Crown Care IV Limited

Balmoral Court

Inspection report

Ayton Street
Newcastle Upon Tyne
Tyne And Wear
NE6 2DB

Tel: 01912652666
Website: www.crowncaregroup.co.uk

Date of inspection visit:
08 August 2016
22 August 2016
25 August 2016
03 October 2016
04 October 2016

Date of publication:
21 November 2016

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

Summary of findings

Overall summary

The inspection took place on 8, 22, 25 August and 3, 4 October 2016 and the first day was unannounced. This was the first inspection of Balmoral Court following a change in registration in February 2016 relating to the provider's brand. An earlier inspection was carried out to check the safety and welfare of people using the service following a serious incident that had occurred at the home.

Balmoral Court is a care home that provides nursing and personal care for up to 58 mainly older people who have dementia-related conditions and other mental illnesses. At the time of our inspection there were 41 people living at the home.

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

We found that the ongoing personal safety of people living at the home was not compromised. Appropriate steps were taken to safeguard people against the risks of avoidable harm and abuse. Measures were in place to reduce the risks associated with people's care and to ensure there were safe working practices.

Safety-related checks were carried out and there was improved maintenance of the building. A decorating and refurbishment programme was nearing completion and more efforts were being made to enhance the environment. Accidents and incidents were suitably reported, analysed and acted on.

New staff were properly checked and vetted before they started working with vulnerable people. There was a full staff team and enough staff to provide people with safe and consistent care. Comprehensive training had been delivered to support staff in developing their skills and enable them to provide people with effective care.

Choices of meals were offered and people were given support with eating and drinking, where needed. Nutrition was assessed and, when necessary, dietetic and other specialist advice was obtained. People were supported in meeting their physical and mental health needs and accessed a range of health care services. However, the management of medicines was not fully robust and required improvement.

The principles of mental capacity law were not always being applied to make sure people's rights were upheld. Formal processes had not been undertaken for making specific decisions about people's care and treatment where they were unable to give their consent.

People and their representatives were provided with information about the service and had opportunities to give their feedback. We observed positive interactions and good relationships between people and the staff who cared for them. This was confirmed by people and their relatives who told us staff were caring and

respectful.

Individualised care plans had been developed to guide staff on meeting people's identified needs and preferences. Care was regularly evaluated and adapted in response to any changes in a person's needs, though reviews of care to consult with people and their relatives had lapsed. A variety of activities were arranged for social stimulation and to help people be included in their local community.

The management team provided leadership and support to the staff. They were promoting an open culture in the service and aimed to work more inclusively with people, their relatives and staff. Any complaints raised were taken seriously and promptly addressed. A more structured approach was being taken to monitoring standards in the home, though this had not highlighted the shortfalls we found during the inspection. The governance arrangements needed to be improved to keep closer scrutiny of the quality and safety of the service.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to medicines management, consent and governance of the service. 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?

Requires Improvement

The service was not consistently safe. The management of people's prescribed medicines was not fully robust.

Suitable arrangements were in place to minimise risks during care delivery and safeguard people against the risk of harm and abuse.

Sufficient staff were employed to safely meet people's needs.

Is the service effective?

Requires Improvement

The service was not consistently effective. People's rights under the Mental Capacity Act 2005 were not being fully upheld.

Staff were supervised and given training relevant to the needs of the people they cared for.

People were supported to maintain their health and well-being, including good nutrition.

Is the service caring?

Good

The service was caring.

Staff were kind and caring and had formed supportive relationships with people.

People were supported to make day-to-day choices about their care.

Staff treated people with respect and protected their privacy and dignity.

Is the service responsive?

Good

The service was responsive.

Care planning was personalised to the individual's needs and the ways they preferred to be supported.

A varied activities programme was provided to prevent people

from being social isolated.

Complaints about the service were responded to appropriately.

Is the service well-led?

Requires Improvement

The service was not consistently well-led. Improved governance was needed to make sure standards at the service were consistently adhered to.

A registered manager was in post. The home had a defined management structure that provided staff with leadership and support in their roles.

Improvements had been made to areas of the service, including the upkeep of the care environment.

Balmoral Court

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 was 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.

