The George Edward Smart Homes

George Edward Smart Homes

Inspection report

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

Summary of findings

Overall summary

The inspection took place on 31 August, 7 September and 29 September 2017. The first day of inspection was unannounced; the second and third days of inspection were announced.

George Edward Smart Homes is registered to provide care for up to 60 people. Personal care and accommodation is provided to older people for long term, or respite care, nursing care is not provided. At the time of our inspection 51 people were using the service. The service comprises of two large buildings over two floors which are linked together

At the last inspection on 24 March 2015, we asked the provider to take action to make improvements in their assessments relating to the Mental Capacity Act and this action has been completed.

At the time of our inspection 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. We have referred to the registered manager as the manger throughout this report.

At this inspection we found the service required improvement in the domains of safe and well led, therefore required improvement overall. This is the first time the service has been rated Requires Improvement

We found a breach of regulation in relation to staffing. We found that sufficient numbers of staff were deployed during the day but night staffing levels were inadequate, particularly in the eventuality of a crisis or emergency. This was discussed with the manager who immediately implemented an additional sleep over night staff whilst a permanent position was recruited to. You can see what action we told the provider to take at the back of the full version of the report.

The manager did not have a dependency tool in place to support them to deploy staff effectively. After discussion the manager devised and implemented a dependency tool to inform them of the staffing levels required to meet people's needs.

We have made a recommendation about the provider's responsibilities in relation to good governance of risks to the people they are providing a service to.

The manager had systems in place to ensure that safe recruitment processes were followed. Disclosure and barring checks were in place and two references were obtained for all staff prior to their employment commencing.

Medicines were safely managed. People's medicine administration records (MARs) were accurate and updated by staff once people had their prescribed medicines. The manager completed audits of medicines

management to help them identify and address any errors.

Staff were well trained and had access to support. This included induction, on-going training, regular supervision and the completion of annual appraisals. This allowed staff to obtain skills and knowledge and share their personal and professional needs with their line manager.

Staff understood how to protect people from risks associated with harm and abuse. Safeguarding procedures and policies were in place and staff were aware of their responsibilities to identify and report any allegations of abuse to the local authority.

Risks to people's health and well-being were identified. Staff had access to risk assessment outcomes and guidance to support them to reduce risks and keep people safe.

People were supported to have maximum choice and control of their lives and the policies and systems in the service supported this practice. People were cared for within the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). People were involved and consulted when planning their care.

Staff respected and protected people's dignity and privacy. For example, staff knocked on doors before entry. People said staff knew them well and treated them with kindness and compassion.

Primary health care services were accessed when people's health deteriorated; the provider had good working relationships with local doctor's surgeries and the local hospice. Staff followed health professionals' guidance regarding people's specific needs. People's preferences around food and drink were respected and support was in place for people with specialist dietary requirements.

Care assessments identified people's needs. Care plans detailed how the service arranged care so people's needs were met in relation to their preferences. This supported people to maintain their health and well-being.

The manager sought people's views on the service, including the quality of care provided. The manager and the staff monitored and reviewed the quality of care through audits, spot checks, and reviews of the service. The Care Quality Commission was kept informed of incidents that occurred at the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Night time staffing levels were insufficient and posed a risk to safety and well-being in the event of an emergency. Prompt remedial action was taken and additional night staff were planned for.

New staff were vetted to make sure they were suitable to work with adults who may be vulnerable.

Staff understood how to keep people safe from abuse and report any concerns.

Where people received support with medicines this was done safely.

Is the service effective?

Good

The service worked within the principles of the Mental Capacity Act and people were encouraged and supported to make choices.

People were supported to access healthcare professional when required.

Staff were well trained and had the knowledge and skills required to perform their duties.

People were supported to maintain a healthy diet and had choices of what to eat and drink.

Is the service caring?

Good

The service was caring.

People told us they were listened to and had their choices respected.

Staff were kind and empathetic and provided support where people needed it.

People were treated with dignity and respect and their confidentiality was protected.

Where people needed palliative support staff involved the care homes team at the local hospice working proactively to support people.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed and care plans were drawn up with them to meet identified needs. Care plans were reviewed as needed.

Activities were planned by a co-ordinator and people made suggestions of activities they would like to see within the service.

Regular 'residents meetings' were held and people were confident to raise issues that mattered to them, knowing that they would be acted upon.

