Villa Maria Care Limited

Villa Maria Private Nursing Home

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?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

Villa Maria Private Nursing Home is a 'care home' which provides nursing care and treatment. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service accommodates up to 26 people. At the time of our inspection 24 people were living in the service. People had a range of needs including dementia, late stage cancer and physical disabilities.

This unannounced inspection took place on 26 April 2018.

At our last inspection in 17 September 2015 we found the service was 'Good' in all the key questions we ask of services and so we rated the service 'Good' overall.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider did not always ensure bed rails were used safely to protect people from the risk of harm. Pressure relieving mattresses were not always used appropriately to reduce the risk of pressure ulcers, although the service reduced the risk of pressure ulcers in other ways. People received their medicines are required.

The provider did not always follow the Mental Capacity Act (MCA) 2005 in assessing whether people lacked capacity to consent to their care. In addition the provider had not always followed their legal duty when depriving people of their liberty.

Although people received care which met their needs and preferences care plans required improvement to act as suitable guides for staff. Care plans, including end of life care plans, were not always 'person-centred' setting out the best ways to care for individuals.

The provider lacked suitable systems to check they were providing care in line with Regulations. The provider had not identified the breaches we found before we inspected the service and so had not taken the necessary action to improve.

The premises met people's needs in relation to their disabilities. A programme was in place to maintain the safety of the premises.

Systems were in place to safeguarding people from abuse and improper treatment. There were enough staff deployed to care for people and the provider checked staff were suitable to work with people through recruitment checks.

Staff were supported with a programme of supervision and training and were encouraged to do diplomas in health and social care.

The provider consulted with people as part of assessing their needs and also reviewed any professional reports. People were involved in decisions regarding their care. People were supported in relation to their health.

People developed good relationships with staff who were caring. Staff were respectful and understood the people they cared for. Staff treated people with respect and maintained people's privacy and dignity.

The complaints process was suitable and the provider responded to any concerns raised appropriately.

Leadership was visible and the registered manager acted as a role model to staff, interacting with people and providing personal care to people in their daily work. The directors were also visible in the home and accessible for people, relatives and staff.

The provider gathered feedback from people and relatives regarding the quality of care and the communicated openly with staff and external professionals.

At this inspection we identified some breaches of regulation. You can see the action we asked the provider to take on the back of our full-length report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. The provider did not always ensure bed rails and pressure relieving mattresses were used safely. The provider did not always assess risks relating to people's care.

People received their medicines as prescribed.

Systems were in place to safeguard people from abuse or neglect.

The provider checked staff were suitable to work with people. There were enough staff to support people.

Is the service effective?

Requires Improvement

The service was not always effective. The provider did not always follow the MCA in caring for people and had not always followed their legal duty when depriving people of their liberty.

Staff were supported with a programme of training and supervision.

People received support in relation to eating and drinking and with their day to day health.

The premises met people's needs in relation to their disabilities.

Is the service caring?

Good

The service continued to be Good.

Is the service responsive?

Requires Improvement

The service was not always responsive. The provider did not always plan people's care, including end of life care, in a 'person-centred' way and care plans were not robust or reliable for staff to follow. However, people were satisfied care met their needs.

The complaints process remained suitable and the provider responded to any concerns appropriately.

Is the service well-led?

Requires Improvement

The service was not always well-led. Good governance systems to check the service met the Regulations was lacking and the provider had not identified the concerns we found.

Leadership of the registered manager and directors was visible and they were accessible to people and staff.

The provider communicated openly with people, relatives and staff.

Villa Maria Private Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection visit to the service took place on 26 April 2018 and was unannounced. It was undertaken by an inspector, a specialist nurse advisor and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we asked the provider to complete a Provider Information Return (PIR).The PIR contains information about the service and how it is managed by the provider. We reviewed this, as well as other information we held about the service such as statutory notifications. Statutory notifications are used by the provider to inform us about information such as safeguarding allegations and police incidents, as required by law.