The inspection took place on 8, 22, 25 August and 3, 4 October 2016 and the first day was unannounced. The inspection was carried out by one adult social care inspector and an expert-by-experience who attended on 4 October 2016. 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 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. We reviewed the PIR and other information we held about the service prior to our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales.

We had contact with the coroner, police and local authority safeguarding team during the course of the inspection in relation to investigation into a serious incident and subsequent death of a person who had lived at the home.

During the inspection we talked with four people living at the home and four relatives. We spoke to the registered manager, the regional manager, the managing director, the clinical lead nurse, with 10 nursing, care and ancillary staff, and two health care professionals who visited the home. We observed how staff interacted with and supported people, including during a mealtime. We looked at five people's care records, medicine records, staff recruitment and training records and a range of other records related to the management of the service.

Requires Improvement

Is the service safe?

Our findings

People and their representatives were given information in the guide to the service that informed them about security in the home and their rights to be protected from harm and abuse. None of the people we talked with expressed any concerns about the way they were treated. Their comments included, "They [staff] are nice to me", "It is the best home and staff and I love it here" and "I feel very safe here and I like it very much."

Safeguarding and whistle-blowing (exposing poor practice) policies were available in the home for staff to refer to. Records showed all staff received annual safeguarding training to refresh their knowledge about the different types of abuse which could occur and the reporting procedure. The registered manager and staff we talked with demonstrated they understood their safeguarding responsibilities. Safeguarding concerns had been promptly notified to the relevant authorities and the provider had co-operated with any subsequent investigations. The registered manager told us they would not tolerate poor practice at the home and acted on any concerns raised. For example, where the whistleblowing procedure had been invoked, they had carried out a spot check during the night, leading to disciplinary action being taken against a staff member.

There were safe systems for handling people's personal finances. Where cash was held on behalf of people for safekeeping, any transactions were suitably recorded. All entries were countersigned by a witness and, where applicable, backed by receipts. Thorough audits were conducted each month to check that people's money was being safely managed.

New staff were properly checked and vetted before they were employed to ensure they were suitable to work with vulnerable people. Application forms with details of employment history were completed and candidates were interviewed. Proof of identity, Disclosure and Barring Service (DBS) checks, and two references, including one from the last employer, had been obtained. A DBS check supports safe recruitment decisions by providing information to employers about an applicant's criminal record and whether they have been barred from working with vulnerable adults and children. Checks were maintained of qualified nurses' registrations to practice and DBS checks were repeated every three years.

The registered manager reported the home had a full team of care and ancillary staff. External agency nurses had been used whilst new nurses were in the process of being recruited. We were told the same agency nurses were requested for consistency of care. This was confirmed by an agency nurse who told us, "I'm booked well in advance and do regular shifts. It's good because I can get to know people." Existing care staff provided cover for absence and a bank care worker was also employed. The registered manager and clinical lead operated an on-call system that enabled staff to get advice or support at any time, and, where necessary, to escalate emergencies to senior management.

Staffing was calculated on a monthly basis using a tool to determine the dependency levels and numbers of people living at the home. This took account of the extent of support each person required to meet their needs and the risk factors associated with their care. At the time of our inspection, staffing was two nurses

and six to seven care workers, including seniors, throughout the day and one nurse and four care workers at night. The registered manager's hours, a proportion of the clinical lead's hours, and the activities co-ordinators' hours were in addition to these levels. Ancillary staff were employed for catering, housekeeping and laundry duties and administrative support was provided.

We observed that staff were visible on both floors of the home, worked at a steady pace, and had time to engage with people. During our visits we did not see any instances of unsafe or inappropriate care being provided. We did however receive negative comments from some people's relatives and staff we talked with about staffing at the home. These were mainly in relation to arrangements for a person who was funded for one-to-one care. It was also alleged that ancillary staff were involved in care tasks, there had been lack of staff cover during a meeting, and that staff who had left had not been replaced. We discussed these comments with the registered manager who gave us explanations and, where necessary, assurance of follow up communication with staff and relatives about the ways in which staff were deployed.

