Care Quality Commission

Highlands Care Home Limited

Highlands Care Home

Inspection report

56 St Leonards Road
Exeter
Devon
EX2 4LS
Tel: Tel: 01392 431122
Website: www.highlandscarehome.co.uk

Date of inspection visit: 13 and 18 May 2015
Date of publication: 18/08/2015

Ratings

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

Overall summary

This inspection took place over two days on 13 and 18 May 2015 and was unannounced. Highlands Care Home is a care home which is registered to provide care for up to 26 people. The home specialises in the care of older people most of whom are living with dementia but does not provide nursing care. There is a new manager who took over the role in January 2015 who is currently applying to CQC for registered manager status. 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.

On the day of the inspection there was a calm and relaxed atmosphere in the home and staff interacted with people in a friendly and respectful way. People were encouraged and supported to maintain their independence. They made choices about their day to day lives when able which were respected by staff.

Summary of findings

Most people at the home spent their time in the communal areas, two large lounges and an adjoining kitchen/dining area. These had been re-furbished and were clean, comfortable and well furnished with attractive décor. However, the accommodation in the lower ground and first floors required considerable attention. For example, some bed linen was thin and old, pillows were thin and flat, some rooms only provided overhead lighting and there were items of furniture which were shabby and needed replacing. We fed this back to the manager who began to carry out a room audit to present to the provider. They said an upgrade of rooms had been planned but there was no timescale.

The home specialised in providing care for people living with dementia. The new manager had begun to gather person centred information about people but this had not yet been used to inform how staff met people's social and leisure needs. However, people's leisure and social needs were not being met in a person centred way and there was a lack of meaningful activities. There were enough staff to meet people's care needs other than the above.

People and their relatives said the home was a safe place for them to live. One person said "It's a good place to be here". Another person said, "Very well orchestrated…we have everything."

Staff had received training in how to recognise and report abuse. All were clear about how to report any concerns. Staff were confident that any allegations made would be fully investigated to ensure people were protected. We had also been informed of any safeguarding issues which had been dealt with appropriately.

People said they would not hesitate in speaking with staff if they had any concerns. People and their relatives knew how to make a formal complaint if they needed to but felt that issues would usually be resolved informally. Formal complaints were dealt with in accordance with the home's complaint's policy. One person said, "I have never had a query go unanswered".

People were well cared for. Most people were unable to be directly involved in their care planning but the new manager had begun to meet with each person's representative to discuss the new care plans. A copy of the care plan was then sent to the representative if they were happy to be involved. The manager said "It's about getting it right for everybody." There were regular reviews of people's health and staff responded promptly to changes in need. One relative felt this had not been pro-active in the past but we found the new care plan format enabled staff to clearly monitor and identify changing need. People were assisted to attend appointments with appropriate health and social care professionals to ensure they received treatment and support for their specific needs. A health professional was visiting during our inspection and their advice was documented and actioned immediately.

Staff had good knowledge of people including their needs and preferences. Staff had training programmes and there were opportunities for on-going training and for obtaining additional qualifications. Training had fallen behind last year so the manager had identified shortfalls and staff were booked on appropriate training to bring them up to date in the near future. Comments about staff included, "I have never felt they are talking down to me", "The staff are very good, caring and excellent, really good." One relative said "I have never heard any carer speak harshly to anyone...they always treat people with respect." One visitor said, "Staff are very good and helpful, they respect people's dignity and privacy" and "There is a sense of calm and given that people have dementia that is good."

People's privacy was respected. Staff ensured people kept in touch with family and friends. Each visitor we spoke with told us they were always made welcome and were able to visit at any time. People were able to see their visitors in communal areas or in private.

Medication was well managed. There were systems in place to ensure secure storage, safe administration and record keeping.

There was a management structure in the home which provided clear lines of responsibility and accountability. There had been a period of change but the manager felt his had settled since they started in January 2015. They said there had been a lot of catching up work to do when they started such as training, new care plan format, staff one to one supervisions but this had been managed well and was on track. Staff had been well informed of changes through regular meetings and internal

Summary of findings

communication. The manager worked closely with a competent senior care worker and both were knowledgeable about how systems worked, people's needs, preferences and how to meet them.

There were effective quality assurance processes in place to monitor care and plan ongoing improvements. There were systems in place to share information and seek people's views about the running of the home. People's views were acted upon where possible and practical. The manager had an open door policy and their office was easily accessible. They obtained feedback from conversations with people, stakeholder surveys, complaints and compliments to continually develop the service.

