Teignbridge House Care Home Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 18 May 2017 and was unannounced. The service was last inspected on 5 February 2015 when it was rated as Good.

Teignbridge House Care Home Limited provides personal care and support for up to 24 people. There were 22 people living at the home at the time of this inspection. Teignbridge House cares for older people including people living with dementia. If people needed support with any nursing care needs this was provided by the local community nurses.

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. The registered manager is also the registered provider of this service. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider did not have effective systems in place to monitor the service and ensure the service ran smoothly. Some management tasks had been delegated to senior staff, such as staff training, care planning and reviews. However, the provider did not regularly monitor these to ensure all tasks had been completed safely and effectively. For example, when staff had completed training this had been recorded by a senior member of staff on individual training matrix. The provider did not have systems in place to check that staff had received training and were competent in areas they had identified as essential. After the inspection we spoke with the provider and the senior member of staff and they took prompt action to improve their training matrix, identify gaps in training and put in place a plan to ensure essential training topics are completed in the near future. However, the lack of a robust quality monitoring system meant there was a possibility the provider may fail to identify staff training needs in the future.

We found that some staff had not completed training on topics such as the Mental Capacity Act 2005 and did not have the knowledge or information necessary to ensure that the service was working within the principles of the MCA and that people's best interests were met with the least restrictions possible. The provider did not have an effective quality monitoring process to help them identify areas where they were failing to meet current legislation. The provider had received advice in the last year from the local authority Quality and Improvement Team (QAIT) to help them draw up their own service improvement plan. However, the plan had not been regularly reviewed or updated and therefore was not fully effective.

People's capacity to make decisions had not been formally assessed, and staff did not have sufficient information or training to ensure they followed the principles of the Mental Capacity Act 2005. After the inspection a senior member of staff told us they were booked to go on a training course provided by the local authority in the near future and they planned to complete mental capacity assessments for people living in the home after they have completing the training.

There was a warm and welcoming atmosphere. People told us they were happy living in the home.

Comments included "People seem so happy here", "I couldn't be happier anywhere than I am here", and "Absolutely perfect!" A visitor told us "I would say it is almost exceptional. Very caring staff. Regular staff. They don't have lots of staff changes. I am really impressed with this care home."

People told us they felt safe. They told us there were enough staff to meet their needs and ensure routines ran smoothly. Call bells were answered promptly. Staff turnover was low and staff recruitment records showed that staff were carefully checked to ensure they were suitable for the post before they began working in the home.

Risks to people's health and safely had been assessed, regularly reviewed, and measures had been put in place to minimise risks where possible. Treatment and advice had been sought where necessary, for example advice had been sought from the Speech and Language Therapy (SALT) team for any persons at risk of choking.

All areas of the home were safe, clean, homely and comfortable. The provider told us about plans for redecoration and improvements in the near future. Staff took good care of people's laundry and followed safe infection control procedures for soiled items. Staff also took a pride in ensuring people slept in beds that were comfortable, clean, and well-made. The kitchen had been inspected by the Environmental Health department and had been awarded the highest rating which showed they followed safe food handling and hygiene procedures.

Medicines were stored and administered safely. Each person had a secure medicines cabinet in their bedroom and received individualised support with their medicines according to their wishes and ability. Some people had chosen to administer their own medicines and they were supported to do so safely. Medicine errors rarely occurred, but when they did there was an ethos of learning from mistakes, reviewing their practice and making improvements promptly where necessary. Most medicines records were accurate and well maintained. Where we found some aspects of recording some controlled drugs and creams could be improved, the provider and staff took prompt action to improve their recording systems and ensure safe practice is followed at all times.

People told us the care they received was effective. Staff were experienced, well trained, and understood each person's needs. Staff were well supervised and supported, and there were daily handovers, staff meetings and communication systems in place to make sure staff understood any changes in people's care needs. People were supported to attend medical appointments when necessary. Medical advice and treatment was sought promptly when necessary.

