Willowmead Residential Home Ltd

Linden House

Inspection report

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

Linden House provides personal care and support for a maximum of 32 older people, some of whom may be living with dementia. On the day of our inspection 24 people were living in the home.

This was an unannounced inspection that took place on 9 December 2015.

The home had a registered manager. 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 and associated Regulations about how the service is run. The registered manager assisted us with our inspection on the day.

People may not always be receiving safe care and treatment from staff because we observed staff struggling to transfer people from chairs to wheelchairs in an appropriate and safe manner. Staff did not always follow correct and appropriate procedures in dispensing medicines.

Although there were a sufficient number of staff on duty we found deployment of staff could have been better organised to ensure an appropriate number of experienced, permanent staff were on duty during a shift.

Summary of findings

Although staff understood their responsibilities in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards we found the legal requirements in relation to these were not always followed by staff. For example, decisions were made on behalf of people without evidence to show how this had been done.

Staff were not always aware of people's dietary requirement and we saw people being given inappropriate foods.

People were not always treated with respect and dignity by staff and staff did not take the time to make sure people knew what they were about to do. However, we did see some good examples of kind care from staff.

Care plans were individualised and contained information to guide staff on how someone wished to be cared for. However, this was not always followed by staff and we found some care records lacked detailed information about the person.

We saw evidence of checks carried out by staff to check the quality of care being provided to people. However shortfalls identified from these weren't always acted on. The registered manager did not always have a good management oversight of the home.

Accidents and incidents in relation to people were recorded and monitored by the registered manager to identify trends. Risk assessments were in place for people for particular issues, such as risk of falls or particular behaviours.

Should there be an emergency in the home, there was guidance in place for staff to follow in order to ensure people's care was not interrupted and if people needed to be evacuated this would be done in a safe way.

Staff were aware of their role in relation to safeguarding people from abuse and were able to tell us how they would report any concerns they may have. Robust recruitment practices were followed, which meant the provider endeavoured to employ staff who were suitable to work in the home.

Care was provided to people by staff who were trained and received relevant support from their manager. This included regular supervisions and undertaking training specific to their role. Staff were involved in the running of the home as regular staff meetings were held.

People's health was maintained as staff involved external health care professionals when appropriate.

Visitors were welcome in the home and felt the registered manager was approachable and supportive. People were given information on how to make a complaint and we were told if people had any concerns they would approach the registered manager.

During our inspection we found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not consistently safe.

Staff did not always follow safe medicines management procedures.

People may not always be safe as staff did not carry out correct moving and handling processes.

There were enough staff on duty to meet the peoples' needs; however deployment of staff could have been more appropriately planned. The provider carried out appropriate checks when employing new staff and

Staff were trained in safeguarding adults and knew how to report any concerns.

Risks to people were assessed and recorded as well as any accidents or incidents.

There was a contingency plan in place in case of an emergency.

Is the service effective?

Requires improvement

The service was not always effective.

Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) processes were not always implemented appropriately.

People were provided with food and drink which supported them to maintain a healthy diet, however staff did not have up to date knowledge on people who may require a particular diet.

Staff were trained to ensure they could deliver care based on latest guidance and best practices.

Staff ensured people had access to external healthcare professionals when they needed it.

Is the service caring?

Requires improvement

The service was not consistently caring

People were not always treated with respect and dignity.

Staff encouraged people to make their own decisions about their care.

Relatives were made to feel welcome in the home.

Is the service responsive?

Requires improvement

The service was not always responsive.

People were supported to take part in activities however they were not always individualised or meaningful.

Summary of findings

Care plans were regularly reviewed however detailed information about people were not always available and some people did not always receive responsive care.

People were given information how to raise their concerns or make a complaint.

Is the service well-led?

Requires improvement

The service was not consistently well-led.

Quality assurance audits were carried out to ensure the quality and safe running of the home. However, actions identified from these were not always carried out.

Staff were seen to carry out poor practices.

Staff felt supported by the registered manager and relatives thought the registered manager was good.

Staff and people were involved in the running of the home.

Linden House

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 checked 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 unannounced inspection took place on 9 December 2015. The inspection team consisted of three inspectors.

Prior to this inspection we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

On this occasion we did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This was because we inspected this service sooner than we had planned to.

Many of the people living at Linden House were unable to speak to us, so instead we observed staff carrying out their duties, such as assisting people to move around the home and helping people with food and drink. However, we did speak with three people briefly. We also spoke with the registered manager, two senior managers, four staff, two relatives and one social care professional.