We found two 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 this 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 always safe. People did not benefit from well maintained and equipped accommodation.

The provider had systems in place to make sure people were protected from abuse and avoidable harm.

People were protected from the risk of harm or abuse.

People were supported with their medicines in a safe way by staff who had appropriate training.

Is the service effective?

Good

The service was effective. People and/or their representatives were involved in their care and were cared for in accordance with their preferences and choices.

Staff had good knowledge of each person and how to meet their needs. Staff received on-going training to make sure they had the skills and knowledge to provide effective care to people.

People saw health and social care professionals when they needed to. This made sure they received appropriate care and treatment.

We found the service to be meeting the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. Staff had a good understanding of people's legal rights and the correct processes had been followed regarding the Deprivation of Liberty Safeguards.

Is the service caring?

Good

The service was caring. Staff were kind and compassionate and treated people with dignity and respect, promoting independence and maintaining people's privacy.

People and/or their representatives were consulted, listened to and their views were acted upon.

People and/or their representatives could be confident their wishes related to end of life care would be followed.

Is the service responsive?

Requires improvement

The service was not always responsive. People received personalised care and support which was responsive to their changing needs but this did not include social and leisure needs.

People made choices about aspects of their day to day lives. People and/or their representatives were involved in planning and reviewing their care.

Summary of findings

People and/or their representatives shared their views on the care they received and on the home more generally. People's experiences, concerns or complaints were used to improve the service where possible and practical.

Is the service well-led?

Requires improvement

The service was not always well led. There were some effective quality assurance systems in place to make sure areas for improvement were identified and addressed but some issues had not been dealt with in a timely way.

The service took account of good practice guidelines.

There was an honest and open culture within the staff team.

People benefitted from a well organised home with clear lines of accountability and responsibility within the management team.

Staff worked in partnership with other professionals to make sure people received appropriate support to meet their needs.

Highlands Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 inspection took place on 13 and 18 May 2015. This was an unannounced inspection which meant the staff and provider did not know we would be visiting. It was carried out by an inspector and an expert by experience over two days. An expert by experience is a person who has experience of using or caring for someone who uses this type of care service.

We reviewed previous inspection reports before the inspection and the information we held about the home. The provider had not completed a provider information return (PIR) as we had not requested one. This document enables the provider to give key information about the service, what the service does well and improvements they plan to make. We had not requested the PIR as this inspection was brought forward because of information of concern. We received two letters of concern about some areas of quality of care such as maintaining people's dignity and provision of drinks. We did not find these were substantiated. The manager was aware of some of the issues which had been addressed prior to the inspection. One concern highlighted the lack of activities for people which we also found constituted a breach of regulation.

At the last inspection carried out on 16 October 2013 we did not identify any concerns with the care provided to people who lived at the home.

At the time of this inspection there were 24 people living at the home. During the day we spoke with 10 people who lived at the home, two relatives, a volunteer befriender and a complementary therapist. We also spoke with the manager, senior care worker and four members of staff and a health professional. We looked at a sample of records relating to the running of the home and four relating to the care of individuals.

Requires improvement

Is the service safe?

Our findings

The service was not always safe. Most people at the home spent their time in the communal areas, two large lounges and an adjoining kitchen/dining area. These had been re-furbished and were clean, comfortable and well furnished with attractive décor. However, the accommodation in the lower ground and first floors required considerable attention. For example, some bed linen was thin and old, there were ripped mattress covers, pillows and duvets were thin and flat, and there were items of furniture which were shabby and needed replacing. Although most people only used their rooms for sleeping, people's rooms and possessions were not valued and cared for. Some rooms only provided overhead lighting which meant people could not turn off their own light without getting out of bed to use the brighter overhead light. One relative said "My mother likes light on at night, carers left the overhead one on so my mother not sleeping. The bedside light had no shade." This had not been addressed. Some areas of storage, were untidy and not pleasant to look at.

This was in breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We fed this back to the manager who began to carry out a room audit to present to the provider. They had also begun to tidy up storage areas. They said an upgrade of rooms had been planned but there was no timescale.

The provider had systems in place to make sure people were protected from abuse and avoidable harm. People told us they felt safe living at the home and with the staff who supported them. One person said "It's a good place to be here". Other people were not able to respond directly about their experiences due to living with dementia but appeared happy and comfortable with staff and each other.

