf at the bottom of the medicines trolley. This was at times, left unattended whilst staff administered people's medicines. Where medicines needed additional security to remain safe, this was adequate but contained medicines which had not been needed for two months. These should have been disposed of safely to help ensure no-one could use them incorrectly. Where refrigeration was required, medicines were kept in a damaged fridge and the temperatures had not been checked for the last three months. This meant the quality of the medicines may

not have been maintained. By the second day of the inspection, a new medicines fridge had been purchased.

Staff were appropriately trained, knowledgeable with regards to people's individual needs related to medicines and confirmed they understood the importance of safe administration and management of medicines. However, there was no evidence of effective hand hygiene between administering medicines to different people. This meant people's medicines were at risk of cross infection from other people. When people had been prescribed creams which staff administered, these had not all been dated to help ensure staff knew when they were no longer effective. There was no audit in place to help ensure all medicines had been given as recorded by staff and to identify areas for improvement. Following the inspection, the provider shared details of a new medicines audit which would be implemented in the service.

A fire risk assessment had been carried out the previous year by an external company and a related action plan created, to help ensure people were protected from the risk of fire. However, recommendations had not always been followed. For example, it noted that emergency lighting must be properly checked and maintained monthly. Two lights had been found not to be working which would put people at risk if there was a fire. During the inspection no record could be found that the emergency lighting had been tested for the last year. Following the inspection, the provider told us the lights had been checked regularly but these checks had not been recorded. They also confirmed they had now updated several aspects of the emergency lighting system and put records in place to help ensure checks were carried out and could be monitored. The risk assessment also stated the fire alarm system needed to be checked weekly. Records showed it was actually tested once a month. This meant there was a risk any faults may not be identified quickly. Following the inspection, the provider informed us these checks were now being done as required and all requirements from the risk assessment had been completed. We have shared this information with the Devon and Somerset Fire and Rescue Service.

Where risks with eating and drinking had been identified, care plans showed advice had been sought from relevant professionals, such as a dietician or a speech and language therapist (SLT). However, assessments, guidance and actions to help mitigate risks relating to weight loss were not always in place. For example, one person who was assessed as at risk of weight loss had no information recorded in their care plan regarding their likes, dislikes or allergies. This meant staff may not be consistently providing food the person enjoyed to increase their appetite. In order to monitor the person's health, staff recorded what the person ate and drank. However, there were gaps in these records and it was not clear whether this was because the person had chosen not to eat anything. This meant it was difficult to gain a clear overview of how much the person was eating and drinking.

Risks to people were not always assessed, recorded accurately or acted upon to keep them safe. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Throughout the inspection, people were observed to be in good health with sufficient to eat and drink. Staff had a good understanding of how to keep people safe and their responsibilities for reporting accidents, incidents or concerns. One staff member told us, "People are definitely safe here. We follow procedures and make sure equipment is used correctly. I will comment if I see staff not using equipment correctly. I'm a stickler for it!"

People were protected by staff who had an awareness and understanding of signs of possible abuse. Staff felt reported signs of suspected abuse would be taken seriously and investigated thoroughly. One member of staff commented, "I wouldn't stand for any abuse. I'd fight their (people's) corner. I'd report it to whoever was in charge." Staff were up to date with their safeguarding training and knew who to contact externally

should they feel that their concerns had not been dealt with appropriately. One staff member confirmed, "I would go to CQC or the safeguarding team at social services. There are enough posters everywhere to let us know what to do." The PIR added, "All new staff have an induction prior to starting and this includes training on the different types of abuse and how to report any suspected or witnessed abuse."

Relatives told us they felt their family members were safe living at Blackdown Nursing Home. People were supported by suitable staff. Robust recruitment practices were in place and records showed appropriate checks were undertaken to help ensure the right staff were employed to keep people safe. The registered manager explained, "I never let people start until their references and checks are back." Staff confirmed relevant checks had been applied for and obtained prior to commencing their employment with the service.

People were supported by staff who were not rushed and acted quickly to support people when requests were made. Staff confirmed they felt there were sufficient numbers of staff on duty to support people and meet their needs.