People knew how to make complaints and were confident that the manager would deal with any issues raised.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The manager did not have a dependency tool in place to determine safe levels of staffing required to meet people's needs.

The manager completed regular audits and checks and action plans were devised where required to maintain the smooth running of the service.

There were shortfalls in the provision of fire safety training and the provider's own written guidance such as aspects of medicines arrangements.

People told us the manager was approachable and we received consistently positive feedback.

George Edward Smart Homes

Detailed findings

Background to this inspection

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

This inspection took place on 31 August and 7 and 29 September 2017. The first day of inspection was unannounced, days two and three were announced. The inspection team comprised three inspectors and two Experts 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. The experts in this case, had experience of caring for older people and caring for people with dementia.

Before our inspection, we reviewed all the information we held about the service. We examined notifications received by the Care Quality Commission. Notifications contain information about changes, events or incidents that the provider is legally required to send us. We spoke with the local authority commissioning and safeguarding teams. We also contacted the local Healthwatch. Healthwatch are a consumer group who champion the rights of people using healthcare services.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This document had been completed prior to our visit and we used this information to inform our inspection.

During the inspection, we reviewed six people's care files, medication administration records and three staff files. We looked at a range of records relating to the management of the service. We spoke with 30 people who used the service. We spoke with six relatives and visitors of people who used the service. We also spoke with six care staff, the registered manager, the chef and domestic staff. We asked for feedback from external

professionals who were involved in supporting people who used the service. We liaised with the local fire service re staffing levels at the service.

After the inspection we met with the registered manager and the nominated individual who acted on behalf of the registered provider.

Requires Improvement

Is the service safe?

Our findings

The manager told us that the service employed 64 people of varying designations. When we spoke with people who used the service, their relatives and the staff about staffing levels the majority said that there were enough staff on duty. However, some people felt they could do with some more, especially at night time. One person told us, "There is always someone about. If you ring the buzzer they always respond to it." Another person said, "Sometimes you have to wait, but they do come."

We looked at the electronic records from the nurse call system. This detailed the time it took for staff to answer the calls for assistance. We saw calls were answered within a timescale of ten minutes with the majority answered by staff within five minutes. We observed that there were sufficient levels of staff on duty during the day to meet people's needs and we saw call bells being answered in a timely manner.

However, we considered that the provider had inadequate staffing levels in place over night to safely meet the needs of people who used the service, particularly in the event of a crisis or emergency. We took into consideration the size and layout of the building and where people who used the service were located. Also the needs and dependencies of the people who were using the service. At the time of our inspection two night staff were on duty between the hours of 22.00 hours until 07.30 hours. This was to meet the needs of 51 people, some of who had varying levels of confusion. We were advised that an on-call manager was available by telephone. We discussed our concerns with the local fire service who visited to complete a fire safety audit. They agreed that two staff on a night was insufficient to support a safe and efficient evacuation in the event of a fire.

We spoke with the dedicated night staff who told us, "First thing on a morning can be hectic. We do the tea round and then the drug round. Often we are disturbed by bells ringing." Another told us, "It doesn't take much to go out of kilter." They explained that in the event of an emergency the on-call manager would come in to support them. However, they did raise concern that it could take up to three quarters of an hour for the manager to get to the service. When we asked the manager about this statement they disputed this fact and advised us that the on-call manager could arrive at the service within thirty minutes. The manager advised that the on-call manager had to attend the home at night on only two different occasions during the last six months. Once when someone had a fall and another time when a person, who was on end of life support, needed higher levels of support than could be provided by two staff.

We needed to know about the needs of people and their dependency on staff support at night. However, the manager did not complete a dependency level assessment of the people who used the service. This assessment tool determines how many staff should be on duty at different points over a 24-hour period.

We discussed our concerns with the manager who implemented a plan to advertise and recruit more night staff with a view to increasing the minimum number to three. Whilst awaiting recruitment the manager arranged for a sleep over night duty person to help ensure the night safety needs of the people who used the service. We made an early recommendation that the provider implement a dependency level assessment tool to ensure safe staffing levels were regularly assessed and maintained. This tool was completed and

implemented by the manager during our inspection. The proposed arrangement to have a third waking person on night duty had not yet been implemented. when we met with the manager and one of the provider trustees on 24 October. This posed a continuing risk to people's safety which we are monitoring.