Risks to people's safety had been assessed and measures to minimise risks were linked into care planning. Areas addressed included specific health conditions, mobility, falls, nutrition, and ways of managing potentially harmful behaviours. We observed that staff were mindful of potential hazards in their day to day work. They ensured cleaning chemicals were safely stored and warning signs were put up in areas that had recently been cleaned. When a person spilled a drink this was cleaned up promptly to prevent the risk of anyone slipping. Service areas including domestic store rooms and doors to the stairwells were secured to minimise the risk of unauthorised access.

Safety policies and risk assessments relating to the environment and safe working practices were in place. An updated fire risk assessment had been completed earlier in 2016 and records were kept of routine fire safety checks and tests. During one of our visits, the fire alarm sounded and we observed that staff responded appropriately. The service had a business continuity plan for emergency circumstances and each person had a personal plan in the event of needing to be evacuated from the home which was updated monthly. Individual risk assessments, with control measures, were in place for chemicals used in the service, in line with COSHH (Control of Substances Hazardous to Health) Regulations. All staff had been trained in COSHH and housekeeping staff had signed to confirm they had read and understood the associated guidance and risk assessments.

Any accidents and incidents that occurred were reported through an electronic system. Entries were suitably recorded, stating the actions undertaken at the time and subsequently. These included referring people for health services and notifying the Care Quality Commission and local safeguarding authority. Where applicable, events had been reported under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013. The registered manager analysed accidents and incidents monthly, looking for any trends or potential safety issues. The analysis was then reviewed by the regional manager to check all necessary steps had been taken.

We observed the upkeep of the building had been improved and a rolling programme of works and refurbishment was nearing completion. To date, this had included redecoration in a number of areas and replacing windows, floorcoverings, furniture and fittings. The registered manager stated the provider responded quickly in authorising items needed for the home and to any requests for their estates team or external contractors to carry out works. They told us the service now had a skilled maintenance person who produced weekly reports on the environment. Records showed they also did a range of safety checks, including of water temperatures, window restrictors, hoists and slings, wheelchairs, bed rails and the call system. Servicing agreements were in place to make sure the home's facilities and equipment were safe and in good working order. For instance, there had recently been a deep clean of the kitchen, testing of portable

electrical appliances, and a test to rule out the presence of legionella bacteria in the water supply.

We checked the arrangements for managing people's prescribed medicines. The nurses ordered and administered medicines and we were shown evidence they were trained and had their competency assessed annually. Medicines were held securely in the treatment room and two new drugs trollies had been purchased. The administration of controlled drugs (medicines liable to misuse) was suitably recorded and subject to weekly monitoring.

We found a number of deficits in the standards of medicines management which had not been identified or acted on. Stock checks of medicines supplied in boxes and bottles, held separately to the monitored dosage system, were intermittent. The checks were not done daily, in line with the home's procedure, meaning it was difficult to determine whether stocks were accurate and corresponded to the amounts received and administered. The temperatures of the treatment room and medicines fridge were not consistently checked daily to ensure medicines were being stored within safe limits.

Insufficient information was available to give clear direction to staff about each person's individual medicines regime. This included limited or no recorded details about the methods for medicines to be given covertly (disguised in food or drinks) and for medicines prescribed on an 'as required' basis. Records did not fully support the safe administration of medicines. There were gaps in the medicine administration records where staff had omitted to sign confirming medicines had been given, or to enter codes to explain why they were not given. We concluded that the service could not demonstrate people's medicines were being managed safely.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

By the end of our inspection an external review of medicines had commenced as part of a project run by the local Clinical Commissioning Group providing support into care homes in the area. The project's medicines optimisation technician told us staff had been receptive to training delivered and had actioned the updates to medicines care plans they had requested.

Requires Improvement

Is the service effective?

Our findings

New staff were provided with an in-house and company induction and worked some shifts supernumerary to the roster, shadowing experienced staff. This was followed by completion of the Care Certificate, a standardised approach to training for new staff working in health and social care. Upon appointment, staff were given key policies relating to their duty of care and were required to verify they had read and understood the code of conduct expected of them. A new staff handbook, setting out the provider's procedures and standards, had recently been produced and was being issued to staff.