Requires Improvement

Is the service effective?

Our findings

Our inspection in November 2015 found people did not always give consent for care and treatment and the provider did not act in accordance with the Mental Capacity Act 2005. Staff did not comply with the legal requirements to make sure people's rights were protected.

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

We found some improvements. For example people had some mental capacity assessments in place and best interests decisions were now being made on behalf of people. Staff made best interest decisions on a daily basis for people. For example, one person no longer had the capacity to choose their own meals but staff supported them to maintain their preferences by always choosing a vegetarian option for them. A staff member confirmed, "I know who lacks capacity. I still ask people what they want and talk things through with them. If they can't respond I will make a decision based on the information in their care plan and information from family." However, mental capacity assessments had not been completed for each decision people were considered not to have the capacity to make. Also, information regarding people's preferences, to support staff to make decisions in people's best interests was not always recorded. This meant staff may not have consistently made the best decision for the person concerned.

The PIR stated, "We discuss with relatives any wishes patients have made when they did have capacity and we ask about likes and dislikes. This is recorded in care plans. If patients need care that they are not able to consent to and relatives don't have power of attorney for health and welfare we have a best interest meeting and involve the patient, if possible, and their relatives, their GPs and any other medical staff, for example, psychiatrists." Best interests meetings had been recorded. However, there was not always an assessment in place to explain why the person was considered to lack the capacity to make the decision themselves; and reasons for reaching the decisions made, had not always been recorded. This meant it was not clear whether the person's rights had always been protected. The registered manager told us they would ensure this information was recorded in the future.

The provider had not always acted in accordance with the mental capacity act. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager had applied for DoLS on behalf of people however, these were awaiting review by the local authority designated officer.

Staff told us they did not provide care or treatment where it was clear the person did not consent. We observed however, staff did not always ask for people's consent before acting. We observed one member of staff start to move someone's clothes, intending to take their temperature, without explaining what they were doing or asking for consent; and another member of going to sit on the arm of a person's chair, with their back turned, talking to another person, without asking the person's consent first. They did not move even when the person expressed their disapproval.

People were observed to be in good health and staff were knowledgeable about people's healthcare needs. Staff confirmed they reported changes in people's health needs to the registered manager or clinical lead. The registered manager told us they had a good relationship with the local GP surgeries and regularly rang to ask for advice. A healthcare professional told us they found staff to be professional and understood the need to record advice given. They had confidence staff followed any guidance they had given about people's health needs.

People's relatives told us their family members liked the food and where they were able, made choices about what they had to eat. One person confirmed, "The food is good." People were encouraged to say what foods they wished to have made available to them and when and where they would like to eat and drink. Residents meeting were used to discuss people's meal preferences so they could be incorporated within the menu. A staff member who worked in the kitchen told us, "If we try something and people don't like it, we don't use it again."

The provider had recently requested a dietician review the home's weekly menus to help ensure they were providing people with a healthy, balanced diet. Action had been taken to increase levels of omega three in people's diet, as recommended by the dietician. A training course about nutrition had also been arranged for staff to attend to increase their knowledge of how to support people to eat a healthy diet.

New members of staff completed a thorough induction programme, which included being taken through the home's policies and procedures and training to develop their knowledge and skills. Staff then shadowed experienced members of the team, until both parties felt confident they could carry out their role competently. One staff member told us they completed several weeks of shadowing shifts to help ensure they felt confident to work alone. They told us, "Even when I started working alone, staff told me, 'If you need me, just call.' Staff helped me understand anything I wasn't sure about."

On-going training was planned to support staffs' continued learning and was updated when required. This included core training required by the service as well as specific training to meet people's individual needs. The provider told us, "I ask staff if there is extra training they would like as they know what will be useful. They've asked for person centred care and diabetes training, so they've now been planned." The PIR added, "Training for staff is also being introduced on privacy and dignity, end of life care and nutrition in dementia." A professional who delivered training to staff at the service had written to us stating, "The provider is very conscientious regarding training for the staff and has an excellent training schedule." The PIR added "Any new staff are being enrolled on NVQ course if they do not already have it."