Failure to develop a systematic approach to determine the number of staff required overnight and to ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed to meet people's care needs is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. (Staffing)

People we spoke with told us they felt safe living at the service. Comments included, "I feel safe, there is always someone about", "I feel very safe. The whole thing really, the staff, the building, everything", "Everyone seems nice and polite, and that makes me feel safe" and "The care staff always make sure that all of the windows on the ground floor are closed at night, and that makes me feel safe."

Staff employed by the service had been recruited safely. A robust recruitment policy was in place. The manager followed safe recruitment practices and recruitment records were detailed. Staff were not allowed to work without a full Disclosure and Barring (DBS) check in place. The Disclosure and Barring Service helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. Full employment history, including any gaps, was sought and two references were obtained for all staff prior to their employment commencing.

The provider had policies and procedures in place to guide staff in safeguarding adults who may be vulnerable to abuse and neglect. We saw t the managers and the staff employed at the service had completed safeguarding adults training in the last year and this supported them to recognise and respond to safeguarding concerns.

The staff we spoke with demonstrated a good understanding of safeguarding procedures. They could identify different types of abuse and knew what to do if they witnessed any incidents. The service had raised no safeguarding concerns in the past 12 months.

Risk assessments were in place on people's care files. These guided staff in how to respond to people's needs and manage the risk. For example, nutrition and falls.

Where people were at risk of falls they had been referred to the appropriate health professional for further assessment to take place. We saw people were provided with tele-communicative devices such as falls pendants to alert staff in the event of a fall or emergency.

Individual Personal Emergency Evacuation Plans were in place which detailed the individual support the person needed in the event of a fire at the service and the support they would need to stay safe or to evacuate.

The service had designated 'fire safe areas' throughout and there were designated fire wardens allocated in the staff team. Staff we spoke with told us, "We have just had fire training and fire warden training." We saw there were weekly fire alarm zone checks and checks of emergency lighting and the fire extinguishers had an annual full service. The provider had arranged fire evacuation practices however, we had concerns that these had not included the night staff. We discussed this with the manager who agreed that plans would be implemented to ensure night time drills were practised.

We looked at the safety of the premises and found the home was exceptionally clean throughout, well

maintained and odour free. The manager demonstrated regular checks on equipment were completed and up to date.

Accidents were recorded in an accident book but we did not see any documented evidence that these records were audited to establish patterns and trends. The manager told us about one person, who had experienced a high number of falls, and how they had been referred to their GP for further investigations.

The provider had a medication policy in place. We found this did not include PRN (as required medicines) protocols, covert medication administration or self-administration procedures. We discussed this with the manager who agreed to update the policy to meet the National Institute for Health and Care Excellence guidelines.

We observed medicines being administered and saw people who used the service received their medicines as prescribed. Staff told us they received training to ensure they were competent to administer medicines. We saw medication was stored securely in locked trolleys. We observed that the temperature of the medicine's storage room had exceeded the recommended temperature of 25 degrees Celsius. This had occurred on seven of the 11 previous days and actions taken to reduce the temperature were not documented. The manager initiated immediate action to resolve this issue.

Good

Is the service effective?

Our findings

At our last inspection in September 2015 the provider had failed to ensure people who used its service were protected by the principles of the Mental Capacity Act 2005 (MCA). The provider had failed to assess people in accordance with the MCA when they lacked the mental capacity to make decisions for themselves. This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. It requires that as far as possible people make their own decisions and are helped to do so when needed. Where people lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was now working within the principles of the MCA. We found significant improvements had been made to the consideration of people's capacity to consent. We saw mental capacity assessments had been completed and best interest decisions had been made where people lacked the capacity to make decisions for themselves. A relative told us, "When my [relative] started to wander, we went through the DoLS process. It was well thought out and approached with care and sensitivity. My [relative] was consulted and their opinion was sought on a regular basis. My [relative's] needs were a priority."

People were actively encouraged and supported to make decisions and people had choice and control over their daily routines. At the time of our inspection three people who used the service were subject to DoLS. The majority of people had the mental capacity to make informed decisions about their care and support and they had signed their own care plans.