Staff had received training in safeguarding adults. They had a good understanding of what may constitute abuse and how to report it. All were confident that any allegations would be fully investigated and action would be taken to make sure people were safe. The manager had informed us of any safeguarding incidents and these had been dealt with appropriately involving the local safeguarding team. Relatives said they felt the home was a safe place for people to live. They told us they would not hesitate to report any concerns if they had any; they felt they would be listened to and action would be taken to address any issues raised.

Staff encouraged and supported people to maintain their independence. There were risk assessments which identified risks and the control measures to minimise risk. The balance between people's safety and their freedom was well managed. For example, one care plan noted that one person would say they had brushed their teeth but this was not always the case so staff were to gently prompt the person. Care staff ensured they prompted people to dress themselves and assisted with sequential dressing. One person was at risk of putting on soiled clothes and this was documented so staff ensured they monitored this. Risks assessments and actions for staff to take were included for risk of pressure area skin damage, falls and nutrition.

There were enough skilled and experienced staff to ensure the safety of people who lived at the home. Staffing numbers were determined by using a dependency tool, although these remained flexible. Staffing could be changed if required, for example if people became particularly unwell or if a person was nearing the end of their life. We saw that people received care and support in a timely manner. During our inspection there were five care workers and the manager, a cook, cleaner and laundry person. Staff were attentive to people's needs. For example, staff noticed one person showing behaviour which they knew indicated they needed the bathroom and discreetly assisted them.

All staff who gave medicines were trained and had their competency assessed before they were able to do so. Medication administration records were complete, for example when administered or refused. Medicines entering the home from the home's dispensing pharmacy were recorded when received and the manager and a senior care worker carried this out together every weekend. This gave a clear audit trail and enabled the staff to know what medicines were on the premises.

We saw medicines being given to people at different times during our inspection. Staff were competent and confident in giving people their medicines. They explained to people what their medicines were for and ensured each person had taken them before signing the medication record. Medicines were thoroughly audited when the new manager

Requires improvement

Is the service safe?

took over in January 2015. For example, out of date medication had been cleared out, regular audits commenced and there had been an external audit by the local pharmacy provider.

A medicine fridge was available for medicines which needed to be stored at a low temperature such as eye drops. Some medicines which required additional secure storage and recording systems were used in the home. These are known as 'controlled drugs'. We saw that these were stored and records kept in line with relevant legislation. The stock levels of these medicines were checked by two staff members at least twice each day. We checked some people's stock levels during our inspection and found these tallied with the records completed by staff.

Good

Is the service effective?

Our findings

There had been a period of change since the new manager started in January 2015. There was now a stable staff team at the home who had a good knowledge of people's needs. Staff were able to tell us about how they cared for each individual to ensure they received effective care and support. People spoke positively of the staff who worked in the home. Comments about staff included, "I have never felt they are talking down to me", "The staff are very good, caring and excellent, really good." One relative said "I have never heard any carer speak harshly to anyone...they always treat people with respect." One visitor said, "Staff are very good and helpful, they respect people's dignity and privacy" and "There is a sense of calm and given that people have dementia that is good.

Staff told us there were good opportunities for on-going training and for obtaining additional qualifications. A number of staff had attained a National Vocational Qualification (NVQ) in care or a Diploma in Health and Social Care and were encouraged to develop. There was a programme to make sure staff training was kept up to date. This had fallen behind prior to the new manager started but they had booked training to bring staff up to date and devised a training matrix to monitor progress. Mandatory training included safeguarding, manual handling, fire, infection control, health and safety and food hygiene. The manager was keen to offer regular training. One staff team meeting had evolved into a training session for staff which they found helpful in relation to an issue raised. The manager had also devised hand-outs for staff to refer to such as infection control. Policies and procedures were accessible to staff. The home also invited students of Health and Social Care from the local college to undertake 12 week placements at the home and worked with their tutors who visited. All staff had received the Care Code of Conduct for Healthcare. This is national guidance which sets the standard of conduct expected of all healthcare support workers. Other training planned included lone worker, hospice care and end of life and governance. It was noted that staff did not have training in specific dementia care. The manager was aware of this as it had not been addressed in the past and was sourcing training for the near future which they told us they would let us know about.

One new care worker said "I'm surprised, I've never done care work before but we get good training and I love it here." There was a clear induction programme for new staff in line with nationally recommended standards. This included working with more experienced staff for a period until each new staff member felt confident to work independently. This time varied with each individual. For example, one new staff member had requested two extra nights shadowing staff and had received extra induction as they had been out of the care sector for a while.