People told us the staff were caring. During the day we saw staff interacting with people in a warm and caring manner. Staff were patient, gentle and kind in their manner. There were lots of smiles and laughter. Staff spent time with each person, chatting and making sure people were comfortable. A visitor told us "They are always so pleasant. I have never heard a cross word from any of them."

People were fully involved and consulted in drawing up a plan of their care needs before they moved in. People held their own care plans in their bedroom and told us they could look at their care plan at any time. The plans were reviewed and updated every month. People told us they were confident the care plans were correct and staff gave them the care and assistance they needed.

Two activities organisers were employed, and between them they provided a full programme of group and individual activities to suit each person. Group activities were provided every weekday, mornings and afternoons. These included games, quizzes, arts and crafts, and musical entertainments. Fifteen people

attended a group activity on the afternoon of our visit and we saw people smiling, happy and enjoying the interaction. Staff also spent time with people on a one-to-one basis each week, and gave special attention to people who had few visitors, and those who preferred not to join in group activities.

People told us the service was well run. People were involved and consulted in various ways. Resident's meeting were held regularly and these were minuted and actions taken where necessary, for example, name badges had been provided for staff after people had requested this. People's views had also been sought through questionnaires. People told us they were confident they could make a complaint if necessary and their complaint would be listened to and acted on. Staff told us they were happy in their jobs and felt well supported.

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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

There were sufficient numbers of skilled and experienced staff to meet people's needs.

The risk of abuse to people was reduced because there were effective recruitment and selection processes for new staff. Staff were confident with safeguarding procedures.

People received their medicines in a safe way. Medicines were managed safely.

People's needs were assessed to ensure risks were identified and safely managed.

People lived in a clean and hygienic environment.

Is the service effective?

Requires Improvement

The service was not fully effective.

People's legal rights were not fully protected because staff were not always following laws to help protect people

People did not always receive care from staff who were trained appropriately

People received the support and care they needed to meet their needs.

People were supported to have a balanced and healthy diet.

Is the service caring?

Good

The service was caring.

People were treated with compassion, kindness and respect.

People received care from staff who respected their privacy and dignity.

Staff were knowledgeable about the care people required and the things that were important to them.

Is the service responsive?

Good

The service was responsive.

People's records were personalised and met their individual needs.

People were offered a range of activities to suit their individual interests and abilities.

The service had a complaints procedure displayed and people knew how to make a complaint if necessary.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well led.

People were not assured of the quality of the service they received because systems to monitor this were not always effective and did not help them plan where improvements were necessary.

There was an experienced registered manager in post who was available and approachable.

People were involved and consulted about the service, and their views were listened to and acted upon.

Staff were supported by the registered manager and staff were able to discuss and raise any concerns or issues.

Teignbridge House Care Home Limited

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 18 May 2017 and was unannounced. The inspection was carried out by one adult social care inspector.

Before the inspection we looked at the information we had received about the service since the last inspection. This included notifications and information we received from health and social care professionals and commissioners.

During the inspection we spoke with the provider (who is also the registered manager) seven members of staff, 12 people who lived in the home and three visitors. We also observed people participating in group activities, and people at lunchtime. We walked around the home and looked at bedrooms, bathrooms, toilets, communal areas, gardens, the kitchen and laundry. We looked at records the provider is required to maintain including care plans, medicines, staff recruitment, training and supervision records and records relating to quality monitoring and improvement of the service.

Good

Is the service safe?

Our findings

Teignbridge House Care Home continues to provide safe care for people living there. People told us they felt safe. One person who had experienced a serious fall in their own home before moving to Teignbridge House Care Home said they now felt safe. They told us "As homes go, this is as good as you could ask for. If you have any worries (provider's name) who owns it is very good. You only have to ask him and he will sort it out."