People had access to health professionals when they needed medical support. People's care records identified that doctors, opticians, district nursing staff, chiropodists and the hospice care at home team were involved in their care. During our inspection we saw community health professionals visiting people at the service. A district nurse who visited daily told us, "We have good working relationships with the management and staff. It's a very open culture and everybody works really well."

We observed people receiving effective care from skilled and knowledgeable staff. Staff we spoke with told us they had an induction when they started work at the service. This covered practical areas as well as areas of knowledge that the staff required. In addition, staff worked alongside more experienced members of staff. Staff knew people well; we saw they had received training in a wide range of subjects. These included first aid, fire warden and fire drill and medication administration.

Plans were in place to provide staff with further training. This included falls awareness and advanced

palliative care. The manager had a training matrix in place which gave them an overview of the training that staff had completed and when refresher training was due. This helped to ensure that the knowledge of the staff team was up to date.

Staff told us they were not afraid to ask for training and they told us training was updated every year. One staff member said, "People get the support they need. I have just had fire and fire warden training." A relative told us, "It's a good team here. They all know what they're doing." Another relative said, "They are a highly trained team. They [the staff] are skilled at dealing with pressure and unexpected situations and extremely well led by the management team."

Staff had regular supervision sessions and an appraisal was completed annually. We looked at three staff files and saw evidence of staff supervision being completed every two to six months. The supervision records on each file contained details such as strengths, challenges and tasks to be completed before the next meeting. One care worker said, "I have supervision every three to four months and an appraisal once a year, I feel very well supported."

People using the service had been assessed to identify specific needs around nutrition and hydration. Where people were at risk of weight loss we saw the provider assessed this risk by using the Malnutrition Universal Screening Tool (MUST). MUST is used to identify adults who are underweight and at risk of malnutrition, as well as those who are overweight.

We saw people were weighed on a regular basis. Where concerns were highlighted the provider implemented food and fluid charts. These documented people's intake. We saw support was obtained from health professionals when required and people's care plans reflected their needs in this area.

One care plan highlighted a dietary risk in the form of diabetes. It included information on how to manage the person's diabetes through healthy and regular meals. Also, what to look for in case of low or high blood sugars and in what circumstance these needed to be checked.

People we spoke with had mixed opinions on the food that was on offer in the service. Comments included, "I've been here for years and the food is A1", "The food is very good but not much choice, however they will give you something different", "It's always hot pots and things mushed together" and "The food is excellent but that might be because I don't have to make it or wash the pots. It's lovely."

People were regularly consulted about the meals that were on offer in the service. A resident's meals survey was completed within the last year, 22 people had responded. Comments included, "More mash please", "Lots of nice tea time choices, might be nice to have available at lunch", and "I would like more curries please." We found that these requests had been fulfilled. Regular resident's meetings also took place where people discussed the menu choices which were on offer and made suggestions.

We observed people throughout the day making themselves hot and cold drinks. There were drinks stations in place throughout the home where people, and their visitors, could help themselves. Drinks were also served regularly from a tea trolley.

Good

Is the service caring?

Our findings

People who used the service told us they were well cared for and they spoke positively about the service and the staff. One relative told us, "First and foremost this is a home and one my [relative] has cherished. My [relative] is loved by the staff and always made to feel deeply cared for. As a family we are warmly welcomed here by each and every staff member." Other comments included, "The staff are marvellous" and "I really like it here. We have lovely carers. I feel that I can talk to them." A relative of a person who used the service told us, "My small grandchildren actively enjoy frequent visits to their [relative] in this very home like setting. Staff go out of their way to make their visits fun. They get Easter eggs, can feed the fish, pick flowers for [relative's name], go into the chicken coop and enjoy a ' rigged tombola ' at the seasonal fairs. To them this is a nice place to come and visit."

People consistently told us they were listened to and their opinions respected. A relative of a person who used the service told us, "I feel I am able to mention any concerns I might have regarding [my relatives] well-being. I'm always listened to." Care workers were caring and courteous when dealing with people who used the service. Throughout the inspection we didn't observe anyone who was unhappy or distressed.

We observed staff supporting the people who used the service. Interactions between staff and people who used the service were meaningful and centred around the needs of the person. Care workers were gentle and unhurried in the way they supported people. All tasks were completed in a kind, caring and respectful manner. A visiting professional told us, "It's a really nice, friendly home. The staff are all very professional, they treat the residents with dignity and respect, they are very personable and very caring."