Staff told us supervisions were carried out regularly. One member of staff told us, "We discuss training, if I'm happy, whether I'm fulfilling all my responsibilities and any concerns I have. I find them useful. If there's anything I'm not sure about, we talk about it. You can ask anything and it gets answered."

People and their relatives spoke positively about staff and told us they were skilled to meet their needs. Comments included, "The staff have been lovely to us, right down to the gardener!" One person told us, "The staff are marvellous. They're all very good"; and minutes from a residents' meeting noted, "[….] said they

love it at Blackdown and is very happy with the care and the staff"

Good

Is the service caring?

Our findings

The providers, registered manager and staff provided a caring environment for people to live in.

Feedback received by CQC about the service and compliments received directly by the service, described the staff and the service people received as very caring. Feedback received by CQC told us, "Mum is so much better, happier and more settled because of the excellent care she has received. I no longer have to worry about how she is as I know she is in good hands and my sincere thanks go to all the wonderful staff at Blackdown. A truly caring home." Compliments received by the service stated, "I never ever saw anything but love for all the patients under your care" and "Thank you for the wonderful care and love you showed mum"

The PIR explained, "We teach staff to treat patients as they would wish their own families to be treated and try to involve relatives with all aspects of care." Staff members reflected this caring philosophy of the provider. One staff member explained, "I think if I can make everyone smile at least once a day, I've done a good job. I feel this is my extended family." A relative told us, "Staff have been outstanding, treating […] with care and respect. They treated her like their gran and it gave me peace of mind"; and compliments received by the service confirmed, "All the care team treat mum with respect and the carers love her as if they she were their own gran" and "It always felt like home and staff were family." A newer staff member told us, "It's their tone of voice, the staff all sound so calm. I'd like to live here!"

People were supported by staff who spoke about them with affection. One staff member told us, "I love working here. I love the interaction with the residents. I love listening to their stories. It's a lovely atmosphere here." One person had recently returned to the service from hospital and several staff greeted them with pleasure telling the person they had missed them.

Relatives and staff told us staff showed concern for people's wellbeing in a caring and meaningful way. The relative of someone who had recently passed away at the home told us, "[…] couldn't tell us how she felt but she was peaceful. You could tell she was well loved and well looked after"; and a staff member explained, "[…] loves to be cuddled and it doesn't matter how busy staff are, they will always take time to give people a hug when they need it. We tell them we love them."

People were supported by staff who took the time to get to know them. This meant they were able to understand and respect people's wishes and needs. One person's care plan guided staff to have a "quiet, gentle and patient approach", as this would help them gain the person's trust.

People's privacy and dignity was respected. Staff informed us of various ways people were supported to have the privacy they needed. One staff member explained, "I always knock on someone's door and wait, if I know they can answer. If I go in and there are visitors there, I apologise and go back later." Another staff member told us, "We're in their home and all staff act as though they are." People's information was not always kept securely. The office door was at times left unlocked, even though it contained private information about people so staff could have easy access to it. By the second day of the inspection, the provider had fitted a keypad to the door so it could be locked but still provide easy access to staff members.

People were given information and explanations when they needed them. A staff member confirmed, "If I'm supporting someone to eat, I tell them what they're eating in each mouthful or what they're drinking. I'd want to know." Another staff member described the positive impact explanations could have on people saying, "I always explain what I'm doing before I do it and whilst I'm doing it. Explaining things can sometimes avert any embarrassment. If you say it in the right manner, you can help people relax. They need to be comfortable with you."

Friends and relatives were able to visit without unnecessary restriction. Visitors told us they were always made to feel welcome and could visit at any time. One relative described staff as, "Very kind and very welcoming." The provider told us, "Relatives can come in any time. One relative stays until 11pm each evening and sometimes relatives stay for lunch." They added, "We always invite relatives to have mince pies with us in the week before Christmas."