During the inspection we spoke with the registered manager, two directors, a nurse, two care workers, the chef, six people and four relatives. We also spoke with a safeguarding lead from social services, a financial advocate and a representative from the London Fire and Emergency Planning Authority (LFEPA). We looked at three people's care records to see how their care was planned, records relating to medicines management, the recruitment and supervision records for three staff, training records and records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

People were at risk of harm because the provider did not always assess and manage risks well. Risk assessments relating to bed rail safety were not always carried out appropriately with infrequent checks to ensure people were safe. We identified mattresses were sometimes ill fitting to the bedframe and observed six people, who were in bed, had gaps of 5 cm between their mattress and one side of the bedframe. Those six people had restricted mobility and were at risk of entrapment in this gap. In addition these six people were at risk of entrapment in the gaps between their bed rails. We found staff had not taken care to put suitable bed rail 'bumpers' in place to reduce the risk for all six people. For one person their bed rail was not raised high enough to protect them from the risk of falling from bed. When we informed staff they were unable to raise the bedrail any higher and it appeared broken. When we discussed these issues with staff we found they had limited knowledge of how to use bed rails safely. We found bed rail assessments for people had not identified the risks we found so risks to people were not always managed well. We raised our concerns with the registered manager who told us they would review the equipment, processes and checks in place as soon as possible.

Processes to reduce the risk of pressure ulcers were in place, although some improvements were required. The provider told us people seldom experienced pressure ulcers at the service and records confirmed this. Staff received training on pressure ulcer prevention and management and understood their responsibilities in relation to identifying and treating them. People at risk of pressure ulcers were supported to turn in their bed and pressure-relieving cushions were provided for people when sitting in the communal areas. People were provided with pressure-relieving mattresses. However, these were not always set at the recommended setting to be useful in reducing the risk of ulcers. One person's mattress was at a setting recommended for a person 45 kg heavier and a second person's for a person 10 kg heavier than them. This meant the mattresses were too firm to provide suitable pressure relief due to the inaccurate settings. We identified staff did not have a good knowledge of the recommended setting for each person based on their weight and the provider was using the manual for a different product to the mattresses used in the service for guidance. In addition there were no systems in place for staff to check mattresses were at the recommended setting while people were in bed. When we raised our concerns with the provider they told us they would review risk assessments as soon as possible.

The way the provider assessed risks relating to people's care and planned to reduce those risks required improvement. For example, the provider had not carried out any risk assessments for one person, admitted to the service 15 days before our inspection, who was on end of life care. This meant the provider could not be sure they had identified or were managing all risks relating to their care appropriately . For other people the provider had not always carried out an assessment of each risk in line with national guidance from the Health and Safety Executive (HSE) and comprehensive guidelines were not in place for staff to follow . The provider had not followed the 'five steps to risk assessment' in identifying the hazard, deciding who might be harmed and how, evaluated the risks and decided on precautions and recorded their findings and implemented their findings.

We observed staff transferred people safely and staff received regular training in relation to this from the

registered manager. Records showed the registered manager also frequently reminded staff of the best ways to transfer people during team meetings. However, the poor risk assessments meant people were at risk of being transferred unsafely if staff followed the unsuitable guidance in place.

Assessments in relation to moving and handling were poor in assessing the risks to people. In addition there was no suitable guidance in place on how to reduce the risks in relation to each person. Details about the size of sling each person should use was not recorded in their risk assessments or care plans. When we queried this with the manager they told us staff knew each person's weight and which sling to use, although they would review documents to ensure this information was clearly recorded. Risk management plans in relation to moving and handling did not clearly set out the type of equipment each person required to transfer. Each plan contained a template list of four types of equipment and the provider had not always taken care to personalise each plan by clearly identifying which equipment was required. The template plan also included other options such as 'complete individual lifting and handling plan', 'encourage resident to move as much as they are able', 'access for specialist equipment' and 'would benefit from a physio referral/ refer to GP'. However, the provider had not always identified which of these actions they had taken and the outcome for each person. This meant guidance in place for staff to follow was not always clear which put people at risk of unsafe care.

We looked at one person's assessment in relation to their risk of choking. This required improvement as it contained contradictory information which could put them at harm. The person had been assessed by a speech and language therapist (SALT) as at risk of choking although the provider had not made their guidance clear for staff. The person received food through a tube into their stomach although the SALT recommended they could occasionally eat foods for taste, but they must be of a particular texture to reduce their choking risk. However, the provider's 'dietary assessment' did not make clear what food the person could eat safely. In addition the provider had not personalised their 'eating and drinking' plan to clearly guide staff on supporting the person to eat safely. The provider had not edited the standard template used in all care plans at the service. This meant for this person their 'action plan' stated the person could have 'normal/ soft/ liquidised' which was incorrect and unsafe guidance for staff. In addition their plan stated they could 'have [a particular type of prescribed food] for taste' although notes from their dietetic review in March 2018 indicated this had been discontinued and they could be offered yoghurt instead. The provider had not updated the person's plan to guide staff on the specific food the person could safely be offered to reduce their risk of choking.