Care workers and other staff deployed throughout the service anticipated and responded quickly to people who required support. We observed an interaction between the maintenance worker and someone who used the service in the entrance to the home. This person was using a wheeled walker which had a squeaky wheel. The maintenance worker approached with a can of lubricant and asked respectfully and cheerily if they could assist. This task was completed in a caring and supportive way and the interaction was natural, friendly and jovial.

It was evident that care workers knew the people they supported well and were aware of each person's needs and preferences. For example, a care worker who was serving mid-morning drinks knew each person's preferred choice. They ensured that people with manual dexterity issues had their drinks served in a cup with handles on it. They also added cold milk so the drink wasn't too hot and changed a drink for a person who had changed their mind after ordering their beverage. People who used the service told us, "The staff are very good, I have no problems with anything" and "I really like it here. We have lovely carer's, I can talk to them."

People who used the service were involved in all aspects of life at the home. Regular 'residents meetings' were held and people told us they were able to have their say on matters that affected them. We observed a 'residents meeting' which was held during the inspection. The meeting was well attended with 18 people who used the service, four staff and the chairman of the board of trustees.

It was evident from our observations that people were confident to participate and raise matters which were important to them. We witnessed very positive interactions between staff and the people who lived at the service. People voiced their opinions and entered into meaningful debates about the topics raised. The chair of the meeting responded appropriately and respectfully to suggestions made and provided explanations in response to people's queries.

Where people required support to enable them to participate in the meeting we saw they were provided with it. During the meeting we observed a care worker supporting a person with a hearing impairment to understand the proceedings. After the meeting person told us, "I have difficulty with my hearing and I don't always catch what people are saying. The carers are very good though. They come to my room afterwards and tell me all about what was discussed and we always get written minutes."

People told us the staff were polite, treated them with respect and provided care and support which maintained their privacy and dignity. Staff demonstrated this by knocking on people's doors before entering. We also observed staff ensured sensitive conversations were not overheard by others who used the service. We saw people had 'do not disturb' signs provided for their bed room doors for when they wanted privacy or when they were engaging in personal care tasks. One person said, "They [the staff] always knock before they come in." A visiting professional told us, "Staff are always respectful. During my visits, I have seen the staff covering people over when supporting with personal care to ensure their privacy and dignity is maintained. I'd put my grandma in here."

The provider had a policy and procedure for promoting equality and diversity within the service. Discussion with staff indicated they had received training on this subject and understood how it related to their working role. People told us staff treated them on an equal basis and we saw that equality and diversity information such as gender, race, religion, nationality and sexual orientation were recorded in the care files.

The manager understood the role of advocacy and had contact details available if anyone who used the service required the support of an independent advocate. An advocate is someone who supports people, particularly those who are most vulnerable in society, to ensure that their voice is heard on issues that are important to them.

The provider took into consideration people's preferences and choices for their end of life care. Where people wanted this planning in place we saw that their choices were recorded and this was reviewed in accordance with their wishes. People, and their families, were involved in the development of a care plan which detailed their wishes in relation to palliative care where this was appropriate. A visiting professional told us, "Where possible the service respects the choices of where people want to be at the end of life. They build up good relationships with families where people lack the capacity to be consulted."

The staff accessed training and sought professional advice from palliative care nurses from the local hospice care home support team when this was required. A visiting professional told us, "The staff recognise the signs of deterioration and they would ring for advice, which would always be acted upon."

Good

Is the service responsive?

Our findings

People who used the service told us they received care that was personalised to their needs and preferences. One person told us, "I can do what I want when I want, there are no restrictions here. I can please myself." A visiting professional told us, "The staff really respect the choices of the residents. I have found that they take suggestions on board and they make changes for the residents."

We saw that the staff worked in a person-centred enabling manner, which took into account people's independent abilities and offered support when they needed it. For example, some of the people who used the service joined in on excursions in the mini-bus and were supported by staff whilst others were very independent and kept their cars on site. They were able to leave and return to the service at times of their choosing. The only proviso was that they signed in and out. This was to ensure their safety and also to take account of who was in the building in the event of an emergency such as a fire.

One person told us, "It gives you a degree of freedom to come and go." Another person told us on one occasion they had forgotten to sign out of the building. They told us the staff were concerned and had made efforts to establish their whereabouts. This had helped the person to realise that it was essential the signing in and out system was used.