People's end of life wishes were discussed with them and, where possible, documented as part of their care plan. Where people had made advanced decisions these were respected. One staff member explained, "I want to keep people as dignified and comfortable as I can up until the end. It's the very last thing we can do for them. We have to be an emotional support for the relatives too."

Requires Improvement

Is the service responsive?

Our findings

Our inspection in November 2015 found care planning did not include activities that would be meaningful to people based on their personal history and preferences.

At this inspection, we found some people's care plans still lacked detail about their background and interests. This is particularly important information for staff to use when engaging with some people living with dementia, as it helps staff provide personalised activities based on people's preferences. A staff member told us, "When people first come in, we talk to them and their relatives about their interests. It makes the relative feel more confident as they know we are interested in people. For example, one person used to teach horticulture, so we know they like to talk about and look at the garden. People have an 'all about me' board in their room which records information about individuals. Then if people lose their capacity, we can jog their memories or help them continue their hobbies." However we observed, there were few times staff talked with people about their interests or supported them with their hobbies during the inspection; and there were no records to confirm when staff had done this.

People had a range of planned activities they could be involved in, led by an activities co-ordinator. For example, local school children regularly visited to sing and talk to people. Outside of these activities we observed people spent time not cognitively engaged or active. Staff focused on providing food or drinks to people rather than engaging in meaningful conversation or activities with people. We only observed staff engaging people in activities on a couple of occasions and there were few items around the home that people could use to keep themselves mentally stimulated. This meant for a considerable part of the day, people had little to do. A relative told us, "I am concerned about how they will keep [...] cognitively stimulated because he won't ask to do things." A staff member explained, "We listen to music, we do hand massages and nails, we sit and chat or read a magazine. There's always time for us to do things with people. The provider confirmed, "I tell staff they must spend time with people and that activities are a part of everyone's job role. Staff do do things with people." However, there were no records of when staff had provided cognitive stimulation for people.

Some people's care plans included people's specific wishes about how they chose, preferred and needed to be supported. However, this level of detail was not included about all people. For example, one person's care plan stated, "Does not really enjoy having a bath or shower"; but gave no guidance about what staff could do to help the person enjoy these more or what the person preferred as an alternative. Staff were able to tell us about individuals' likes and dislikes but one staff member confirmed, "A lot of the information isn't recorded, it's word of mouth." The provider told us this detail would be added in the future as people's care plans were transferred onto a computerised system. The PIR stated the provider aimed to involve staff more in writing care plans in the future which would help ensure their knowledge was recorded so people's needs were met in a consistent way. Care plans were reviewed on a regular basis by the registered manager to help ensure they were up to date.

Handover between staff at the start of each shift ensured that important information was shared, acted upon where necessary and recorded to ensure people's progress was monitored. A staff member confirmed,

"Changes to needs are discussed in handover and also recorded on the computer system for staff to see."

People were empowered to make choices where possible. For example, one person explained, "I have a choice about when I get up and go to bed." The registered manager also told us some people did not like staff checking on them at night, as it disturbed them. This had been discussed with people, recorded and was respected by the staff.

The service had a policy and procedure in place for dealing with any concerns or complaints. The policy was clearly displayed in the home. People's concerns and complaints were encouraged, investigated and responded to in good time. The registered manager stated in the PIR, "I deal with any complaints personally and immediately and always ensure that the complainant is entirely satisfied with the outcome." One person commented through a satisfaction survey distributed by the provider, "Everyone here is very friendly and helpful. No complaints at all"; and relatives told us, "I can find no fault at all" and "Everything I've mentioned to staff, they've listened to."

Requires Improvement

Is the service well-led?

Our findings

Our inspection in November 2015 found that although not a breach of regulations, some arrangements planned for improvement had not been completed within a reasonable timescale because of lack of management time.

At this inspection, the registered manager told us they had now recruited more staff and so could spend time on management responsibilities rather than providing care for people. There was a management structure in the service which provided clear lines of responsibility and accountability.