The staff we talked with were happy with the training and support they received. A newer staff member told us, "Everyone has been very supportive." Other comments included, "We always get training on the computer and about resident care. I'm also doing my NVQ (vocational qualification)" and "I'm up to date with all my training and get regular supervision."

The registered manager told us there had been an emphasis on more face-to-face training and most of the training provision during 2016 had been delivered this way. They felt the training had been well received by the staff and this was confirmed by those we spoke with. A training matrix was kept that gave an overview of the courses undertaken by the staff team. This demonstrated all staff had received mandatory training in safe working practices, such as moving and handling, fire safety, first aid and infection control. A range of other topics relevant to the needs of people living at the home had been completed. This included training in caring for people with dementia, nutrition and hydration, equality and diversity, and end of life care. Further training in ordering medicines, catheter care and urinary tract infections had been provided by members of the care home project team. Care staff were also given opportunities to study for nationally recognised care qualifications. All training, including e-learning was regularly checked by the registered manager to ensure it was up to date and, where necessary, that courses were arranged.

There was a delegated system for providing staff with bi-monthly individual supervision and annual appraisals. This ensured that staff were able to discuss their performance and training needs and were supported in their personal development. A schedule was kept which showed all staff were on course to receive supervisions and appraisals at the stated frequency. The regional manager told us sessions had been brought up to date and they continued to monitor progress during their visits to the home.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service worked within the principles of the MCA. We saw almost all staff had received updated training in the MCA and DoLS during 2016. Improved systems had been implemented for making DoLS applications and monitoring when the safeguards were due to expire. The majority of people living at the home now had DoLS in place to enable them to receive the care and treatment they required.

We observed that in practice staff sought people's permission before providing any support. However, a proactive approach had not been taken to assessing mental capacity and making decisions in people's best interests. For instance, staff had omitted to follow formal processes to authorise decisions for people who needed to be given their medicines covertly. We had raised this issue at a previous visit, but action was only taken when we highlighted it again during this inspection. Although many people had complex mental health needs, there was an absence of mental capacity assessments having been carried out with a view to making best interest decisions about specific areas of people's care. It was also evident that the number of people who had representatives with legal powers to make decisions on their behalf had not been fully established. We concluded the service was not always properly fulfilling its' responsibilities in applying the MCA to uphold the rights of people who were unable to give consent to their care and treatment.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home cared for people with cognitive impairments and staff were trained in using techniques for supporting people who had challenging or distressed behaviours. The use of restraint or excessive control were not advocated and, where necessary, a specialist challenging behaviour team was accessed for advice and support with individuals.

Where a person required one-to-one support for close supervision, this was provided in a designated area of the home, with staff being rotated at two hourly intervals. Care staff told us they had experienced a number of difficult months caring for the person, whose behaviour was unpredictable and deemed as high risk. They said this had gradually improved as they became familiar with the person and records confirmed the extent of harmful incidents had reduced. The registered manager and clinical lead acknowledged the difficulties faced and felt the person's care was now being more effectively managed.

On-going efforts were being made to enhance the care environment. Some signage was in place and doors were painted in different colours to help people find their way around and identify rooms. A number of large pictures had been purchased that we were told would form part of stimulating themed areas which were being created.

People's nutritional needs were routinely assessed and care planned. Specialist advice was sought from dieticians and speech and language therapists (SALT) where risks had been identified. For example, one person had a detailed care plan devised following an assessment by a SALT. This guided staff on providing a diabetic diet of pureed food and support with eating and drinking, including making sure the person was positioned correctly during meals and to check all food had been swallowed. It was evident the person was having an adequate food intake and was steadily gaining weight.

The chef showed us they were informed and maintained information, about people who were assessed as being nutritionally at risk. Full fat milk, cream and butter was available and we were told these were added to foods to aid calorific content. Snacks and drinks, including fortified milkshakes, were also served between meals. Special diets to meet cultural and medical requirements were catered for. A four week menu cycle with choices of meals was in place and daily preference sheets were used to record each person's choice, or any alternatives requested. Good hydration was also encouraged, with choices of hot and cold drinks being

offered, including four different flavours of fruit juices.