Falls risk assessments were also insufficient as the provider did not follow the five steps to risk assessment when reviewing the risks. Guidance in place for staff to follow in reducing the risks was also lacking. When we raised our concerns with the provider they told us they were aware risk assessment and planning documentation required improvement and they intended to improve this as soon as possible.

These issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's medicines were managed safely. People and relatives did not raise any concerns about the way staff supported people with medicines. We viewed records of medicines administration for fifteen people which indicated people received their medicines as prescribed and there were no omissions. Guidance for staff to administer 'as required' medicines to people was not accessible to staff during our inspection. However, after our inspection the registered manager sent us guidance for several people and confirmed they had been in the process of putting these in the medicines folder and in people's files. Staff received training in medicines management to understand their responsibilities in relation to this with assessments to check staff retained the required knowledge and skills.

One person was administered medicines covertly. The provider had assessed their capacity to consent to this in line with the Mental Capacity Act (MCA) and had made the decision to administer covertly in their best interests. Most medicines were stored safely although topical medicines were not stored in locked cabinets in line with best practice. This meant there was a risk people may access the medicines inappropriately. Although a nurse told us 'homely remedies' (medicines which can be purchased over the counter) were available for people there was no written guidance for each person setting out which homely remedies they could receive safely. The provider told us they would review these issues as soon as possible when we raised our concerns.

People were safeguarded from abuse because of systems the provider had in place. People told us they felt safe and relatives agreed. Comments included, "I'm safe here, I like it here" and "I think it's very safe." A relative said, "Staff understood their responsibilities to raise concerns and report safety incidents, concerns and near misses. Staff received training in safeguarding adults at risk to help keep their knowledge current. The registered manager understood how to report allegations of abuse to the local authority safeguarding team and to work with them as part of any investigations. There had been no safeguarding allegations at the service since our last inspection. However, the provider worked closely with the local authority safeguarding team and a advocacy service in relation to a safeguarding allegation which was raised before a person used the service. We spoke with the safeguarding lead and advocate during our inspection and they fed back the service supported the person well and was keeping them very safe.

People were supported by staff who the provider checked were suitable to work with them. The provider ensured staff completed an application form detailing their employment history and reasons for wanting to care for people. In addition the provider obtained references from former employers, carried out criminal records checks and checked candidates' identification and right to work in the UK. The provider also checked nurse personal identification numbers to check they were suitably registered with the Nursing and Midwifery Council (NMC).

People were supported by sufficient numbers of staff. People and relatives told us staffing levels were sufficient. We observed there were sufficient staff throughout the service to meet people's needs promptly. Staff told us they had enough time to care for people and we observed staff did not appear rushed at any time. Two staff told us more staff would be helpful in the morning and if the number of people at the service increased. The provider told us they did not reduce the numbers of staff when the number of people at the service reduced and their staffing levels were consistently high enough when numbers of people, and their needs, increased. Staff told us, and rotas confirmed, agency staff were occasionally used to cover staff who were on leave and the service also had a team of bank staff to cover shifts.

Staff supported people through suitable infection control procedures. Staff used personal protective equipment (PPE) when caring for people and practiced good hand hygiene. We observed staff supported people to wash their hands before eating. The registered manager trained all staff in infection control with a particular focus on good hand hygiene given the importance of this in reducing infections. We observed the service was clean with no malodours and domestic assistants were employed to keep the service clean. The provider had suitable laundry systems in place to wash contaminated clothes and bedding. The chef told us the service was inspected by the Food Standards Agency (FSA) in the past week and was rated 'four stars' which was a reduction on their previous 'five star' rating. The check explained the reason for this and told us the measures which had been taken immediately to improve. We found practices in the kitchen were suitable to reduce the risk of food-borne infections.

People received care in premises which were safely maintained. We observed the service was in a good state of repair and staff confirmed any repairs were promptly carried out. The provider had systems to reduce

risks relating to fire safety, gas safety, electrical installation, electrical appliances, water temperatures in line with national guidance. The provider had some systems in place to reduce risks relating to Legionella, a water-borne bacterium which can make people unwell, although they lacked a formal risk assessment as recommended for care homes by HSE. This meant they could not be sure they had sufficiently identified risks and were managing them well enough. The provider told us they would review our feedback when we raised our concerns about this.

