Acacia Number 1 Limited

Acacia House - Tenterden

Inspection report

Ashford Road
St Michaels
Tenterden
Kent
TN30 6QA

Tel: 01580765122
Website: www.1stchoicecarehomes.com

Date of inspection visit:
26 May 2016
27 May 2016

Date of publication:
09 September 2016

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 26 and 27 May 2016 and was unannounced. The service was previously inspected in June 2014 and no breaches in the legal requirements were found.
Acacia House provides nursing and personal care for up to 47 older people, some of whom may be living with dementia and other complex health conditions. The service is an old house with a new extension on the ground floor. There are 44 rooms of which 3 can accommodate 2 people. The lower floor contains a dining room, and three lounges. The upper floor, which is traversed by narrow corridors, is accessed by a lift and two staircases. People's rooms were personalised by items of furniture and personal items. The older part of the house retains its original features and the lounge area on ground level leads out into a secure garden space. At the time of this inspection there were 43 people using the service.

There is 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.

Quality monitoring was not always effective. Shortfalls in people's care and treatment had not been identified by the provider or senior managers. People and staff were not always consulted or involved in the running of the service.

People did not always receive their medicines in accordance with their prescriptions or medical guidance. People's wishes in relation to the end of their lives were not always recorded.

People were not always involved in the decisions about their care and treatment. If people or their representatives were involved in care decisions the process was not always recorded.

People had a range of activities which they could chose to participate in. However, people who were at risk of social isolation were not offered a choice of activities and had limited opportunities to spend time with others.

Staff understood their responsibility in protecting people from the risk of harm. Sufficient staff were available to meet people's needs but there was an ongoing need to recruit new staff. Safe recruitment practices meant that suitable staff were employed to work with people. Staff had received training to enable them to provide the right care and support to people.

People received care and support from staff who were caring and ensured their dignity and privacy was respected.

Risk assessments and support plans had been developed to give person centred care. Staff had the relevant information about how to minimise identified risks to ensure people were supported in a safe way. People

had access to a range of healthcare professionals when they needed them to support their care and treatment.

People knew how to complain and would be happy to speak with a manager if they had any concerns. Families and staff felt they could raise any concerns or issues they may have with the registered manager, who they said was approachable. People felt their views and experiences were listened to.

The provider had notified us of the outcome of referrals which they had made to the supervisory body for authority to deprive a person of their liberty.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the end of this report.

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.

Medicines were not always given as they were prescribed.

Risk assessments for people were detailed and current and reflected their needs.

Staff understood how to protect people from harm and abuse.

Processes to recruit suitable staff were in place.

Is the service effective?

Good

The service was effective.

Staff received induction, training and support which enabled them to give effective care.

Food and drink was varied, sufficient and met people's dietary requirements.

People were supported by a range of healthcare professionals to ensure their care and treatment needs were met.

Is the service caring?

Requires Improvement

The service was not always caring.

People's wishes regarding their end of life care had not always been sought.

People were cared for by kind and attentive staff and their privacy and dignity was upheld.

Relatives were made welcome and could visit when they wished.

Is the service responsive?

Requires Improvement

The service was not always responsive

Care was not always reviewed with the participation of people.

People were offered a range of activities but this was limited for people who remained in their rooms.
Information about how to complain was readily available.

People and their families told us they would be happy to speak with the management team if they had any concerns.

Is the service well-led?

Requires Improvement

The service is not consistently well-led.

People and staff were not actively involved in developing the service.

Quality monitoring systems were in place, but they did not always identify where improvements to people's care and treatment was needed.

The registered manager had created strong links in the community which benefitted people living in the service.

Acacia House - Tenterden

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 26 and 27 May 2016 and was unannounced. One inspector and a specialist nurse advisor carried out the inspection. The specialist advisor had clinical expertise in nursing older people and people living with dementia.