Medical history details had been gathered and care plans were drawn up for meeting people's physical and mental health needs. A range of health care professionals was accessed and all contact, including any advice or changes in treatment, was documented. Future decisions, such as instructions about resuscitation and emergency health care plans, were also in place for people. A relative told us, "I'm very pleased with the treatment my [family member] receives."

The registered manager felt the service was benefitting from taking part in the care home project. The aim of this was to prevent avoidable admissions to hospital and a nurse specialist from the project was assigned to the home and visited at least weekly. The nurse specialist told us the home had secured experienced nurses and felt that people were provided with good continuity of care. They described staff as actively engaging with them, seeking and acting on their advice about people's health and welfare, and working with them in a co-ordinated way.

Good

Is the service caring?

Our findings

People and their relatives were complimentary about the care provided and the staff. They told us, "The staff are nice. I get on with them all", "The staff are very caring and my [family member] is treated with dignity and respect", "They (staff) are all lovely and very caring" and "Even though [family member] can't talk, I know they are happy here and happy with the staff." A staff member we spoke to related how they took pride in their work and how much they had appreciated praise they had recently received from a person's family.

We observed good relationships between people living at the home and the staff. As staff went about their daily work they acknowledged people and often stopped to check on how they were and to have a chat. People looked comfortable in the company of staff and we saw there was warmth and good natured humour between them. For instance, one of the housekeeping staff joked and had banter with a person which set them off laughing. On another occasion, a person was tactile towards the registered manager and teased them, which was taken in good humour. Staff had a caring attitude and spoke respectfully to and about the people they supported. We observed a person being comforted and reassured by staff when they became upset, to good effect.

The staff we talked with were knowledgeable about people's needs and gave us clear accounts of the approaches they took when supporting individuals. When people were resistant to care interventions we saw staff worked flexibly, respecting their wishes and going back at a later time to check if their help would be accepted. Where more immediate support was needed, such as on two occasions when people had continence accidents, staff managed this in a sensitive and prompt way.

We observed that staff were vigilant to the dynamics between people who lived together and good at judging individuals moods. At times, they stepped in discreetly to divert and reassure people whose actions might have adverse effects on themselves or others. The registered manager felt nursing and care staff were well attuned to the needs of caring for people with behaviours which could be unpredictable. The regional manager agreed, informing us there were generally few incidents involving people being harmed by one another.

We saw that staff took measures to preserve people's privacy and dignity. They knocked on doors, whether they were open or closed, before entering a room and adjusted a person's clothing to protect their modesty. Staff had been given training in dignity and respect and advanced training was being arranged for staff who were taking on roles to champion dignity and care for people living with dementia. Three staff were taking part in a sponsored 'memory walk' organised by the Alzheimer's Society to raise awareness of people affected by dementia.

People were provided with an informative guide to the service that set out what they could expect from living at the home. This included some information about local history, people's memories of the area and details of local amenities and places of interest. Other information about the service, such as social activities and a noticeboard dedicated to promoting dignity in care, was displayed for reference. Care records were held electronically and staff were trained in data protection and confidentiality to ensure they understood

the importance of protecting people's personal information.

People and their families had opportunities to give their opinions about the service through meetings and surveys. The home accessed advocacy services, where needed, to help represent people's views and some people had Independent Mental Capacity Advocates.

Changes had been made to care practices to ensure people were better supported at peak times. For instance, medicines were no longer given during meals and two sittings at mealtimes had been introduced on the ground floor. We observed this had resulted in improved support for people who were frailer and needed assistance with eating and drinking.

The dining area had been enhanced and a staff member told us, "Sometimes if people are reluctant to eat we can tell them that we've reserved a seat at the restaurant. They're more likely to make the effort because it feels like they are eating out." We saw that staff sat with each person who needed help, offered encouragement and gave support in a dignified way. People wore aprons protecting their clothing from food spills, though one person was only given a plate guard after they had spilled food from their plate. We also noted that the table, where four people who needed support with their meals sat, was stripped bare although the other tables in the dining room were nicely set. These issues were raised with the registered manager as learning points around the mealtime experience.

People able to express their views told us they enjoyed the food and we saw there was little waste at the end of meals. One relative said they thought the standard of food had gone down and a staff member mentioned an occasion when a particular food item had run out. The head chef had been promoted to their position in recent months. They told us they appreciated being given feedback and that comments books were kept on both floors of the home specifically for this purpose.