Records did not always show what actions had been taken in order to meet people's needs or keep them safe. For example, one person had a catheter in place and was assessed as being at a high risk of urinary tract infections. However, catheter care for the person had only been recorded on one date. This meant it was not possible to identify when the person's catheter had last been changed and when it was due to be changed again. People who were at risk of skin breakdown were supported by staff to change positions to reduce the impact on particular areas of skin. However, records showing which areas of people's skin were at risk, and when they had been supported to move, were inconsistent. Although we did not identify any concerns with people's current health, records did not show whether their needs had been consistently met. The home's policy regarding pressure sores identified two scoring tools staff should use; but did not advise staff which tool to use, how often to use it, or what actions to take as a result of the outcome. Staff were not provided with sufficient guidance to ensure they were following best practice.

The registered manager regularly audited care plans and risk assessments, however they had not identified the lack of detail or up to date information in some people's care plans and risk assessments. They had not had tools in place to help them identify areas for improvement highlighted during the inspection such as gaps in records to monitor people's healthcare and gaps in fire safety records. There were no audits carried out of incidents, falls or medicines to identify if any improvements could be made from any emerging themes or trends.

The provider had also not guaranteed the quality of the service by monitoring records and the care provided to people. Following the inspection, the provider shared some new audits and procedures that would be implemented regarding fire safety, medicines and falls.

The provider had not ensured records accurately reflected people's current needs and risks or that gaps in records were identified. The quality of the service had not been assessed or monitored effectively. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People, relatives and staff told us they thought the service was well led and described the management of the home to be approachable, open and supportive. One member of staff told us, "The manager is lovely. I've never been made to feel so welcome." The registered manager and provider described how they also treated staff like their family members and this helped them maintain a consistent staff team who felt well supported.

Staff told us they were happy in their work, understood what was expected of them and were motivated to provide and maintain a high standard of care. The provider inspired staff to provide a caring environment for people. Staff had clearly adopted the same ethos and enthusiasm and described how they treated people living in the home as their family.

The registered manager took an active role within the running of the home and had good knowledge of the staff and the people who lived there. People and staff had confidence the registered manager would listen to their concerns and would be received openly and dealt with appropriately. One member of staff told us, "If there's something I'm unsure about, I can ask the manager or the owner for advice. I feel confident I can ask."

Staff were positive about how the service was run and told us they felt empowered to have a voice and share their opinions and ideas they had. Staff meetings were held to provide a forum for open communication. One staff member explained, "We discuss any changes to regulations or changes to the way we need to work. We can voice our opinion and share information. I think they're quite useful. It's nice to be kept in the loop with any changes."

People benefited from staff who understood and were confident about using the whistleblowing procedure. The service had an up to date whistle-blowers policy which supported staff to question practice. It clearly defined how staff that raised concerns would be protected. Staff confirmed they felt protected, would not hesitate to raise concerns to the registered manager, and were confident they would act on them appropriately.

The Provider and registered manager valued people's feedback and acted on their suggestions.
Meetings were held for residents and relatives to express their views about the service and questionnaires were distributed annually to gain the views of people, relatives and professionals.
The PIR stated, "We are improving the access to our large grounds so patients and relatives are able to use them more easily. This was an issue raised at a residents and relative meeting we had this year" and "Any issues raised in the questionnaires are dealt with and relatives are invited to come and speak with me about any issues causing them concern." The manager and staff also monitored the quality of the service by regularly speaking with people and their relatives to ensure they were happy with the service they received.

The registered manager had introduced a policy in respect of the Duty of Candour (DoC) and understood their responsibilities. The DoC places a legal obligation on registered people to act in an open and transparent way in relation to care and treatment and to apologise when things go wrong.

The service had notified the Care Quality Commission (CQC) of all significant events which had occurred in line with their legal obligations. We used this information to monitor the service and ensure they responded appropriately to keep people safe.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not always acted in accordance with the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured all risks to people using the service were properly assessed, recorded and acted upon. Medicines were not managed safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured, by assessing and monitoring the quality and safety of the service, that contemporaneous records were in place for people or that risks to people were mitigated.