The inspection was brought forward in response to concerns raised with us about people being unable to access their call bells at night. Prior to the inspection we reviewed all the information we held about the service, including previous inspection reports and statutory notifications. A notification is information about important events, which the provider is required to tell us about by law. The provider had sent 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.

During the inspection we looked at records related to health and safety, food and drink, medicines, recruitment, and training. We reviewed three staff recruitment files and looked at documents such as staff rotas, meeting records, quality assurance questionnaires, complaints, policies, and monthly audits.

We spoke with six people and five relatives. We spoke with the provider, the registered manager, three nursing and care staff, three ancillary staff, and two visiting healthcare professionals. We reviewed ten people's care records to see how their care and treatment was planned and delivered. We observed how people were supported by staff during their lunch and during activities in the communal rooms. 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

Relatives and people told us they felt safe. One relative said they had no complaints about the care. Two visitors said there were not enough staff and that there was not a lot of time spent with people 'upstairs'.

People were not receiving medicines that the doctor had prescribed for them. Medicines administration records (MARS) showed that some medicines prescribed for people to have regularly were being giving on an 'as and when required' (PRN) basis. This suggests that the staff had not read the prescription properly or that the medication was not required regularly and should have been reviewed by the GP and the prescription changed to PRN. Newly updated guidelines for staff to follow about giving medicines PRN were in place awaiting typing in the manager's office. We discussed the need to have them put with the MARs as quickly as possible. The registered manager informed us that this would be done although the old MAR sheets were still in place for staff to refer to but this had not been done. Some people had transdermal (skin) patches prescribed. The recording of the placement and removal of the patches was not fully documented so people were at risk of the new patches being placed on the same part of the body twice within three weeks, which is not in accordance with the manufacturer's guidance. One person had not received their cream, which would help protect them from skin soreness, in the way it was prescribed because the stock had run out. We checked this and the new prescription had been delivered but not started. MAR charts are kept in people's rooms so we checked the MAR before the cream had arrived. All of the MAR charts we checked had either been put in place the day before or on the day of inspection suggesting there had been a long interval between the cream arriving and being put into place for the person to receive.

The failure to ensure the proper and safe management of medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were two medicine storage rooms, one upstairs and one downstairs. These were kept clean and tidy and had air conditioning units and fridges to maintain constant cool temperatures for maintaining the quality of the medicines. These temperatures were regularly checked and recorded in line with national guidelines. Medicines trolleys were locked and secured to the wall when not in use. Photographs were attached to people's MARs to ensure staff administered the right medicines to the right person. Where warfarin was prescribed for people the care plans reflected the increased risk of bruising and bleeding to them and how staff should provide the appropriate care and treatment. One person had authorisation from the GP for the covert administration of their medicines; however the nurse and manager stated they did not need to give these medicines covertly as the quality of their relationship supported the person to take the medicine willingly.

Our observations highlighted that two people in their rooms could not reach their call bells, and two people had no call bell to use so that they could not call for help when they needed to. One of the people without a call bell was able to call for help and were able to move around and other was not. The registered manager told us the missing call bells were due to be replaced by the contractor because they were faulty and that people were checked regularly by staff to ensure their needs would be met and that the contractor had not responded quickly enough to the request made by the provider to replace the call bells. Our visit prompted

a call to the contractor and the call bells had been replaced by the end of the inspection.
Calls from people's call bells were recorded on a computer system and could be called up on a screen for a check by the registered manager. We checked this system to ensure that staff were responding. The period checked showed that call bells were being answered within a few minutes even at night.

The premises and environment were generally tidy but some lifting equipment, floors, lifts, and bathroom surfaces were noted to be in need of cleaning. There was no housekeeper in charge, and domestic assistants were working through the building in accordance with a task sheet, review of which indicated that not all areas on the list were completed every day. During inspection one person's room carpet was identified as being both dirty and hazardous and this was pointed out to the registered manager. The carpet in this room had been already scheduled for replacement, and this was expedited so that it was completed by the time the inspection was over. We identified housekeeping standards as an area for improvement.