Good

Is the service responsive?

Our findings

We observed that staff were attentive and responded appropriately to people's needs and requests. There were no occasions where we saw people being left unsupervised or having to wait for an extended time to be attended to. Routines appeared flexible and people were supported at their preferred pace and not rushed. Where able, people made choices about their individual care, such as getting up later in the morning and choosing where they spent their time.

Arrangements were made to ensure people's needs were assessed and could be met before they were admitted to the home. Thereafter a range of assessments relating to care needs, dependency and risk factors were completed, enabling individual care plans to be developed. The care plans we looked at addressed identified needs and included the person's routines and preferences. The plans were generally well-recorded, detailing how cognitive impairment and/or physical frailty impacted on the person's care and the extent of support staff would provide in meeting their needs. Good summaries were also devised which gave staff overviews of people's care.

An improved system had been introduced to make sure care plans were evaluated every month. There was evidence that care plans were adapted in response to people's changing needs. For example, where a person's health had improved and they no longer required palliative care. However, annual care reviews with people and their relatives had lapsed. The registered manager informed us they would be drawing up a schedule to make sure reviews were brought up to date.

Daily reports on people's welfare were made which fed into the handovers that took place between shift changes. This ensured staff were kept updated about significant information, such as visits by health care professionals and any changes in people's well-being.

We observed and were informed about some of the ways that people were given personalised care. We saw a staff member showed considerable sensitivity to a person's religious beliefs and background when engaging with them. Another member of staff told us they were learning key phrases in a person's primary language to enable them to communicate with one another more effectively. The registered manager related how they had bought cakes for a person to encourage them when they were refusing to eat. They had also spent time sharing music that another person liked from their smartphone.

Records showed that information about people's life history, personality and social interests had been gathered. Families had often contributed this information to help give staff an understanding of the person's lifestyle. A newer member of staff told us they had found this information, and the summary of care needs, particularly useful in helping them to get to know the people they cared for.

The home employed two activities co-ordinators whose working hours were being adjusted to provide cover seven days a week. Weekly programmes were arranged with separate activities for the ladies and gentlemen. The current programme included crafts, board games, puzzles, a coffee morning, reminiscence, karaoke, and afternoons for films, music and pampering. There was also a regular visit from the 'sweet lady'

who provided old-fashioned confectionery for people to buy.

We talked with one of the co-ordinators who told us about other activities which had taken place, such as pet therapy and a recent session of virtual reality reminiscence. This had entailed people wearing goggles to be transported to different areas like the coast and Newcastle city centre and a retired member of the clergy had been able to 'visit' a cathedral. A nurse told us that those people who had taken part had enjoyed the session and found it stimulating. During one of our visits we observed five people taking part in a crafts session that was led with patience and enthusiasm. People produced Halloween themed cards and appeared to have enjoyed the activity.

People were able to go out locally accompanied by staff and there were monthly visits to a club for a meal, bingo, raffle and entertainment. Forthcoming events were planned including a visiting singer and raffle at Halloween, two sessions of entertainment and a pantomime in November. A Christmas fayre and party were being organised and the co-ordinator was contacting a local school for pupils to be involved.

There was a complaints procedure that people and their representatives could use if they had any concerns about their care or the service. The procedure had been highlighted for attention in the home's monthly newsletter. People and their relatives told us they would feel comfortable raising any concerns they had with the staff or registered manager. Relatives commented, "We feel we can just talk to the carers about any problems" and "I've no concerns at all." However, one relative said there had been times when they had visited and found their family member's care had not been provided in a timely way. This was relayed to the registered manager who agreed to arrange a meeting with the relative to discuss and resolve the issues raised.

Four complaints had been made during the year, each of which were appropriately documented and investigated. Where applicable, we saw complaints had led to changes in practice and the reinforcing of standards of care with staff. Compliments about the service had also been received, including thanks from a person's family for 'the warmth of your dignified and supportive care' and stating 'We regard you all equally as beacons of compassion and care'.

Requires Improvement

Is the service well-led?