We reviewed a variety of documents which included four people's care plans, four staff files, training information, medicines records and some policies and procedures in relation to the running of the home.

We last inspected Linden House in February 2014 where we found no concerns.

Requires improvement

Is the service safe?

Our findings

One relative told us they felt their family member was safe at Linden House and never worried about them when they weren't there. However, we found some incidents when we felt people may not always be a safe as they should be.

Staff did not always use appropriate methods to transfer people. One person was seen being supported to use a stand aid hoist and we heard them telling the two staff members they did not like using it. One staff member said, "I know, that's why we keep encouraging you to stand up." When the staff used the hoist we saw the sling slipped up and the person's midriff was exposed. We saw their legs were still bent which indicated the sling was either not fitted correctly or it was the wrong size for the person. A second person was also hoisted using the stand aid hoist. Again, the sling slipped up meaning it was digging into their upper arms. We saw one of their legs was swinging whilst they were trying to stand up. At one point a member of staff said, "This isn't working. I think we're going to have to start using the full hoist." Throughout the whole procedure the person showed signs of distress. We looked at these people's care notes and could not find any guidance for staff on which hoist or sling should be used in order to transfer them in a safe and secure manner.

People's medicines records were not always up to date which meant staff may not know when people had received their medicines. Each person had a medication administration record (MAR) which stated what medicines they had been prescribed and when they should be taken. MAR charts included people's photographs to ensure staff gave the medicines to the correct person. However, we found the MAR records were not completed fully. For example, we found medicines for one person had not been signed for. Another person did not receive their 08:00 medicines until approximately 11:30 because they had refused them earlier in the morning. We saw the MAR had been completed as though they had received their medicines at the correct time which meant that medicines due later in the day may be given too early. We spoke with the senior staff member who took action to correct these omissions.

Guidance for PRN (as needed) medicines were in place so people received PRN medicines when they were in pain. When people received PRN medicines this was recorded on the back of their MAR record. Medicines were stored securely and we saw records for stock checks and for checking the temperature of the clinical room and fridge. However we found this was not done consistently. For example, there were seven days in the last month the fridge temperature was not checked or recorded and 11 days in the last month the room temperature was not checked or recorded. Which meant staff could not ensure medicines were always stored at the temperature they should be.

The lack of proper medicines management and people being kept safe from harm was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were sufficient numbers of staff deployed on the day of the inspection to help meet people's individual needs. However, we found that deployment of staff was not always thought through properly. For example, we saw one senior staff and five care staff on duty of which three staff were new to the home and two were agency. The sixth member of staff was only seen to administer medicines. This left only one permanent member of staff who knew people well who told us they found this quite stressful and felt like they were, "Failing the residents" because of this. The previous night, three agency staff had been on duty and on further occasions we read in the rota the night shift had been covered by two agency and one bank staff. The registered manager told us the agency staff they used had worked in the home many times and they knew people and their needs well. We did find this to be the case, although we observed the permanent member of staff was seen to be rushed and we heard them telling other staff what they needed to do. We also saw one of the provider's senior manager's supporting people in the morning following breakfast as inexperienced staff required assistance.

The registered manager told us five or six care staff would be on duty during the morning. The sixth member of staff's role (after supporting people to get up and have their breakfast) was to run the activities within the home as the activities co-ordinator was on sick leave. They said a dependency tool was completed at head office to review people's dependency and to identify whether or not staff levels needed to be increased. One staff member told us, "It's important there are enough staff to support people in a person-centred way, people are the priority."

We recommend the provider reviews their deployment of staff to ensure staffing levels include a sufficient number of qualified, permanent staff.

Requires improvement

Is the service safe?

Risk assessments had been drawn up to help keep people safe. We read risk assessments in people's care plans were around people's mobility, food and fluid and skin integrity. Where one person was at risk of falls there was guidance to staff on how to reduce these risks in order to keep the person safe. For example, by making sure staff knew their whereabouts at all times because they walked around the home a lot. A staff member told us about the risks of another person and that this person had a sensor mat on their floor beside the bed to alert staff if they got up during the night. A further person had a risk assessment around their particular forms of behaviour. There was guidelines for staff which were written in detail and contained information on prevention, triggers and what action to take.

Staff were aware of their role in recording accidents and incidents. We read there had been very few incidents in the last six months. We saw that where people had had an accident this was recorded in a book with the date, time, what action staff had taken and what the outcome was. Each month the registered manager reviewed the accidents and incidents and reported on these to head office. This demonstrated that the registered manager had a good overview of any accidents and incidents that happened in the home and was able to identify any trends in order to take action to try to prevent reoccurrence.