People living in the home, visitors and staff told us there were enough staff to meet people's needs and ensure routines ran smoothly. On the morning of our inspection there were four care staff on duty plus the provider. There was also a cook and an activities organiser. In the afternoons there were usually three care staff on duty, the provider or a senior member of staff plus an activities organiser. Overnight there were two awake care staff. During our inspection we saw staff were attentive to people's needs and responded quickly to any requests for assistance. Call bells were answered promptly. Staff told us there was good teamwork and they worked closely to support each other at all times, including covering vacant shifts where possible. If they were unable to cover vacant shifts within the staff team they used agency staff. The provider told us they tried to make sure they only used agency staff who had previously worked in the home. We spoke with an agency member of staff during the inspection who told us they had worked in the home a number of times in the past and always enjoyed working there. They told us "It's lovely. Residents are well looked after and staff are lovely. It's a really friendly home."

The risks of abuse to people were reduced because there were effective recruitment and selection processes for new staff. This included carrying out checks to make sure new staff were safe to work with vulnerable adults. Staff were not allowed to start work until satisfactory checks and employment references had been obtained. Recruitment files showed at least two satisfactory references had been obtained and Disclosure and Barring Service (DBS) checks had been completed before they began working in the home. The DBS checks people's criminal record history and their suitability to work with vulnerable people. This showed the provider had taken care to obtain sufficient evidence of the applicant's suitability. Staff turnover was low.

Staff had received training and regular updates on safeguarding vulnerable adults and knew how to recognise and report any incidents of abuse. Staff told us they were confident they could raise any concerns with the provider and he would take prompt and appropriate action.

Risks to people's health and safely had been assessed, regularly reviewed, and measures had been put in place to minimise risks where possible. Treatment and advice had been sought where necessary, for example advice had been sought from the Speech and Language Therapy (SALT) team for any persons at risk of choking. Care plans contained evidence that potential risks such as pressure sores, falls, malnutrition, weight loss and dehydration had been assessed using nationally recognised assessment tools. There were no people suffering from pressure sores at the time of this inspection. Staff had received training and information on safe care practice to minimise the risk of pressure sores. Where risks had been identified actions had been taken to minimise these where possible. For example, pressure relieving mattresses and cushions were in place where necessary. We also found hoists and moving and handling equipment had

been provided where necessary and manual handling plans were in place. A personal evacuation plan (PEEPs) had been drawn up for each person.

All areas of the home were safe, clean, homely and comfortable. All radiators were covered to prevent burns. Windows on the first floor had been restricted to prevent accidental falls from windows. Repairs and maintenance had been carried out regularly and promptly where necessary and the provider told us about plans for redecoration and improvements in the near future. Records showed that fire alarms and equipment had been tested regularly by the provider and checked and maintained on a regular basis by a company specialising in fire safety.

Safe laundry procedures were followed. Staff took good care of people's clothing to ensure clothing was returned to the correct person. Staff followed safe infection control procedures for soiled items and knew what temperatures different items should be washed and dried. Staff took a pride in ensuring people slept in beds that were comfortable, clean, and well-made.

Medicines were stored and administered safely. We asked a visitor if they felt confident staff looked after people's medicines safely. They replied "Absolutely! And they made sure they are taken as well." Each person had a secure medicines cabinet in their bedroom and received individualised support with their medicines according to their wishes and ability. Some people had chosen to administer their own medicines and they were supported to do so safely.

Medicine errors rarely occurred, but when they did there was an ethos of learning from mistakes, reviewing their practice and making improvements promptly where necessary. For example, after errors were found in the past the security of medicine storage had been improved. They had also implemented red tabards with the words 'do not disturb' for staff to wear when they administer medicines. All staff who administered medicines had received training and were regularly updated. A senior member of staff told us they were always keen to receive any new training and information to help them improve the safety of medicines in the home.

Most tablets were supplied in four weekly blister packs. Records of medicines administered were well recorded and accurate. Most creams were recorded each time they had been applied by staff, although some emollient creams had not always been recorded. We also noted that the recording of pain relief patches could be improved to ensure the manufacturers' guidance on the siting of the patches is followed. A senior member of staff took immediate action to improve the recording of emollient creams and the administration of pain relief patches to ensure safe practice is followed at all times.