The sluice rooms, laundry and the medicines rooms were clean and hygienic. Staff we spoke with understood the principles of the prevention of the spread of infections. The laundry staff and care staff described how they dealt with soiled laundry to help reduce the spread of infection in the event of a virus. Staff did not wear uniform. The registered manager said that this was based on research showing that some people living with dementia perceive people in uniform give their home an institutional image and that people respond better to staff in normal clothing. The staff had access to supplies of personal protective equipment, such as gloves and aprons, to assist them in preventing the spread of infections which they wore appropriately.

The registered manager utilised a dependency tool to establish the care needs of people and used this to plan for staffing levels. These levels were checked on a monthly basis by the provider, however if people's needs increased the registered manager called more staff on duty. For example if more people needed assistance to eat than expected a staff member may be extended on shift or brought in early for a shift so they provided assistance to those already on duty. The registered manager told us that a minimum of six care staff and one nurse would be on shift. A senior carer was on each shift to lead the team of care staff and they were responsible for medicine management. The registered manager stated that she normally planned for seven or eight care assistants in the morning and six in the afternoon dependent on the assessed dependency levels of people, with one RN and three or four carers at night.
During the inspection there were two registered nurses (RN) and eight care staff rostered to care on the morning shift for the 43 people in the service. This reduced to six care staff and two registered nurses in the afternoon. Half the care staff were allocated to the upstairs and half downstairs with a registered nurse overseeing the care and treatment of people who required nursing, who had rooms mainly on the ground floor. Whilst the geography of the home was complex there were sufficient staff to meet the current needs of the people living both upstairs and downstairs. Staff were observed visiting people who were nursed in bed or spent most of the day in their rooms regularly to make checks and support their care.

Care staff were supported by an activities person, two domestic assistants, a laundry assistant, a maintenance man, a cook and a kitchen assistant. The service was currently advertising to recruit one new full time registered nurse which would reduce the need to enlist agency staff and provide better continuity of care for people. Some local agency staff were utilised on occasions when staff levels were low, particularly when nurses were required and on the current roster all registered nurses for the night shifts were agency staff. Other agency staff, from a specialist agency were used long term, so they would get to know people and be able to support them effectively. Staff told us they thought there were sufficient staff to carry out their role safely and that the team felt stable. Feedback from visiting professionals and relatives told us they also felt that this was enough staff. One staff member said that they felt there was enough time for completing care tasks and for spending additional time with people, especially those nursed in their rooms.

Recruitment practices were safe. The appropriate checks had been completed before staff worked unsupervised in the service, which included references and records of Disclosure and Barring Service (DBS) checks. The DBS checks assist employers in making safer recruitment decisions by checking prospective staff members are not barred from working with people who use services. The manager interviewed a candidate for the vacant registered nurse position on the day of inspection.

People told us they felt safe in the service. Relatives said that they felt their relatives were safe, and that any concerns they had would be acted on straight away. Staff understood the safeguarding policy of the service, could identify types of abuse and knew what to do and whom to contact if they witnessed any incidents. All the staff we spoke with said they would report any concerns to the registered manager and that they were confident the registered manager would respond appropriately. Staff said they were aware of how to whistle blow (report concerns outside of the organisation) but had not had a need to do so.

There were risk assessments in place to provide guidance to staff in order to reduce the risk of harm to people. People were able to take risks as part of their day to day lives. For example one person went independently outside the service into town. Others went out to church related activities.
Staff were knowledgeable about the risks to people and worked in line with people's assessments to make sure people remained safe. Where risks such as developing sore skin had been identified, action had been taken to reduce the likelihood of these risks occurring. For example some people were nursed on air mattresses. The mattresses were self-regulating but staff checked them daily to ensure they were working correctly. Specific risk assessments were also carried out in relation to falls, how people should be transferred or helped to mobilise, the use of bed rails, prevention of choking, and people taking adequate food, fluids and medicines. People taking warfarin, a high risk medicine that thins the blood, had detailed risk assessments showing staff what the side effects might be and what to do about them, who to contact for advice regarding this, and blood test and dosage information so that people's blood condition could be monitored closely and the medicine administered in safe doses.