In the event of an emergency the home's contingency procedures would be followed and people's care would continue with as little impact as possible for them. Each person had an individual personal evacuation plan in place. In the hallway of the home there was a folder which could be 'grabbed' by staff in the event of an emergency. This gave staff all the necessary information they needed to help ensure people were kept safe. In the event the home had to close, arrangements were in place to relocate people to a neighbouring home.

Staff had a good understanding of the different types of abuse and described the action they would take if they suspected abuse was taking place. This helped people to stay protected from the risks of abuse. Staff were able to tell us about the role of the local authority in relation to safeguarding. We read information about safeguarding concerns that had been recorded for the home and saw that staff had taken appropriate action.

Staff recruitment records contained the necessary information to help ensure the provider employed staff who were suitable to work at the home. They included a recent photograph, written references and a Disclosure and Barring System (DBS) check. DBS checks identify if prospective staff had a criminal record or were barred from working with adults at risk.

Requires improvement

Is the service effective?

Our findings

We found the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) processes were not always implemented appropriately. 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. 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.

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). We checked whether staff were working within the principles of the MCA.

Although staff demonstrated a good knowledge of the MCA and DoLS we read where people were unable to make decisions for themselves, staff had not always followed legal requirements. For example, we read people's capacity had been assessed but did not find DoLS applications for people in respect of the locked front door. The registered manager told us they had submitted one application for a person who lacked capacity. However, applications for other people who did not have capacity had not been completed. One person required some invasive treatment and a note was written in their care records to say a best interest decision had been made not to proceed with this. Although this was written, we did not find any details of a best interest meeting to show how this decision was reached. Another person had a similar note to say a best interest decision had been made to provide them with care and treatment at the home, but no records to back this decision up were included in their care notes.

Consent to care and treatment was not always given by people who had the legal authority to do so. For example, we read in one person's care plan their consent had been signed by their daughter who had power of attorney. However, the power of attorney was for financial affairs only and not health and welfare.

The lack of following legal requirements in relation to consent was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were not always aware of people's dietary requirements and nutritional needs, for example, if someone did not eat a particular food or if they were diabetic. We spoke with the chef on duty on the day who told us no one in the home was diabetic or had any allergies. We saw the only information they held about people was what portion sizes they preferred.

We had read in one person's care plan, 'dementia has affected my ability to swallow so I have a soft diet and encourage me to do as much for myself but I may need starting off'. There was also recommendation to use a plate guard. However when lunch arrived it was a standard meal of beef stew. There was no plate guard and staff automatically sat down to support this person to eat. We pointed out to the member of staff that this person's care records said they required a soft diet. Staff did not act on our information immediately but after the intervention of one of the provider's senior managers we noted a message in the communications book for staff to say this person should have a pureed diet until the situation was investigated. Another person, for cultural reasons, did not eat beef or pork. However we saw this person being given the beef stew for lunch. We noticed that the puddings (which were hot) were brought into the dining room long before people were ready for them, meaning they would have been cold by the time they came to eat them.

The chef told us they asked people the day before what they would like for lunch the following day. This did not take into account that some people may forget what they had asked for though. We did not see any visual choice of foods offered for people to help them make a decision. For example, showing people two plated-up meals.

People's individual nutritional needs not being met was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who needed it were supported to eat in a dignified, unhurried way. We saw one member of staff help someone to eat and heard them chatting with this person

Requires improvement

Is the service effective?

throughout. We heard staff ask people what they would like on their spoon next and ask people to indicate when they were ready for the next mouthful. As a result one person ate all of their meal which looked and smelled appetising.

One person told us, "Actually, the food is very good here so whatever it is it will be nice." Another person told us they had enjoyed their breakfast. We saw people being offered hot and cold drinks regularly throughout the day. A relative told us their family member's appetite had improved since they had lived at Linden House. We noted staff regularly weighed people in order to monitor whether or not they were eating a sufficient amount to avoid them being at risk of malnutrition. People who required it also had a fluid intake chart to record the amounts they were drinking.

People were supported by staff who were trained. One staff member said they had done a week of shadowing when they first started followed by training which was good and consisted of a mixture of hands-on and e-learning. Another member of staff told us they had received induction from senior managers which covered how the home was run, systems and processes. They said they felt they had been given the information they needed to do their job. Training they had completed included safeguarding, medicines and care planning.