During our inspection the provider also received an inspection from the London Fire and Emergency Planning Authority (LFEPA). We spoke with the LFEPA inspector and they confirmed the provider had suitable systems in place to reduce the risk of fire across the service. One improvement was required in relation to fire doors although the provider had already identified this and was in the process of replacing fire doors across the service. The provider redecorated people's bedrooms since our last inspection and new flooring was planned in communal areas in the next few weeks. We identified the flooring in one area of the lounge was a trip hazard and the directors told us they would review this when flooring was replaced across the service.

Requires Improvement

Is the service effective?

Our findings

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. Staff and the provider told us there were many people at the service who they had reason to believe lacked capacity in relation to their care. However, the provider lacked processes to assess people's capacity and to make decisions in their best interests in line with the MCA. Besides a capacity assessment in relation to covert medicines for one person, no other MCA assessments were in place. Staff told us there was reason to believe this person lacked capacity in relation to other areas of their care, although the provider had not assessed their capacity in line with the MCA. This meant the provider did not always provide care in line with the MCA and decisions may have been made without following 'best interests' planning in line with the MCA.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The provider made DoLS applications for some people appropriately and understood the requirement to keep these under review. However, we found the provider had not made DoLS applications for some people who met the criteria of requiring constant staff supervision and who were not free to leave without staff support. We were not concerned people were being deprived of their liberty inappropriately, but that the necessary processes had not been followed to deprive people of their liberty in line with the law. Our discussions with the provider showed there was some confusion as to when DoLS applications were required and the provider began to make a DoLS application during our inspection.

People were positive about the food they received and of the chef. One person told us, "The chef is very good. She cooks me my own food every day." A relative said, "The food is delicious, it's all freshly cooked." People's likes and dislikes in relation to food were not always well documented in their care plans. However, the chef and staff had a good knowledge of people's preferences and the menu was based on these. The chef also knew people's dietary needs such as those relating to diabetes, risk of malnutrition and choking and these details were clearly recorded for the chef to refer to. The provider did not always provide people with meals from their cultural and ethnic backgrounds, although halal meat was always provided for one person. People told us they enjoyed the traditionally British meals. We observed staff supported people to eat appropriately and provided adapted cutlery to aid people where necessary.

People's risk of malnutrition was monitored by staff and there were no concerns about people losing weight. A relative said, "Weight-wise they keep an eye on [my family member]. He was very skinny when he came in [and has put on weight]. The chef is brilliant." A staff member told us, "The chef took it as a personal challenge to get [a person] to eat as they were not eating at all when they arrived. The chef researched and took him from no appetite to loving his food and he even has seconds. Plus, he's put weight on which he really needed to do." However, we identified the provider had not always carefully calculated people's BMI

each month for one person and so the provider could not use these information reliably as part of their monitoring. The provider told us they would review their calculations as soon as possible. People were also supported to remain hydrated and we observed staff frequently encouraged people to drink throughout the day.

People were cared for by staff who were supported by the provider. Staff received supervision with their line manager every two months during which they reviewed the care people required and issues relating to their role. The provider told us annual appraisals were planned for the following month to review staff performance and set goals for the coming year. The registered manager introduced a new training programme which included 'blended learning' using a variety of methods including face-to-face instruction, practical tasks, observations and online training. Through the training programme staff studied a different topic each month and topics included those which were relevant to their role. Staff were supported to do diplomas in health and social care and the registered manager told us they had enrolled several staff on level 3 diplomas recently. A new staff member told us they completed a two day induction which included shadowing existing staff to learn how people preferred to receive their care. The registered manager told us new staff did not complete the 'care certificate' as most had already achieved level 2 or 3 diplomas in health and social care. The care certificate is a nationally recognised training programme which sets the standard for the essential skills required for staff delivering care and support.

People were supported to maintain their health by staff. People and relatives were satisfied with the support people received in relation to their health and we found staff understood people's health-related needs. However, information to guide staff on maintaining people's health was not always comprehensive or accurate as discussed in the 'Safe' and 'Responsive' sections of the report. The provider referred people to any specialist healthcare services they required, such as speech and language therapists, dietitians, physiotherapists and tissue viability nurses.

People's needs and preferences were assessed by the provider, although assessments were not always thorough or well recorded. Prior to using the service the provider reviewed people's physical, mental health and social needs through meeting with people and their relatives to find out more about their needs. People were encouraged to visit the home to find out whether they would like to live there. The provider also reviewed any professional reports, such as those from social services, as part of their assessment. The provider met with people and their relatives to check their care continued to meet their needs.