A record was kept of accidents and incidents. Staff completed an accident or incident form for each event which had occurred. These records were reviewed by the registered manager each month to look for any trends or changes which may be needed to people's care. Details of action taken to resolve the incident or to prevent future occurrences were recorded where appropriate. The results of the frequency, time of day and severity of falls were colour coded along the lines of a traffic light system and those people who were identified as being in the red category for example were referred to the GP, the physiotherapist or to the falls clinics as a matter of urgency.

People were kept safe by regular and up to date health and safety checks and audits of the environment. Records of checks were current and covered the main services, utilities and appliances. Staff fire drills were documented and people had personal evacuation plans in place (PEEPS) that were current and documented the specific ways people would be supported to be evacuated by staff in an emergency.

Good

Is the service effective?

Our findings

Staff told us they received the training and support they required to deliver safe care and treatment to people and people told us the staff were 'very good'.

New staff received an induction period during which they shadowed team members for several days, had to read and learn policies and procedures and undertake training on site. The provider utilised a company to deliver mandatory training such as moving and handling, the Mental Capacity Act, health and safety, safeguarding and food hygiene. These staff had completed the induction training that new staff received.

Training for all staff was provided regularly. Staff we spoke with told us they had recently attended or had been booked to attend training. Staff had been provided with specific training to meet people's care needs, such as equality and diversity and caring for people living with dementia. Senior carers were also trained medicines administration. We looked at the providers training matrix which identified training completed and when updates were required and saw that training was up to date or booked for all staff. Some staff were being encouraged by the registered manager to take on more responsibility in the service by sending them on further training courses. One nurse was undertaking a 'train the trainer' course to enable them to deliver training within the service. Specialist training for staff included end of life care. The cook had received training on eating disorders so they could understand how to support people who could not eat or who were at risk of losing weight. The registered nurses in the service completed online training with the nursing and Midwifery council to ensure their skills were up to date.

Staff received support and guidance from managers to carry out their role. Staff had regular formal supervision (a meeting with the registered manager to discuss their work) and annual appraisals to support them in their professional development. They told us this gave them an opportunity to discuss their performance and identify any further training they required. This helped to ensure the care and treatment they delivered to people was as safe as possible.

The Mental Capacity Act 2005 (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. Care plans contained assessments showing that people's capacity had been checked by a responsible person such as the registered manager, GP or community mental health practitioner. When people lacked mental capacity to take particular decisions, any made on their behalf were recorded and declared to be in their best interests and as least restrictive as possible. We saw records confirming the involvement of people in decision making that was less complex and of relatives being involved in best interest decisions concerning care and treatment. People were encouraged to make daily decisions whenever possible such as what clothes to wear, what to eat, or what they wanted to do during the day.

People were asked for their consent to having bed rails in place to help protect them from falling, and for having photographs taken of them, and that where possible people had signed this themselves in their care plan or relatives had done so for them.

People can only be deprived of their liberty so that they can 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 are called the Deprivation of Liberty Safeguards (DoLS). Policies and procedures were in place for the MCA and the DoLS. We could see from records that a number of people had authorised DoLS in place and other people had applications in process in line with the person's assessed requirements. Either family members or healthcare professionals had been involved to ensure decisions were made in the person's best interests to keep them safe and these were appropriate to the person's health and mental capacity and were the least restrictive possible. When we spoke with staff about the MCA and DoLS they were able to tell us about it and how it applied to people in their care.

We saw that people enjoyed the food offered during the inspection and that there was a choice of food on the menu and adequate amounts to eat. People told us 'the food is all nice' and 'food is excellent' and that they could choose what they wanted to eat. A four week rolling menu offering two choices of main meal per day, a warm or cold choice of supper and additional sandwiches if people required extra food was offered. Staff asked people daily what their choices for the day would be. Baskets of fruit were offered daily to people .