Staff had the opportunity to meet with the registered manager on a regular basis. We read supervisions had taken place with staff. One member of staff told us they found these useful. The registered manager told us they had only been at the home since June and they were aware that some annual appraisals were overdue. They said they planned to start a programme of appraisals in January 2016. We looked at the records and saw of the 22 staff, eight staff were overdue their appraisal. An appraisal is important as it is an opportunity for staff to discuss any aspect of their work, any concerns they may have or training requirements. One staff member said they were encouraged by the registered manager to take additional qualifications as a result of their appraisal.

The health needs of people were met. Care plans evidenced the involvement from external health professionals to provide guidance to staff on a person's changing needs. We read people had involvement from the GP, district nurse, chiropodist and dentist. For example, we read one person had some redness on their skin and saw the district nurse had been called to give advice. Another person had been losing weight earlier in the year and we read records to show staff had involved the GP and this person's weight was now stable.

The environment was not particularly suitable for people who may be living with dementia. We saw the corridors of the home all looked the same which meant people may not be able to identify where their rooms where or where they were within the home. Most people had their names on their bedroom door, although not everyone did. We saw paper signs around the home to indicate to one person the direction of their room. Menus were not in an appropriate format as they were typed in very small print. The registered manager told us they had submitted plans to head office to improve the environment. For example, by painting corridors and doors different colours and fitting memory boxes outside people's rooms. They hoped this work would start early next year.

Requires improvement

Is the service caring?

Our findings

A relative said, "The staff are caring. I very much like the home – no one is negative."

We saw people were assisted when they needed to be and staff had some time to interact in a social way with people as well as carrying out their duties. However, we did observe staff displaying some care which showed a lack of respect and dignity to people.

People were not always treated with respect. We heard one member of staff laugh out loud and say, "Ha ha, she just slapped herself" when a person accidently hit themselves in the face. A member of staff from head office walked through the lounge area during the morning and although addressed staff members did not acknowledge people sitting in their chairs. We heard one person call out, "Hello, hello" several times at one point but staff did not acknowledge this.

One person was brought into the lounge and asked to sit on a chair without explanation that this was for them to be weighed. After they were weighed we heard the person ask what the result was to which the staff member replied, "You've lost." The person seemed upset and confused that they had lost weight, but was not reassured by staff. Later the staff member told us that in fact this person had put on weight but she had not told the person. We asked the staff member to inform the person, which they did, and saw they looked relieved at this news. We had read in this person's care records that what was important to them was, 'to maintain control over my daily life and to ensure you always tell them what was happening'.

Other people were also weighed in the lounge in front of people and whilst a game of skittles was taking place which interrupted the game. Each time we saw people being asked to sit on the weighing chair but did not hear staff explain to them why they wished them to do this. Instead they said, "Come and sit over here, come and sit down."

During lunch time one person was offered a drink of apple juice but the staff member returned with orange and blackcurrant. We heard the person said they thought they had asked for apple to which the staff member replied, "I thought it was breakfast." We did not see or hear staff offer to get some apple juice for this person. We heard the radio on in the dining room at breakfast time tuned into a 'pop' radio station. We heard it go out of tune for a period of approximately 10 minutes. Staff did not appear to notice or correct this.

On another occasion we heard a member of staff say to one person, "Look what I've got. A hot chocolate and biscuits" to which the person responded, "It's like winning the lottery." They started to support this person to drink. However, the staff member then muttered to herself, "Why does my hair keep falling down" and left the room leaving the person's drink on the sideboard. When they returned they started making drinks for other people and did not return to this person to help them finish their drink.

People were escorted to the dining room in preparation for lunch. We saw staff support one person to get up from their chair and heard a staff member say, "Just walk straight ahead. Ignore the wheelchair." We then saw staff push the wheelchair up behind the person without warning them and ask them to sit down. Another person was asleep in their chair and we saw their head was down on the arm of the chair and staff did not try to reposition them at all during the morning.

People were not always treated in a dignified manner. We saw people being transferred from their chair to a wheelchair by staff using a hoist. However, on two occasions people's tops rode up as they were being lifted meaning their midriff was exposed. Just before lunch we saw staff place a sling on one person in their chair and try to encourage them to stand using a standing hoist. The person was not compliant so staff removed the sling and fetched the full hoist. They proceeded to put another sling on this person with a lot of yanking and pulling, but staff then discovered the batteries for the hoist were dead, so instead they said to the person, "Would you like to eat your lunch here (in the lounge)?" One staff member supported someone into the lounge in a wheelchair. We heard another staff member said, "Not here, she sits over there." The first staff member asked how this person got from their wheelchair into the chair and the second staff member said, "Just get her to walk."