Staff one to one supervision sessions had also been behind but the manager had now booked all supervision. This enabled staff to discuss career and training needs, any issues and for the manager to assess competency using a set format.

People had access to health care professionals to meet their specific needs. During the inspection we looked at four people's care records. These showed people had access to appropriate professionals such as GPs, dentists, chiropodists, district nurses and speech and language therapists. People said staff made sure they saw the relevant professional if they were unwell. One person had recently had new specialist shoes, other people had seen the GP who was visiting during our inspection. We saw the manager and senior care worker updating a care plan with advice and actions from the GP and the visiting district nurse. Other people had been referred to the tissue viability team and specialist equipment had been sought with regular updates made to health professionals. In one care record the GP had written "Legs less swollen due to good elevation by care staff." This demonstrated the staff were involving outside professionals and taking appropriate action to make sure people's needs were met.

Staff were allocated tasks at a handover meeting before a shift to ensure people's specific needs were met consistently. For example, some people required regular exercises following physiotherapy and care workers ensured these were done.

Most people who lived in the home were not able to choose what care or treatment they received. The manager and staff had a clear understanding of the Mental Capacity Act 2005 (the MCA) and how to make sure people who did not have the mental capacity to make decisions for themselves had their legal rights protected. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are

Good

Is the service effective?

assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. Throughout the day staff demonstrated that they were familiar with people's likes and dislikes and provided support according to individual wishes. For example, one person was very mobile and staff were very effective in following the person gently with their lunch and guiding them to various places to eat it as they moved around. Staff said "There's no particular spot, just where they land."

The majority of people required some restrictions to be in place to keep them safe. The manager had made appropriate applications to the local authority to deprive people of their liberty in line with the Deprivation Of Liberty Safeguards (DoLS) set out in the Mental Capacity Act 2005. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. Discussions had taken place with appropriate professionals and the people's advocates. Staff were aware of the implications for people's care. The provider kept up to date with changes in legislation to protect people and acted in accordance with changes to make sure people's legal rights were promoted. For example, when they started work the manager saw that some decisions had not been made clearly in people's best interests such as the use of bed rails and pressure mats to monitor people's mobility safely. They were working through the care plans and writing to relatives to discuss the implications for people to ensure best interest decisions were made and recorded correctly.

Each person had their nutritional needs assessed and met. The home monitored people's weight in line with their nutritional assessment. One person at the home had previously lost a significant amount of weight. Staff told us, and the person's care records showed, that appropriate professionals had been contacted to make sure the person received effective treatment. This person had psychological issues and staff kept a food diary to feedback to the health professionals. This had been effective and a person centred plan had been devised using finger foods, softer diet and smaller portions. This person's weight had stabilised and they had now begun to regain some weight which showed the care was effective.

Everyone we spoke with was happy with the food and drinks provided in the home. Comments included "Plenty of drinks and food", "Nice. The meals are good, we get a choice at the table. We can have sandwiches or two hot meals" and "The food is surprisingly good. I have made one or two requests and they have remembered. I am happy with the food."

We observed the lunchtime meal being served in the dining room. People sat at tables which were nicely laid and each had condiments for people to use. People chose meals in advance and were offered a choice of two meals on the day. A picture of the food was displayed on the dining room door. The home used an external caterer but assessed each meal and supplemented with more home made items such as roast potatoes, home made cakes and desserts. The cook was clear about people's dietary preferences and special diets such as puree or soft. Throughout lunch people were treated with respect and dignity. People were offered their choice of drinks. They were not rushed. There was friendly banter between people. This helped to make lunchtime a pleasant, sociable event. We did feed back to the manager that some people had been assisted to sit at the table for a hour before lunch which meant they were waiting a long time.

People had the equipment they required to meet their needs. There were grab rails and hand rails around the home to enable people to move around independently. There was a lift to assist people with all levels of mobility to access all areas of the home and people had individual walking aids, wheelchairs or adapted seating to support their mobility.

Good

Is the service caring?

Our findings

People were supported by kind and caring staff. Staff talked with us about individuals in the home. They had good knowledge of each person and spoke about people in a compassionate, caring way. For example, when the GP and district nurse were discussing someone's care if was clear the staff were confident in their knowledge of recent events and issues relating to the person's care. The complimentary therapist said they had visited the home for many years and found the staff very good, caring, excellent and really good." A relative said "I have never heard any carer speak harshly to anyone. Staff always treat people with respect."