Where people had been prescribed medicines with variable dosages, for example Warfarin, there were safe procedures in place to ensure blood levels were regularly checked by health professionals, and there were prompt and safe communication and recording systems in place to ensure care staff had up-to-date information on the daily dosage needed. When people were prescribed medicines that must be administered at regular intervals throughout the day, outside of normal medicine administration times, there were safe systems in place to ensure people received their medicines at the correct time.

A secure stock cupboard contained a locked refrigerator for medicines that had to be kept cool. The cupboard also contained a secured cabinet for controlled drugs, and stocks of homely remedies. There were two 'just in case' bags supplied for people who had been seriously ill and possibly close to death. The bags had not been opened, or recorded in the controlled drugs record if necessary. The contents were unused. During our inspection the provider took immediate action to check with the pharmacy on the continued storage of the medicines. After the inspection we spoke with the provider and also with their pharmacy

supplier. We were given assurances the medicines had been returned to the pharmacy and the pharmacist was working with the provider to ensure that safe storage, retention and recording of 'just in case' bags would be followed in future.

Most people held and managed their own money, with the support of families or financial representatives where necessary. One person had asked the provider to store a sum of money, and we saw this was held securely. The provider also assisted one person to pay a bill regularly. There were no records in place to setting out the reasons why the provider had agreed to carry out the task, or show alternative methods of payment had been explored. There were no protocols in place to show how the person was protected from potential abuse. The provider agreed to address this promptly.

Requires Improvement

Is the service effective?

Our findings

Not all aspects of the service were fully effective.

Where people lacked capacity to make important decisions about their lives, their care plans did not guide staff about the decisions the person was able to make, or where they needed other people to make decisions in their best interests. Care plans did not contain assessments carried out by staff or health or social care professionals to establish the person's capacity to make decisions. Staff we spoke with understood the importance of allowing people to make decisions about day to day matters such as daily routines, what to wear, and what they wanted to eat. However, they were less certain about the procedures they should follow if people lacked capacity to make important decisions about their health and welfare or finances. For example, when people were unable to make decisions about the use of bed rails, or medical treatment, staff were unclear about the processes to follow to ensure the person's best interests were met. They were unable to provide evidence in care plans to show how this process had been followed. Although staff had an awareness of the Mental Capacity Act 2005 not all staff had received training in the topic.

This is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Need for consent.

After the inspection we spoke with a senior member of staff who told us they had previously completed capacity assessments for people, but they were uncertain if the assessments were correct and had removed them from the care plans. They were booked to go on a training course provided by the local authority in the near future and planned to complete mental capacity assessments for people living in the home after completing the training.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Applications had been submitted to the local authority for people whose liberty was restricted to enable them to remain safe and they were awaiting assessment by the local authority to be carried out. Staff were aware of the need to make applications for any people who may need this approval in the future.

People told us they felt the staff were skilled and understood their needs fully. A person told us "I think they know what they are doing." At the start of every new member of staff's employment they received induction training that ensured they had the basic skills needed to provide effective support for each person. New staff who had not had any previous experience in caring for people were expected to complete a nationally recognised qualification known as the Care Certificate. This qualification is designed to give staff the basic knowledge they require to provide safe and effective care. New staff carried out 'shadow' shifts at the start of their employment to enable them to gain the basic skills and knowledge required before working on their own with people.

After new staff had completed their induction period they were expected to complete a wide range of mainly

computer based training topics. Competence in each topic was tested through questionnaires. After the inspection a senior member of staff sent us a training matrix showing the training topics completed by each member of staff. This showed all staff had completed training on first aid, moving and handling, and safe handling of medicines. However, there were some gaps in the training matrix for other topics. Some staff had not yet received training on topics such as safeguarding, dementia, coping with aggression, equality and diversity and the Mental Capacity Act. The training matrix did not identify the dates when the training was expected to be completed by. The senior member of staff told us they were in the process of reviewing the training records and expected all staff to complete essential training within the next six months. They also told us that most staff either held, or were in the process of gaining, a nationally recognised qualification in care, for example National Vocational Qualifications (NVQs) or diplomas.