We looked at the care files of six people who lived at the service. Prior to being admitted people's needs had been assessed and their level of care was established by the provider before being offered a place. This ensured people's needs could be met before they were offered residency within the service. The information gathered at this assessment was then used to devise the person's individualised care plan.

People told us they were consulted about their care needs and relatives said they were involved in the assessment process. One relative told us, "Before admission my [relative] was consulted about their care needs. My [relative's] opinion is sought on a regular basis, this is reviewed regularly and they [the staff] ensure that my [relative's] care plan still meets their needs."

Care plans were detailed and contained person centred information which reflected people's individual needs and how these needs were to be met. For example, one care plan stated, "I prefer to have a bowl of water brought to me in my room. I don't feel safe sat at the stool at the sink and I cannot stand for any length of time." Another care plan said, "I do not wish to join in the daily activities. However I would like to be informed if the activity is something that I have expressed an interest in."

The care plans contained details such as, the independent abilities of each individual, what support they needed with each task and their preferred method of delivery of care. People's care needs and their care plans were reviewed monthly and we saw that changes were made to the plan when required. It was evident that the staff on duty knew people very well and, because of this, they were able to anticipate and respond to people's needs without delay as they knew people's preferences and how they wanted to be supported.

We saw relevant specialists were contacted when required to support with care and forward planning. For

example, district nursing staff were visiting the service to apply dressings and support wound care. Another example was the day before the inspection the manager had contacted the local hospice to register a person whose condition had deteriorated. We were told by a visiting professional from the local hospice service. A relative we spoke with said, "Minor changes in [my relatives] physical and mental health are spotted quickly and reported to me or medical help sought. Equally I feel I am able to mention any concerns I might have regarding [my relatives] well-being. I am always listened to."

The service employed an activities coordinator. They planned the activities, organised trips out, and coordinated fund raising activities such as the forthcoming Macmillan coffee morning. People who used the service were encouraged to follow their interests and take part in activities, both inside and outside the service. There were varied activities on offer throughout the week with at least three activities planned at different times each day. These included scrabble, dominoes, sherry mornings, musical movements, craft, carpet bowls, flower arranging and outings in the service's mini-bus to places such as the sea-front or local shopping centre. We also saw the service recognised and met people's spiritual and cultural needs. Holy Communion and hymn singing was arranged for people who wished to participate. The service had good links with the local community. We saw that U3A (The University of the Third Age) held regular classes within the home. U3A is an international movement whose aims are the education and stimulation of mainly retired members of the community, those in their third 'age' of life.

People who used the service were involved in suggesting and planning activities which were on offer. During the 'residents meeting' suggestions were made to introduce alternative activities to the activities programme. These included, indoor golf putting , another night out to the local pub, accompanied shopping trips and more visiting speakers such as the 'hedgehog hospital' talk and the 'fishy tales' talk. One person suggested conker tournaments, they said, "It would take us back to our school days. We could be the first home to have a world championship conker tournament." These suggestions were taken on board by the activities coordinator who agreed to complete the necessary risk assessments and organise the suggested activities. We later heard the conker tournament had been a great success.

Regular 'residents meetings' were held and people told us they were able to have their say on matters that affected them. We observed a 'residents meeting' which was held during the inspection. The meeting was well attended with 18 people who used the service, four staff and the chairman of the board of trustees.

It was evident from our observations that people were confident to participate and raise matters which were important to them. We witnessed very positive interactions between staff and the people who lived at the service. People voiced their opinions and entered into meaningful debates about the topics raised. The chair of the meeting responded appropriately and respectfully to suggestions made and provided explanations in response to people's queries.

Where people required support to enable them to participate in the meeting we saw they were provided with it. During the meeting we observed a care worker supporting a person with a hearing impairment to understand the proceedings. After the meeting person told us, "I have difficulty with my hearing and I don't always catch what people are saying. The carers are very good though. They come to my room afterwards and tell me all about what was discussed and we always get written minutes."

Complaints were managed according to the provider's policy and procedure. The complaints policy was displayed on a notice board in the main entrance hall to the home. This ensured it was accessible to people who used the service and visitors. We saw one complaint had been raised with the provider in the last 12 months. We saw the manager had followed the complaints procedure. They had responded to the complainant, completed a full investigation, and apologised to the family with lessons learned documented

and cascaded to staff.