The premises met people's needs in relation to their disabilities although it was not specifically adapted for people with dementia given the wide range of needs of the people using the service. The service was wheelchair accessible with spacious bedrooms and communal areas. Lifts enabled people to move between the floors of the home. The provider was in the process of framing pictures of people to place on their bedroom doors to help them recognise their rooms. However, the provider had not considered using pictures of some people when they were younger as their dementia may have meant they did not recognise themselves at their current age. The provider told us they would consider our feedback.

Good

Is the service caring?

Our findings

Staff supported people in a caring manner. One person told us, "They look after me very well. They do everything to help me." A relative said, "They are brilliant. Really lovely staff. The staff are constant more or less and having the same care workers gives continuity of care. There's a good rapport between the residents and the staff." A second relative told us, "I'm very happy as [my family member] has been settled from the day that he got here. I expected him to have trouble in getting settled in." A different relative commented, "[My family member] is always clean and cheerful." We observed when a person found their drink to be too cold staff immediately replace this with a drink which had not been in the fridge.

People's needs and preferences were understood by staff. Our discussions with staff and our observations showed they knew and understood the people they cared for. People's preference for male or female care workers was recorded in their care plans and people's preferences were respected.

Staff understood how to communicate with people. We observed staff adapted their communication depending on the person they were speaking with. When a person requested to speak with staff we observed the registered manager pulled up a chair next to them, listened intently to what they had to say and responded clearly and appropriately to their concerns. The person was experiencing pain and the registered manager made arrangements for them to be visited by their GP the same day. We observed staff communicating with a different person in writing as they had limited verbal communication and staff kept a supply of paper and pens in their room to facilitate this. The chef asked people individually which meals they would like each day. However, the service did not use pictures of food to help some people better understand and select the choices. The chef told us the use of pictures was something they would be interesting in using at the service in the future.

People's privacy and dignity were maintained by staff and people were treated with respect. We observed staff were discreet when offering and providing personal care to people, ensuring doors were shut for privacy. We observed staff addressed people by their preferred name when speaking with them and listened carefully to what people had to say. Staff took care to make the dining room visually appealing with tablecloths, placemats and small vases of flowers. We observed staff supported people to eat their meals respectfully gaining permission to assist them and informing them of what they were about to do at each stage. Staff supported people to keep their clothes clean with aprons and supported people to wipe their hands and face during their meals when necessary. Staff spoke about people respectfully and told us they enjoyed caring for people at the service. People received choice in relation to their care and were involved in decisions. For example, people were able to choose where they spent their time in the home and where they ate their meals.

Staff were allocated sufficient time to care for people in a personal way. People and relatives told us staff spent enough time interacting and conversing with people and our observations were in line with this. We observed staff speaking with people calmly and staff also told us they had sufficient time to care for people in an unhurried manner.

Requires Improvement

Is the service responsive?

Our findings

Although people received care which met their needs, care plans required improvement. A relative told us, "I have been involved in my husband's care plan." A second relative said, "The staff are very good and they did well to nurse her after [a recent illness]." People and relatives were satisfied the care met people's needs and was provided in a meaningful, not task-based way. However, one relative commented, "I wish that they would encourage [my family member] to walk more." Information in care plans was often standardised with little individualisation. Each person's care plan folder contained a summary of information about them including their backgrounds, people who were important to them and their hobbies, interests and preferences. This particular information was useful for staff to refer to in understanding more about the person. However, information to guide staff in how to care for them in a way which met their needs and preferences for each area of need was lacking. We spoke to staff and the registered manager about our concerns and it was clear that staff relied on their own knowledge of people rather than from information in the care plans. This meant there was a risk staff may provide care in inconsistent ways as staff may differ in the way they believed people preferred to receive their care. The registered manager told us they identified care plans required improvement to better reflect the best ways to care for each individual and had a plan to implement new documentation.

This forms part of the breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People received care from staff who were trained in end of life care. The provider was an accredited 'beacon care' provider of end of life care with the Gold Standard Framework and this involved staff attending regular, comprehensive training to enhance their knowledge and skills. People were encouraged to consider how they would like to receive care and the end of their lives and their relatives were also invited to contribute their views.