Care plans included nutritional and hydration assessments to ensure that people received any specific diet they required, together with any support necessary such as assistance to eat, pureed food, or fortified fluids. This information was given to the cook – who was then aware of those special needs and able to cater for them. There were three people who required pureed food; we were told this was done in as attractive a way as possible so the people would be encouraged to eat. It was noted during lunch that food for a person being assisted to eat by a member of staff was softened but appeared colourful and served in separate portions on the plate and the person ate well.

People were encouraged to inform staff of their dietary likes and dislikes every few weeks so that their choices could be provided. One person told us that if they wanted something in particular they would get it. A relative told us that their relative needed to 'graze' rather than eat regular meals and that the service was 'very good' in that they provided their relative with the means to do this. The cook had received additional training in dementia, and eating disorders and applied the this knowledge to the planning of the menu in order to encourage people to eat.

A daily record was kept of what people were eating and the staff were able to spot anyone who was not eating and report problems to the registered manager. Full fat dairy products were used due to their nutritional value. People were weighed monthly and weight losses monitored closely, with oversight from the senior management team. Support had recently been given to a person who was losing weight, this was to establish the cause and seek professional dietary advice. People's needs for fluid intake were assessed and monitored. People had cold drinks close to hand in their rooms and we observed hot drinks trolleys being taken round the service at regular intervals. People nursed in bed, who had more difficulty drinking and who needed support to drink had fluid charts to record the amounts of fluid they were taking in. This was totalled up daily by staff and measured against the optimum amount required for wellbeing Staff knew the minimum amount of fluid people should have and it was recorded in the care plans. One person had a nursing risk assessment to ensure that they were offered at least two litres of fluid to drink per day..
People were encouraged to go to the dining room to eat, where mealtime seemed to be a positive experience with people interacting with each other and staff chatting to people as they handed out meals and drinks. There was a lot of sociable talking between people.

People were referred to healthcare professionals promptly to receive the treatment to meet their health needs such as chiropody, speech and language therapy or dieticians and the advice obtained was

incorporated into people's care plans. One person had suffered an injury the day prior to inspection and had been sent to hospital where they were having treatment. Staff had responded appropriately to the incident, recording events on an accident form and in the care plan. A relative told us that they were able to relax in the knowledge that if their loved one had a problem, "staff would be onto it straight away". A healthcare professional we spoke with said that staff took a 'holistic approach' to ensure people's needs were met as fully as possible and without delay and that staff in the service were quick to identify problems and respond with the appropriate action, or referral to other healthcare professionals.

Requires Improvement

Is the service caring?

Our findings

One person's relative told us, "It's fabulous, fantastic. The care is simply wonderful". Another told us that it was "Sociable" and "Staff are very good, very pleasant". They felt they would definitely be told of any problems regarding care and treatment and that they were made welcome when visiting.

Despite the service having accreditation by the Gold Standards Framework for end of life care, (a nationally recognised system for best practice in end of life care) we saw just one advanced care plan in place that stated clearly what the person's advanced needs and wishes were. Other care plans reviewed showed that end of life pathways, or advanced care plans had not been completed in partnership with people. This does not promote good practice to ensure people are supported in accordance with their wishes at the end of their lives. This is an area we have identified as requiring improvement.

We saw caring interactions throughout the service, between all staff and people. Staff used respectful language and tone of voice, used people's preferred names and knocked when entering people's rooms. Staff we spoke with told us their aim was to give people respect. We observed one person in their room from where music was playing. Through the open door we could see the person was thoroughly enjoying the music. As staff passed they smiled, waved to the person and acknowledged to us that this person 'lived for music' and that the music being loud and the door open was the person's choice.