Staff were well supervised and supported. Each member of staff received individual supervision session approximately every two months. Supervision sessions were recorded and well planned. Staff meetings were held regularly and these were minuted. Staff also received relevant information through daily handovers and communication systems which ensured staff were aware of, and understood any changes in people's care needs.

People were supported to attend medical appointments when necessary. Medical advice and treatment was sought promptly when necessary. People told us the provider or staff always accompanied them to appointments where necessary. Records of medical appointments contained evidence of treatment and advice. Community nursing records for each person were stored in people's rooms with their care plans and this ensured good communication systems between community nurses and care staff. One person told us they had seen a physiotherapist that morning who had given advice on exercises. They told us they followed the exercises regularly and their mobility had improved significantly as a result.

Staff had received guidance and training to help them support people with dementia, mental illness, anxiety or aggression. This included guidance from organisations such as the Alzheimer's Society, and from community psychiatric nurses. Where people displayed behaviour that might cause upset to themselves or others the incidents had been recorded, monitored and reviewed. This helped staff understand the reasons for the behaviour, recognise potential causes, and consider other ways of supporting the person more effectively. They had liaised with doctors and health professionals where necessary to ensure there were no underlying health problems.

People's nutritional needs were met effectively. People told us they enjoyed the meals. One person said the food was "Very nice. We are always given a choice." Another person said the food was "Very good. Nicely cooked and presented well." We also heard that staff would always offer an alternative meal if they did not like the choices offered. Several people told us they had recently enjoyed fried egg and chips as an alternative to the two main meals offered, and they had thoroughly enjoyed this. Staff spoke with each person every day to tell them about the meals planned for the following day, and check on their preferred options. We were shown daily records of the meals chosen by each person.

One person said they had not eaten much of their lunch because the size of the portion they had been given was too large. We spoke with a senior member of staff who told us there was a record of each person's likes, dislikes and dietary needs displayed in the kitchen including the size of portion they preferred. They also told us staff always checked the reasons why a person had not eaten their meal and made sure other alternatives were offered. If people experienced poor appetite or were at risk of weight loss, food and fluid intake levels were recorded and carefully monitored. People were offered drinks and snacks at regular intervals throughout the day.

Good

Is the service caring?

Our findings

People continued to receive a service that was caring.

All of the people we spoke with praised the staff. During the day we saw staff interacting with people in a warm and caring manner. Staff were patient, gentle and kind in their manner. There were lots of smiles and laughter. Staff spent time with each person, chatting and making sure people were comfortable. We observed staff supporting people to move around the home. They allowed people to move at their pace, chatting with them as they walked and gave gentle support, guidance and encouragement.

Staff talked about the importance of caring for people in the way they would want to be treated, or how they would want their relatives to be cared for. Staff told us they would be happy for any member of their family to live at Teignbridge House. Staff knew each person well, and understood the things that were important to each person. They knew about each person's care needs and how they wanted to be supported. For example, they knew the foods people liked and disliked, and their preferred daily routines. Staff were seen offering people choices throughout the day.

One visitor told us, "They are always so pleasant. I have never heard a cross word from any of them." Another visitor told us staff always went out of their way to make sure people had everything they wanted. They gave an example of a food item the person particularly liked, and said the staff did their best to make sure the item was always available, or quickly replaced when it ran out. They said "I think he is particularly lucky with the staff.

During the inspection we observed staff supporting a person who was becoming agitated. The staff were calm, caring and understanding in their approach. They offered support promptly, respected the person's wishes, and quickly helped to reassure the person and calm them down.