Our findings

The service had an experienced registered manager who had been in post at the home since 2015. They were aware of the requirements of their registration and had ensured the Care Quality Commission (CQC) was notified of events affecting the service.

A policy on the 'duty of candour' was in place. This duty requires registered people to be open, honest and transparent with people about their care and treatment and the actions they must take when things go wrong. The policy had recently been put into practice following a serious incident that had occurred at the service. This had included co-operating with the police investigation and safeguarding process and writing to people's families to assure them about the safety in the home.

The registered manager was supported in their role by the provider's senior management team. They were supervised by the managing director and had ongoing input from the regional director who was visiting the home on a regular basis. There was a defined management and staffing structure that supported the running of the home. This included clinical, named nurse and keyworker responsibilities and 'heads of department' accountable for the standards of catering, housekeeping and social activities.

Staff were positive about the management and leadership in the service. Their comments included, "I'm confident with the new management and I've seen good improvement in the last year", "The management are great and treat all the staff the same" and "I can see a constant improvement in everything now." Staff felt able to approach the management if they had any concerns or issues they wanted to raise. They told us, "I'd speak to [registered manager] or [regional manager]" and "They're very approachable and open to new ideas. Any problems, you just go and talk to them." Many of the staff we talked with described good morale, for example, "I enjoy coming to work here" and "I love it. There's really good team work and I find the management are responsive."

The registered manager and clinical lead had held a series of 'flash meetings' with staff addressing different aspects of the service, people's welfare, contact with external professionals, and any accidents/incidents/near misses. The regional manager had also recently met with the nursing staff. Full staff meetings had however lapsed and the registered manager told us no-one had attended the meeting that had been scheduled in August 2016. We were informed a meeting was arranged for later in October 2016 to give staff of all grades an opportunity to discuss employment and practice matters.

The regional manager told us they appreciated staff involvement and were continuing to consult them about ways of developing the service. The managing director was currently reviewing methods of demonstrating how the company valued and rewarded staff and recognised best practice. A survey to obtain the views of staff was also being considered.

The registered manager reported that resident and relative meetings were not well attended. They were therefore looking at combining the next meeting with a social event and aiming to get the timing right to enable more families to come along. The last meeting, held in August 2016, showed open discussion had

taken place about changes in the staff team and improvements being made in the building. Whilst only three relatives had attended, feedback was mainly positive about confidence in the management of the home.

Monthly newsletters had been reintroduced since July 2016 to keep people and their families updated about the service and satisfaction surveys were carried out every three months. The surveys asked people's opinions about the environment, health and well-being, daily life, meals, communication and overall satisfaction. The findings were displayed in the home's entrance, set out into a 'you said, we did' format to show how they had influenced the service. We saw however, that the latest surveys had not been conducted with people's relatives to obtain their views.

A more structured approach was being taken to assessing the quality of the service. The registered manager had started to do regular, often daily 'walk arounds' to keep themselves appraised of what was happening in the home and to validate the care that people were receiving. They followed a routine, including meeting with people and staff, discussing clinical issues, sampling records, observing a mealtime and preparing for the following day's priorities. A range of monthly audits were conducted, looking at aspects of the service such as housekeeping, infection control, medicines, and accidents. The regional manager also carried out various checks on the quality of the service including observations of people's care experiences and a themed monthly audit.

However, the quality system had not been effective in identifying some of the shortfalls we found during this inspection. These related to medicines management, assessing mental capacity and making best interest decisions on behalf of people. Some elements of communication were also noted to be lacking, such as consulting people's relatives through care reviews and surveys, and clarifying that attendance was required at full staff meetings. We concluded that the governance arrangements had not been robust in monitoring compliance with the regulations relating to the quality and safety of the service.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The management told us they were aiming to consolidate improvements in the service by continuing to enhance the environment, embed quality assurance and ensure staff transferred their learning from training into everyday care practice.

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 11 HSCA RA Regulations 2014 Need for consent The provider had not acted in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice. Regulation 11 (1)(3)

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 provider had not ensured the proper and safe management of medicines. Regulation 12 (2) (g)

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 provider had not ensured that effective systems were operated to monitor and improve the quality and safety of the services provided. Regulation 17 (1)(2)(a)