The lack of respect and dignity shown to people was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff knew how to communicate with people who may be slightly confused. One person said, "Do you see that animal

Requires improvement

Is the service caring?

over there?" We heard the staff member respond saying, "Where are you looking? Do you remember I brought my dog in?" This distracted the person and they then chatted about the staff member's dog.

People were encouraged to be independent and could make their own decisions. We saw people walking around the home and sitting where they preferred, particularly at lunch time. One person went out for the day. A staff member said, "I get people to do as much as they can themselves."

We observed some lovely instances of nice, kind care. For example, during the morning we saw one member of staff laughing and joking with two people. We heard one person speak to the staff member in a foreign language and even though they could not fully understand what they were saying, they still took time to listen and show they were interested.

We saw another staff member support a person to have their cup of tea and they sat and chatted with them whilst they manicured their nails. We heard them ask the person about their past, what sort of music they liked and what they did as a job.

During lunch the sunlight was very bright in one area of the dining room. A staff member noticed this and pulled the curtain after asking people. Later on another staff member noticed someone's hearing aid was not in properly and discreetly asked if they could sort it out for them.

A staff member offered to take one person to the lounge. When they refused, they offered their hand before saying, "That's okay, you don't have to come if you don't want to" in a reassuring way. Another staff member approached a second person and asked them if they would like to go into the lounge but the person looked confused. We saw the staff member make a more exaggerated gesture to explain what they were saying and the person understood this and went with them. A member of staff told us, "Staff need to be given responsibilities to motivate, encourage and help them (people) grow. It's not just putting someone in a chair and making sure their cushions are how they want them."

Relatives and friends were welcomed into the home and people were encouraged to maintain relationships with people close to them. Relatives told us they always felt welcomed when they arrived at the home. We saw visitors arrive throughout the morning and always heard staff offer them a drink.

Requires improvement

Is the service responsive?

Our findings

The registered manager told us the activities co-ordinator was on long term sick leave and head office had agreed to an additional member of staff each morning for activities. In addition an external worker came in three times a week to do chair exercises and there was an arts and craft session weekly. Currently people were working on a 'dignity tree'. The registered manager told us she booked entertainers every couple of weeks and, "Always try to make sure there is something going on." We saw one staff member painting someone's nails and a skittles game took place which everyone was encouraged to participate in. Exercises took place in the afternoon and again everyone was encouraged to join in and they appear to enjoy this. However, after the instructor had left people seemed at a loss to know what to do. One person said, "What are we meant to do now?" We saw entertainment had been booked for three events during November and December. One staff member told us, "Sometimes there is enough activities. I will be relieved when we have an activities co-ordinator again."

Activities were not always individualised or person-centred which meant people might not have access to things which had meaning for them. They were very generic and the activities board did not reflect what took place. For example, on the day of our inspection the activity for the morning was shown as, 'flower arranging' and the afternoon's activity was, 'relaxing'.

The lack of person-centred care was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans were comprehensive but did not always give staff, who may not know a person, a full picture of the person and who they were. Care records contained regular assessments of care needs, day time routine, mobility, food and weight information. However, it was not always easy to obtain a clear picture of a person easily and quickly in the records. For example, we read that two people liked to sit together and speak to each other in their own language, but we did not read until the end of the care plan where one of these people had been born and what second language they spoke. Although the care records contained 'all about me' sections we found in some of the records little in the way of past histories, likes and dislikes or past hobbies. Some of the information in one care plan was not accurate. For example, one person had written in their care plan they had a bed sensor to inform night staff if they got up during the night, however staff told us this person was no longer able to mobilise.

Staff did not always provide care which responded to people's needs. For example, a staff member told us about one person who needed to have their legs raised during the day. However, we did not see staff encourage this person to do this and their relative told us their family member did not have their feet elevated as much as they should. We also read that one person needed to be weighed weekly, but records showed us that this was not happening. We saw this person was weighed monthly or less often.

We recommend the provider reviews care records so they are person-centred and contain complete information about an individual to ensure staff follow guidance in care plans.

However, other people did receive responsive care. For example, one person's appetite had declined and they needed a lot of prompting to eat. We saw staff do this during lunchtime. Another person was showing signs of anxiety. We saw staff recognised this and put their favourite music on in the hall where they liked to sit.