We also heard examples of people being offered alternative rooms when rooms became available. For example, one person who had moved into an upstairs room when they first moved into the home had been offered a downstairs room as soon as one had become available. We heard how much this had improved the person's daily life as they were able to participate more in daily life of the home, and go out more easily. The provider and staff also supported and encouraged people to personalise their bedrooms with items of furniture, pictures and personal effects to make their rooms feel homely. We asked one person if they were happy with their room and they told us "It's a beautiful room – don't you think so?"

Relatives and visitors told us they were always made to feel welcomed and involved. They were kept well informed of any changes in peoples, care. One visitor told us they were always offered drinks whenever they visited.

During the inspection we observed staff supporting people in a manner that respected their privacy and dignity. Staff knocked on doors and called out before entering. When staff supported people with personal care tasks they did so in a discreet and respectful manner, ensuring personal care was always carried out in

privacy.

Good

Is the service responsive?

Our findings

People continued to receive a service that was responsive to their needs.

People were fully involved and consulted in drawing up a plan of their care needs before they moved in. The registered manager visited people before admission to carry out an assessment of their needs and to make sure the home would be able to meet those needs. This information was used to draw up an initial care plan to ensure staff had the information they needed to meet the person's needs safely when they moved in.

People held their own care plans in their bedroom and told us they could look at their care plan at any time. The plans contained detailed information about each person's health and social care needs, and explained how they wished to receive their care. Care records included people's personal histories and backgrounds, hobbies and previous work, people who were important to them and their favourite foods, music and TV programmes. This helped staff to deliver personalised care. Staff told us they used the care plans and felt the information was clear and easy to use. A member of staff told us they sat down with each person every month to review and update their care plan. People told us they were confident the care plans were correct and staff gave them the care and assistance they needed. One person told us "The girls are very good. All of them. They give us a shower every day."

Staff made a record of all personal care provided. There were also checklists in place to remind staff about essential tasks such as making sure the person's hair was brushed, teeth or dentures cleaned, nails clean hearing aid in place, their bed made and bin emptied. We saw that everyone was well dressed, with hair attractively styled, and clothing was clean and neatly ironed. Staff had supported people to wear clothing and jewellery of their choice. People received regular manicure and nail care sessions and many of the women had their nails attractively painted.

Two activities organisers were employed, and between them they provided a full programme of group and individual activities to suit each person. Group activities were provided every weekday, mornings and afternoons. These included games, quizzes, arts and crafts, and musical entertainments. The planned activities included reminiscence sessions such as 'touch and feel', taste testing, fruit tasting and smells (for example mint and lavender). These sessions included discussion about their memories associated with the smells, tastes and textures they experienced. The activity organisers kept a record of people who joined the group activities, and whether people enjoyed the session. They reviewed the records on a regular basis to help them plan future group activities, and also to review each person's individual needs, making sure they catered for every person's interests and wishes. The activities organisers also sat down with each person at least once a year to review their social needs. This helped them to find out about interests such as music, films and hobbies they could assist the person to enjoy or participate in.

All planned activities were displayed clearly on a notice board in the main lounge. People were encouraged to attend group activities, but if they chose not to join in this was respected. Fifteen people attended a group activity on the afternoon of our visit and we saw people smiling, chatting, and enjoying the interaction. People also told us about other activities they enjoyed, including visits from entertainers, and people who

brought in pets and animals people could hold or stroke. Staff also spent time with people on a one-to-one basis each week, and gave special attention to people who had few visitors, and those who preferred not to join in group activities. Monthly newsletters were produced giving a range of information about the home, forthcoming activities, and any special events such as birthdays and celebrations.

People were involved and consulted in various ways. Resident's meeting were held regularly and these were minuted and actions taken where necessary, for example, name badges had been provided for staff after people had requested this. People's views had also been sought through questionnaires. People told us they were confident they could make a complaint if necessary and their complaint would be listened to and acted on. None of the people we spoke with told us they had ever had reason to make a complaint. One person told us "Oh it's good. They really do their best. Any problems, they will listen and sort it out."