Staff interacted well with people, touching, reassuring and complimenting people. The complimentary therapist was available through private arrangements but people were clearly enjoying their hand massages. One person said "Staff are gentle when they put me in my wheelchair, they use my zimmer frame first." One relative said "Personal care is very good, they show respect. I can't fault the staff." An Age UK Befriender said about the person they were visiting "People always looks very well, clean, tidy, nails done." Each visitor we spoke with said they thought all the staff were caring.

Throughout the day we saw staff interacting with people in a caring and professional way. There was a good rapport between people; they chatted happily between themselves and with staff. When staff attended to tasks assisting people they explained what they were doing first and reassured people. One of the concerns we received stated there were unpleasant odours throughout the home. However, we did not find this to be the case on either day of our unannounced visits. The home had no offensive lingering odours and staff ensured people were assisted to the bathrooms discreetly. The manager had removed chair protectors as they were institutional and people were assisted to maintain their continence.

Staff supported people who were in pain or anxious in a sensitive and discreet way. We saw one staff member comfort a person who had become very distressed. They treated the person with kindness and spent time with them to find out why they were upset. They offered them reassurance and the person was visibly calmer a few minutes later. Another person's clothes had become dishevelled and staff ensured they maintained their dignity. Most people were not able to tell us about their choices directly due to their dementia. However, one relative said they had requested their mother not go to bed before their usual time and confirmed that this had happened and they had been listened to. Care plans contained people's preferences to give staff a basis to work with.

Care records contained detailed information about the way people would like to be cared for at the end of their lives. The manager was working through discussions about care planning with each person's representative which included end of life preferences. There was information which showed the manager had discussed with people if they wished to be resuscitated. Appropriate health care professionals and family representatives had been involved in these discussions. The manager and senior care worker discussed end of life arrangements with the GP and district nurse during our inspection. This was done sensitively and the manager ensured the GP spoke to the person's relative and actioned the advice such as ordering a new medication prescription immediately.

Requires improvement

Is the service responsive?

Our findings

The new manager had begun to gather information about people but this had not yet been used to inform how staff about people's social and leisure needs. Although an external entertainer who visited weekly was present during the morning of day one of our inspection there was a lack of person centred activities to engage and stimulate people. Due to people spending most of the day in the communal areas, they were able to interact with staff and watch what was going on so there was a low risk of isolation. However, people's leisure and social needs were not being met in a person centred way. There was no activities co-ordinator, although an advert had been placed to employ one, but in the meantime care staff were not pro-actively involved in meeting these needs consistently. One care worker was allocated four hours a week activity time but this was not enough to ensure each individual was able to engage in meaningful activities or stimulation in a person centred way.

Apart from the external entertainer who engaged some people for a morning there was little stimulation. Although staff were kind and caring we did not see one to one engagement for any period with people. Most people sat in their chairs and watched people going past, watched TV in the TV lounge or slept. There was some engagement such as one person was independently knitting, another person was given some paper and a pen to write with and a care worker said they had decorated some cakes with people a couple of weeks ago. Records did not record any information about people's wellbeing such as behaviour and mental health which could affect their wellbeing or what they had done that day. Overall, there was little activity and no evidence that person centred information or specialist dementia knowledge had been used to enhance people's quality of life.

This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The manager was aware of this issue and said they would discuss options with the provider to ensure this was addressed in a timely way.

People received care and support that was responsive to their personal care needs because staff had good knowledge of the people who lived at the home. Staff were able to tell us detailed information about how people liked to be supported and what was important to them.

People who wished to move to the home had their needs assessed to ensure the home was able to meet their needs and expectations. Staff considered the needs of other people who lived at the home before offering a place to someone. People were involved in discussing their needs and wishes if they were able and people's relatives also contributed. The manager had included the Alzheimer Society "This is Me" document in the assessments and care planning. This ensured that people and/or their representatives were able to express personalised details about themselves.

During the inspection we read four people's care records. This was a new computer format and all were personal to the individual which meant staff had details about each person's specific needs and how they liked to be supported. Information relating to how their personal care needs were met was followed by staff but social and leisure information had not yet been used to inform activities as stated above. Staff at the home responded to people's changing needs. For example, one person had been getting upset when an injection was due so staff had discussed with the relative and GP and tablets were now given instead. Other people had clear body map records to show why and where topical creams were required. One person liked a certain condiment with their lunch which they received to promote their appetite. Other information stated how to comfort people if they became distressed or frustrated, detailing particular triggers for staff to be aware of.