People were supported to maintain relationships with those that mattered to them to help reduce the risk of social isolation and loneliness. One person told us, "My family visit all the time and I have a large room to accommodate this, although we can sit in other areas if we want to." We observed visitors were welcomed throughout the day and the registered manager told us there were no restrictions on visiting hours to encourage visiting. The registered manager told us recently staff supported a person newly admitted to the home who was distressed to settle. They did this by taking them to sleep besides their partner, who was also using the service, during the night. One person was supported to attend a day centre which was an important part of their lives.

People were supported to take part in activities they were interested in, although we found improvements could be made. One person told us, "I really like to read, and the library visits and brings me a box of books. I don't really join in many things but I don't mind the entertainers." A relative told us, "[My family member] participates in activities that he's interested in." There was a structured activity programme in place and activity leads spent time engaging people in various activities through the week. In the communal lounge and conservatory people had a choice of watching TV or listening to the radio and the room lay out

accommodated these two choices well. We observed some people were engaged in individual activities such as reading newspapers and a person was using their laptop. The provider told us the activity leads engaged people in activities such as arts and crafts, board games, quizzes and bingo and photos of people engaging in recent activities were updated each month in the lounge. In addition representatives from the local church attended one day every second week to engage people in worship and activities. Entertainers were booked to perform for people and recently a youth group had visited to meet with people. However, during our inspection we observed activities to stimulate people were lacking. We observed staff did not engage people in activities as part of their day to day role when no other activities were scheduled, despite having sufficient time to do so. We fed this back to the provider as an area for improvement.

The provider's complaints policy remained suitable. A relative told us, "I've no complaints and when I have had a concern I've spoken with the manager." People and relatives were confident the provider would respond to any concerns or complaints they made. The provider told us they had not received any complaints in the past year. However, they told us about a concern a relative had raised and showed us how they had responded to this by meeting with them to discuss the issues and issuing a letter summarising the action they would take to improve.

Requires Improvement

Is the service well-led?

Our findings

The provider's quality assurance systems were not sufficiently robust. The provider's quality assurance systems meant they were not always aware of the issues we found such as those relating to risk assessments, MCA and DoLS. Because the provider's quality assurance procedures meant they had not always identified the issues themselves they had also not taken the required action to rectify them. This meant the provider lacked suitable systems to comprehensively assess and monitor the service.

This forms part of the breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The provider had sufficient quality assurance processes in place to monitor and improve other aspects of the service including recruitment, staff support and supervision including the training programme in place. The registered managed had improved the staff training programme to include monthly training using blended learning in a diverse range of topics. The registered manager also had good oversight of the quality of day to day care staff provided to people.

Leadership was visible across the service. A relative told us, "[The directors and registered manager] are all very approachable, and very visible." A second relative said, "I know who the manager and the owners are, and I can speak with them at any time." The registered manager had been in post for almost a year. They had a level 5 diploma in leadership and management and had managed similar nursing homes previously. People, relatives and staff were positive about the registered manager and told us they were accessible and supportive. The registered manager was a good role model for staff. They spent much time interacting with people and providing direct personal care and support. In addition they shared their lunchtime with people each day and their leadership was clear and visible. The two directors were also visible leaders and they told us at least one of them would be present at the service each day to maintain oversight and be accessible for people, relatives and staff. We observed the directors spent much time engaging with people and their visitors, listening to their stories and finding out more about their lives. Nursing staff were also visible role models who carried out personal care alongside care workers.

Our discussions with the registered manager showed they understood their role and responsibilities in providing quality care to people and they understood the need for improvements in the areas we found to be lacking. Feedback from people and relatives plus our discussions with staff and our observations indicated staff understood their role and worked well as team.

The provider communicated openly with people and their relatives and had an 'open-door' policy where people were encouraged to share their views or concerns at any time. The provider also gathered feedback from people and relatives during individual meetings and annual reviews led by social services. People and relatives were invited to share their views at any point by filling in satisfaction surveys available in the reception area or to post comments in the suggestions box. The provider also gathered feedback from people more informally during social events such as BBQs and during the course of day to day interactions.

The provider also communicated openly with staff and had systems to gather and review their feedback on the service. The provider held staff meetings every two months where staff were able to share best practice and raise any concerns. In addition staff received supervision every two months with their line manager. The registered manager told us they read supervision notes for every member of staff to understand any issues they may be experiencing and to note any additional training requests. The provider sent questionnaires to staff to find out more about their views and experiences and used these as part of improving 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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not always assess the risks to the health and safety of people of receiving care or treatment. Regulation 12(1)(2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not always establish systems or processes to assess, monitor and improve the quality and safety of the services provided to people. Regulation 17(1)(2)(a)