Many of the people living at the home could not communicate verbally due to their health conditions. Whilst people were involved in developing their care plans as much as possible, care plans were largely developed with the person's relatives to find out the person's likes, dislikes and preferred routines. Staff worked with all people so that they learned how to support them. Key workers were nominated so people had someone to help them with identifying needs, such as toiletries and clothing and to liaise with the families when they visited. One visitor told us that they had been providing shop-bought eye drops for their partner for a while prior to their arrival in the service. When this was noted by staff the doctor was approached and the person now had this treatment prescribed for them.

The communal areas were full of people in the mornings and staff moved around people talking to them or encouraging them to do the activities. Staff asked where people would like to sit in the communal areas and one staff member assisted a person to sit with people they knew in the garden when they seemed unsure where to go, guiding them to a seat and telling them the names of those around them. During the gardening activity they approached from the same level as the person and spoke clearly and kindly and helped the person by holding their hands to plant the seeds and described what they were doing. We also observed staff chatting with people in their bedrooms upstairs between tasks, even though people were not always able to respond in return. People who needed assistance with eating during mealtimes were helped with dignity and respect; staff encouraging them to eat, chatting to them, but not rushing them.

Relatives told us they could visit people whenever they wished and we observed that they were able to visit in people's rooms, or in communal rooms and we saw that a private lounge room was made use of frequently for people to meet visitors, who were made welcome and offered a cup of tea. We saw that one

visitor brought dogs in to visit their relative, something other people seemed to enjoy too.

Information about people was securely held in lockable offices. Noticeboards with confidential information on them were located on boards in these offices, on walls where they could not be seen when doors were opened. Meeting minutes we reviewed confirmed that staff considered confidentiality of information as part of their responsibility. Staff handovers were held behind closed doors so that confidential information would not be heard.

Requires Improvement

Is the service responsive?

Our findings

A relative told us that staff had 'their finger on the pulse' in terms of care and that staff were approachable and helpful. Another relative told us, "I feel confident in what they do".

Prior to moving into the service people were assessed by the registered manager to ensure their needs were known and could be met. The resulting care plans were comprehensive, giving detailed assessments of the person's assessed needs, addressing risk and creating guidance for staff to follow to in order to give care according to the person's wishes, needs, and preferences. Care plans we checked showed that some reviews of care, to update the person's needs and preferences, involved either the person or the relatives, and some did not. Although such discussions had occurred informally between staff and relatives they did not always involve all relevant people or were not recorded. The inconsistency in this care planning, involving relevant people is therefore an area we have identified for improvement.

Care plans contained 'Maps of Life' which told staff about the person's history, family tree, and hobbies so that staff could get to know people and support them in conversation or activities. There was an activities co-ordinator who worked weekdays and provided a different activity daily; this was planned up to August. During inspection we observed people enjoying playing instruments along to music, and another where staff were assisting people to plant seeds in small pots. These activities occurred in the mornings, seemed to be enjoyed and the communal room was full of people. One person enjoyed ironing and this activity was supported, with the staff providing the equipment and light supervision, underpinned by a detailed risk assessment which formed part of the person's care plan. People were encouraged and supported to maintain relationships and activities that were important to them. Some were supported to go out with relatives on trips, and one person visited the local town, shops and church as they wished. Residents meetings were arranged but the previous two scheduled meetings had been cancelled. The last one was in October 2015 and the next one scheduled for the Saturday after inspection. People had suggested variety of activities, including finding a celebrity to open their new sensory garden. Other comments related to what people thought of the new visiting hairdresser.

People who remained in their rooms seemed less engaged in activity other than the television or staff coming in with drinks or for a quick chat. We spoke to the registered manager about this who said that people were encouraged to join in with activities and most people who remained in their rooms did so by choice. The registered manager described how they had put plans in place to access training and resources for a reminiscence collection they were obtaining from the library. We saw that 'Talking books' were delivered to people with vision impairment. Ensuring people are offered activities and there is a plan in place to deliver these to people who choose to remain in their rooms, or who are in their rooms due to their health is an area we have identified as requiring improvement.