People we spoke with told us that they knew how to raise concerns and would not hesitate to complain if the need arose. One person told us, "We are encouraged to stand up and complain if we have a concern." A visiting trustee told us, "I always speak to new residents to make sure they are settling in. If any resident approaches me with a concern I try and resolve the issue for them."

We saw the provider had received a number of compliments over the past 12 months. Comments included, "Thanks to all the staff for the wonderful loving care given to my [relative]", "I have enjoyed staying here. Your kindness and friendship means so much" and "I am grateful to the nursing staff who looked after [relative's name] so tenderly."

Requires Improvement

Is the service well-led?

Our findings

George Edward Smart Homes is a charitable trust which has a board of trustees to whom the registered manager reports. The service has been registered with the Care Quality Commission (CQC) since 2010 as has the manager.

During the inspection we found there were insufficient numbers of night staff deployed to cover the service safely at night and we have covered this in more detail in the 'Safe' domain of the report. The manager did not utilise a dependency level assessment of the people who used the service. Although there was no evidence that anyone had come to any harm night staff did describe some of the difficulties encountered in such a large building overnight. The local fire officer was clear that two night staff was not enough for the number of people being cared for and posed a real risk in the event of a serious incident such as a fire.

When we discussed this with the manager they responded quickly and plans were put into place to ensure the safer running of the service. We met with the manager and one of the provider trustees to discuss staffing levels further and found them to be appreciative of our concerns. They acknowledged their role and responsibility in assessing and mitigating risks as part of their own internal governance arrangements.
We recommend that the provider review their internal systems and processes for effective assessment and mitigation of risks related to the safety and welfare of people using the service.

The manager was aware of the responsibility to report accidents, incidents and other events that occurred within the service. Notifications such as safeguarding and expected deaths had been submitted as required to ensure people were protected through sharing relevant information.

The people who used the service, visitors, staff and healthcare professionals gave positive feedback about the manager. People consistently told us the service was well-led, comments included, "I had an issue with my care plan. I raised it with the manager who was excellent, couldn't do better", "Management are easily accessible at all times. They are approachable, knowledgeable and sympathetic" and "It is an exemplary team which is well-led and in my opinion strives to make life the best it could possibly be for their residents and their families."

There was a clear management structure within the service and the manager had clear oversight over departmental managers, such as the housekeeper, and the staff team overall. It was evident the manager acted as a positive role model to staff deployed throughout the service.

We found the management team were accessible and approachable. We observed the manager and staff communicating in a way that demonstrated a transparent and open culture. Staff told us they would feel confident reporting any concerns or poor practice to the manager and felt that their views would be taken into account. One care worker told us, "The manager's door is always open, nobody is afraid to raise issues if they need to."

The quality assurance system consisted of audits, checks and questionnaires. Records showed that some

aspects of the service had been audited on a regular basis such as maintenance, repair and safety checks. However, we found audits could be developed in other areas such as audits of medication and accident reports. This was discussed with the manager and by the second day of inspection we saw that these were being developed and implemented.

Action plans had been devised by the manager to drive improvements to the service and these had time-scales for completion. For example refurbishment and modernisation plans. Policies and procedures were in place which gave guidance to staff about all practical aspects of running the service. These reflected current guidance and good practice.

Staff meetings were held monthly and we observed from the minutes that there was good attendance at these meetings. Staff told us that they were encouraged to share their views and discuss areas of concern or good practice. At the last meeting staff had been reminded about the use of terminology when supporting residents, staff rotas were discussed, the development of end of life care plans was explored and the team reviewed the needs of the people who used the service.

People who used the service had their own meetings, these were held monthly. These were used to gather their views on how the service was run and how it would better meet their needs. Questionnaires were sent out to enable people to feedback on varying aspects of the service, such as the menus. An audit and action plan of their responses to a questionnaire was displayed on the notice board in the main entrance of the building.

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 18 HSCA RA Regulations 2014 Staffing The provider failed to develop a systematic approach to determine the number of staff required to meet the needs of the people who used the service. The provider failed to ensure that sufficient numbers of suitably qualified, competent, skilled and experienced staff were deployed to meet people's care needs safely.