Most people were unable to be directly involved in their care planning but the new manager had begun to meet with each person and/or the person's representative to discuss the new care plans. A copy of the care plan was then sent to the representative if they were happy to be involved. The manager said "It's about getting it right for everybody." There were regular reviews of people's health and staff responded promptly to changes in need. One plan said "pressure sore greatly improved, fed back to son."

People and their representatives said they would not hesitate in speaking with staff if they had any concerns. People and their representatives knew how to make a formal complaint if they needed to but felt that issues would usually be resolved informally. Formal complaints had been dealt with appropriately including negative comments received from the annual quality assurance survey. For example, laundry processes had improved and

Requires improvement

Is the service responsive?

relatives had been reminded that they were able to visit at any time. Empathetic and meaningful written responses had been sent to the complainants. Issues were taken seriously and responded to in line with the provider's policy. The complainants had been advised of the outcome of the complaint investigations. One person said "I have never had a request that has been ignored."

Requires improvement

Is the service well-led?

Our findings

There was a management structure in the home which provided clear lines of responsibility and accountability. A new manager was in post who had overall responsibility for the home since January 2015. Since their employment they had begun to look at all aspects of the home to see where improvements could be made. For example, medication storage, care planning and representative involvement, complaints responses, staff training and supervision. These were all underway. However, we found two breaches, which the manager was aware of: the issues of accommodation refurbishment and lack of meaningful activities especially for people with dementia still needed addressing. For example, there was no clear timescale to address the state of the accommodation. Also interim measures had not been put in place to provide meaningful stimulation for people whilst an activities co-ordinator was sought.

The manager was supported by a knowledgeable senior care worker. The provider was not involved in the day to day running of the home but was supportive and accessible. The manager said they would also be keen to address the issues and actions were already being taken following the first day of our inspection. The manager was able to receive support and advice from the manager of another care home owned by the provider, and they had contact on a regular basis to discuss management issues.

The manager and senior care worker were available throughout the inspection. We observed that they took an active role in the running of the home and had a good knowledge of the people who used the service and the staff. People appeared very comfortable and relaxed with the management team. We saw members of the management team chatting and laughing with people who lived at the home and making themselves available to personal and professional visitors. Staff told us, and duty rotas seen confirmed, there was always a senior care worker on each shift. Staff said there was always a more senior person available for advice and support.

All of the people spoken with during the inspection described the management of the home as open and approachable. The manager showed enthusiasm in wanting to provide the best level of care possible. Staff had adopted the same ethos and enthusiasm and this showed in the way that they cared for people. One staff member said “I love working here, we are well supported.” One person said “The manager is very nice and friendly, everyone is.”

The manager had an open door policy and they were available to relatives, people using the service and health professionals. They kept up to date with current good practice by attending training courses and linking with appropriate professionals in the area including college tutors in health and social care.

There were some effective quality assurance systems in place to monitor care and plan on-going improvements. There were audits and checks in place to monitor safety and quality of care. A recent quality assurance survey had been analysed and any negative comments had been directly addressed and the outcome fed back to people. We looked at care plan audits that had been carried out and saw that any shortfalls had been addressed with staff. All accidents and incidents which occurred in the home were recorded and analysed and action taken to learn from them. This demonstrated the home had a culture of continuous improvement in the quality of care provided.

There were systems in place to share information and seek people’s views about the running of the home. These views were acted upon where possible and practical. The service did not currently have a residents meeting but the manager was offering people’s representatives one to one discussion to look at care planning on an individual basis. This enabled the home to monitor people’s satisfaction with the service provided and ensure any changes made were in line with people’s wishes and needs.

The home had notified the Care Quality Commission of all significant events which have occurred in line with their legal responsibilities.

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 15 HSCA (RA) Regulations 2014 Premises and equipment This was a breach of Regulation 15 (1) (a) (c) and (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 Premises and equipment How the regulation was not being met: People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because bedroom accommodation did not always provide of suitable, clean, good quality furniture and bed linen, and the rooms were inadequately maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care This was in breach of regulation 9 (1) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person Centred Care How the regulation was not being met: People's social and emotional needs were not being met in a person centred way.