Medical histories were included in care records to show how staff responded to people's changing needs. For example, involving external professionals or if they had any particular risks which required specialist equipment, such as the need for a pressure relieving mattress.

There was a communications book that staff used to share information about people and to notify staff of anything important they needed to know about individuals. We saw relatives were involved in their family member's care plan. We read a note from one relative thanking the registered manager for going through the care plan with them.

People were provided with information on how to make a complaint or comment on any issue they were not happy about. There was a complaints leaflet available for people which gave people the necessary information they required. For example, the response times in dealing with their complaint and who they could contact if they were unhappy with the response. There was a complaints log in the home. We noted it was difficult to find all information relating to a complaint and to identify whether or not complaints had been resolved fully. Following the

Requires improvement

Is the service responsive?

inspection the registered manager sent us a log they had developed which allowed them to keep much better records relating to complaints. A relative told us, “If I had a complaint I would go straight to the registered manager.”

Requires improvement

Is the service well-led?

Our findings

Quality assurance checks took place to help ensure a good quality of care was provided and the environment was a safe place for people to live. However, actions from these audits were not always carried out consistently by staff. For example, we read a medicines audit had taken place and saw one of the identified actions was the recording of the fridge and room temperature. We found that this was not always being done by the relevant staff. Other quality assurance checks carried out included health and safety checks, nutrition audits, a falls audit and night checks. However, audits of care plans had not been undertaken to identify some of the shortfalls we had found.

The registered manager was aware of their responsibilities but did not always have a good management oversight of the home. We saw some examples of poor practice by staff, for example poor manual handling procedures and staff standing by people whilst supporting them to eat. The registered manager told us during feedback that they had noticed and identified these types of behaviours previously and had been reminding staff of the way in which they should act. Despite this she had not ensured best practice was always being followed by staff.

The lack of action following audits and ensuring staff follow best practice was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider also carried out regular governance visits. We read the last visit took place in September 2015 when they focussed on the laundry. They identified areas where staff needed to improve and we read the outcome of this visit was discussed at the next staff meeting as well as during supervisions. Actions had been completed to remedy the shortfalls.

Relatives were happy with the care provided by staff. A relative said, “The registered manager is very approachable.” Another told us they were made to feel welcome and staff had been nice when they had rung the home.

Staff told us they liked working at the home. One said, “I love coming here.” Another told us, “I like working here. I like care.” They told us they felt supported by the registered manager. One member of staff said, “I really like the registered manager who is fair and doesn’t patronise staff.”

Another member of staff told us they felt supported in the role by the registered manager and senior managers who visited the home regularly. They told us, “I met with them (managers) last week to talk about how things are going and ideas I have.” They added they felt the culture in the home was changing. They told us, “I like to see staff sitting beside people and encouraging independence. Staff need to all be working from the same page and follow guidelines.”

Staff understood the ethos and values of the home. One staff member told us, “It’s about people’s needs and them feeling this is their home. This is across the board, if it wasn’t I wouldn’t be here.”

There was an open culture in the home. We saw the registered manager check staff were carrying out their role in the way they should. For example, when one staff member was not sitting beside a person to support them to eat, we heard the registered manager tell them they must always sit beside a person and not stand. The registered manager was visible throughout the day and interacted with people in an easy manner showing us they were very much involved in the daily running of the home.

Relatives and professionals had the opportunity to feed back their views on the care and treatment provided by staff. We read from the most recent survey to which nine relatives had responded that they felt happy their family members were cared for in a safe environment and were treated with respect and dignity by staff. However, we did read some relatives had commented that more activities in the afternoon were needed. A healthcare professional had written, ‘staff very caring and attentive’.

Staff were involved in the running of the home. We read regular staff meetings were held and these were used as an opportunity to cascade information from the provider to staff, discuss any aspect of the home and for staff to contribute by making suggestions for improvements. We read there were separate meetings for night staff, or kitchen staff in order to focus on particular aspects of the home.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered provider had not ensured staff were doing that was possible to mitigate risks to people.** **The registered provider had not ensure the proper and safe management of medicines.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The registered provider had not followed legal requirements in relation to consent.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The registered provider had not ensured people were being provided with person-centred care.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs **The registered provider had not ensured people's nutritional needs were being met.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
	The registered provider had not ensured people were treated with respect and dignity.
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered provider had not ensured shortfalls identified through audits were corrected and staff were following best practice.