Relatives told us that they felt fully informed of all issues that affected their relatives. They had good communication from the registered manager who worked with them to resolve problems and always told them about the developments in people's care and treatment. People and relatives we spoke with told us that they would definitely go to the registered manager with any issues or complaints and they were

confident they would be listened to.

An up to date complaints procedure was in place. The registered manager was responding to one current complaint, in line with the provider policy. A large file of cards and letters was seen, representing the compliments received from relatives.

We recommend that the service seek advice and guidance from a reputable source, about supporting people to express their views and involving them in decisions about their care, treatment and support.

Requires Improvement

Is the service well-led?

Our findings

Visitors commented 'there is a firm hand at the helm' and that the service was 'well led and organised' but another said that the staff seemed divided, saying "It's them and us", referring to nurses and care staff. The registered manager told us that they knew their staff well and supported them. Care and nursing staff we spoke with told us they were listened to by the registered manager if they had ideas or concerns, and that the staff team worked together in their aims to provide care to people. The provider told us that they felt the culture of the service was open and that staff were supported and were clear about the aims of the service. However, we found that issues raised by staff regarding the culture of the service had not always been addressed by the management team.

There had been a significant turn-over of staff within the service over recent months. Staff leaving included an activities coordinator, and a deputy manager, as well as care staff. We were informed that there were simple reasons for this, such as staff moving on. Some staff we spoke with told us the staff team was 'stable' or 'balanced'. However another spoke of staff disagreeing with each other and the staff 'bicker between themselves'. Staff meetings were divided into nurses' meetings and care staff meetings. Staff meeting minutes indicated that all staff did not agree with others about being supported in the service, or there being enough staff to deliver good care. Staff felt that they were not listened to and that their needs for development and support were not listened to. The lack of teamwork in the care team and the differences in opinion posed a risk that it could impact on delivering people's care and treatment in a safe and person centred way.

There were systems in place to assess and monitor the quality of care and treatment people received. However, these had not been effective in identifying or resolving shortfalls we found during the inspection regarding medicines, end of life care, activities for people who are at risk of being socially isolated, and care planning. The failure to have an effective system in place meant that people were at risk of receiving care which did not meet their needs or wishes. In addition to this, people had not been given proper opportunities to feedback their views of the service. Although residents meetings had been arranged, but these had not been held in recent months having been cancelled.

The failure to fully assess and monitor the care people received, and the failure to consult with people and staff regarding the running of the service are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A quality assurance survey had recently been sent out by email for people's relatives to complete. There had been few responses returned so this was going to be repeated and sent to individuals in person. Relatives we spoke with told us that the registered manager regularly asked them about the care and support that was provided to their family member and was able to resolve problems as a result although this information was not always recorded in the care plan unless it concerned a person's care and treatment. . A newsletter had been produced to keep people informed of events and developments within the service.

The registered manager was experienced in the role and visible day to day, Monday to Friday, and they

worked occasional shifts as a registered nurse. They understood their role and complied with the requirement to notify the CQC of significant events which affected the service.

The registered manager had formed active links within the community to enhance the service provided to people and to showcase what the service does well. For example a local pre-school group of children attend the service to meet people and attend activity sessions with people, which we were told was an experience enjoyed by all.

A recent donation had been received from a 'Community Champions' scheme, which was being utilised to transform part of the garden, which we were told was requested by people. The service is utilised for the training placement of student nurses and health and social care students from schools and colleges in the local area. These placement students were not counted in staff numbers and were supervised by qualified staff in order to learn the basics of care. Due to this tutors and professional advisors were on site frequently, which helped all staff in the service to update their knowledge of best practice. Feedback was sought from students and tutorial staff following each placement, and was predominantly positive about their experience in the service.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had insufficient policies and procedures in place to manage medicines safely. Regulation 12(2)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not respond to staff in response to issues raised. Regulation 17(2)(a)