Requires Improvement

Is the service well-led?

Our findings

Some aspects of the service were not well-led because monitoring and improvement systems were not fully effective.

The provider was also the registered manager of the service. They were fully involved in the day to day running of the service but had delegated some tasks to senior members of the staff team, for example staff training, care planning, and medicine administration. Although the provider received regular verbal reassurance from the staff team that tasks had been carried out, they did not always monitor or carry out their own checks or ensure all tasks had been completed safely and effectively. For example, when staff had completed training this had been recorded by a senior member of staff on individual training matrix. The provider did not have systems in place to check that staff had received training and were competent in areas they had identified as essential. This had resulted in the provider being unaware that staff had not received training or updates in some topics relevant to the needs of people. The lack of a robust quality monitoring system meant the provider had failed to identify staff training needs.

We found that some staff had not completed training on topics such as the Mental Capacity Act 2005 and did not have the knowledge or information necessary to ensure that the service was working within the principles of the MCA and that people's best interests were met with the least restrictions possible. The provider did not have an effective quality monitoring process to help them identify areas where they were failing to meet current legislation. The provider had received advice in the last year from the local authority Quality and Improvement Team (QAIT) to help them draw up their own service improvement plan. However, the plan had not been regularly reviewed or updated and therefore was not fully effective.

The provider told us about their plans to improve the service in future, for example redecoration and replacement of some furniture. However, their plans were not recorded and they did not have a system in place to regularly review the plan and make sure targets for improvements were met.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good governance

After the inspection we spoke with the provider and the senior member of staff and they took prompt action to improve their training matrix, identify gaps in training and put in place a plan to ensure essential training topics are completed in the near future.

We also found some systems to monitor the service were in place and were effective. For example, there were systems in place to make sure care was regularly reviewed and staff were kept informed of any changes. A senior member of staff showed us records of monthly care plan reviews and amendments, and staff were asked to sign to confirm they had read these and understood the changes.

The provider involved people in the service and regularly sought their views, for example through resident's meetings, questionnaires and monthly care plan review meetings. Where people had commented on areas

for improvement, for example lounge furniture, the provider was in the process of arranging samples of furniture to be demonstrated so that people could choose the furniture they preferred.

People told us the service was well run. Staff told us they were happy in their jobs and felt well supported. A visitor told us "I would say it is almost exceptional. Very caring staff. Regular staff. They don't have lots of staff changes. I am really impressed with this care home."

There were clear lines of accountability and staff roles and responsibilities. People who used the service, relatives and staff understood the staff hierarchy and knew who to speak with if they had any queries or concerns. A member of staff told us there was good teamwork and a happy working atmosphere. They said "It's a good mix. Everyone gets on with each other. (Provider's name) is very supportive and approachable. He deals with issues fairly." Another member of staff said the provider had been very supportive to their individual circumstances, saying "They are very understanding."

The provider promoted the ethos of honesty, learned from mistakes and admitted when things had gone wrong. For example, where medicines errors had been found in the past they had reviewed their practice, learned from their mistakes and made changes and improvements where necessary. This reflected the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment.

The statement of purpose states that people 'deserve a home where individuality is emphasised. We have staff that find the time to give attention to small details, and all our residents are actively encouraged and given the choice to enjoy the company of others.' During our inspection we saw staff giving people time, paying attention to details, encouraging choice, and giving people opportunity to make lasting friendships with others.

As far as we are aware, all significant accidents/incidents were recorded and, where appropriate, were reported to the relevant statutory authorities. We have no reason to believe we have not been informed of any significant incidents which have occurred within 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	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider has failed to ensure staff are familiar with the principles and codes of conduct of the Mental Capacity Act (MCA) 2005. Where people lack capacity to make important decisions about their lives the provider has failed to ensure staff have sufficient information to act in accordance with the MCA and associated code of practice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider has failed to operate effective systems and processes to make sure they assess and monitor the service and improve the service where necessary.