Mentfade Limited

Kynance Residential 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?	**Good**

Summary of findings

Overall summary

This inspection took place on 11 and 12 February 2016 and was unannounced. The home provides accommodation for up to 32 people, including some people living with dementia care needs. There were 28 people living at the home when we visited. The home was based on two floors connected by a passenger lift; there was a good choice of communal spaces where people were able to socialise; all bedrooms had en-suite facilities.

There was a registered manager in place. 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.

People's safety was compromised in some areas as some first floor windows did not have restrictors in place to prevent people falling and fire safety checks had not been conducted since the end of November 2015.

Other risks to people were managed effectively. However, measures needed to reduce the level of risk had not always been documented, so may not have been applied consistently.

Staff did not follow legislation designed to protect people's rights and freedom or complete correct processes to help make sure decisions were only taken in the best interests of people. However, they did seek consent from people before providing care and support.

People received personalised care from staff who understood their needs and they were supported to make choices. However, this was not supported by the care planning system, which was not always personalised or up to date. The registered manager showed us a new care planning system they were introducing to address this.

People felt safe at the home. Care staff knew how to prevent, identify and report abuse, although non-care staff had not received safeguarding training.

Suitable arrangements were in place for managing medicines safely, but staff did not always record the use of topical creams or check that hand written entries on medicine records were accurate.

Whilst people received enough to eat and drink, we received mixed views about the quality and temperature of food. An extension was planned to the dining room to enhance the environment, and allow space for a food warmer, to help improve people's mealtime experience.

Feedback was sought from people and changes were made to menus and activities as a result. However, two visitors felt they were not always listened to.

People were supported by sufficient staff and the registered manager followed safe recruitment practices. Staffing levels had recently been increased in order to meet people's changing needs. Staff provided effective care; they were suitably trained and appropriately supported in their role.

People had access to healthcare services when needed. Staff enjoyed positive working relationships with external professionals, including doctors and nurses from the local surgery.

Staff treated people with kindness and compassion and formed caring relationships with them. They protected people's privacy, promoted their independence and involved them in planning the care and support they received.

Staff recognised that people's needs varied from day to day and responded effectively. People had access to a wide range of activities; these had been tailored to their individual needs and included trips to local attractions in the home's minibus.

People liked living at the home and felt it was run well. There was a clear management structure in place. Staff understood their roles, were happy in their work and worked well as a team.

There was an open and transparent culture. The registered manager encouraged staff feedback and visitors were welcomed. Quality assurance processes were in place to assess key aspects of the service. These had identified the need for an improved care planning system, which the registered manager was implementing.

We identified two breaches of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have taken at the back of the full version of the 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.

Some upper floor windows did not have restrictors in place and fire safety checks had not been completed for the previous two months.

Individual risks to people were managed effectively, although necessary measures to protect people were not always recorded. Care staff knew how to identify, prevent and report abuse, although ancillary staff had not been trained in safeguarding.

Suitable arrangements were in place to manage medicines safely, although staff did not always record the administration of topical creams or check that hand-written entries in medicine records were accurate.

They were enough staff to meet people's needs and recruitment practices were safe. Appropriate emergency arrangements were in place and information was available to support people if they had to be evacuated.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not follow legislation designed to protect people's rights and freedom.

People's nutritional and hydration needs were met. We received mixed views about the quality of the meals, although plans were in place to address this.

People received effective care and support from staff who were suitably trained and appropriately supported in their work.

People had access to healthcare services and staff enjoyed good working relationships with healthcare professionals.

Is the service caring?

Good

The service was caring.

People were cared for with kindness and compassion. Staff interacted positively with people and built caring relationships with them.

People's privacy was protected and they were treated with dignity and respect.

Staff encouraged people to remain as independent as possible and involved them in planning their care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People received personal care from staff who understood and met their needs. However, this was not supported by care plans, which were not always personalised or up to date.

Feedback was sought from people and visitors, although this was not always acted on. An appropriate complaints policy was in place and people knew how to raise a complaint.

Staff supported people to make choices and were responsive to their changing needs.

People had access to a wide range of activities which had been tailored to their individual interests.

Is the service well-led?

Good

The service was well-led.

The provider's vision, to provide a high quality service in a homely environment, was understood and shared by staff.

There was a clear management structure in place. Staff understood their roles, were motivated, and worked well as a team.

There was an open culture and visitors were welcomed at any time.

An appropriate quality assurance system was in place, which had identified the need for improvements to the care planning system.

Kynance Residential 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 took place on 11 and 12 February 2016 and was unannounced. It was conducted by two inspectors and an expert by experience in the care of older people. 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 previous inspection reports and notifications we had been sent by the provider. A notification is information about important events which the service is required to send us by law.

We spoke with nine people living at the home, three family members, a visiting doctor and a visiting community nurse. We also spoke with a director of the provider's company, the registered manager, two deputy managers, six care staff, a member of kitchen staff, a housekeeper, a cleaner and a staff member responsible for arranging social activities.

We looked at care plans and associated records for six people and records relating to the management of the service. These included staff duty records, staff training and recruitment files, records of complaints, accidents and incidents, and quality assurance records. We also observed care and support being delivered in communal areas.

The home was last inspected on 15 January 2014, when we identified no concerns

Requires Improvement

Is the service safe?

Our findings

The Health and Safety Executive (HSE) provides guidance to care home providers about the risks of people falling from windows. This recommends that control measures, such as window restrictors are fitted to windows which people could fall through and are at a height that could cause harm. The provider's risk assessment also required these to be in place. However, we found some windows, in people's bedrooms on the first floor of the home, did not have restrictors in place and could be opened fully. This put people's health and safety at risk.

The provider had a system in place to test the fire alarm, emergency lighting and automatic door closures on a regular basis. However, these tests had not been completed since the end of November 2015. We brought this to the attention of the registered manager, who told us the person responsible had retired; a new staff member was due to take over the task, but had not done so yet. The registered manager took action to ensure this was done with immediate effect. Other fire safety work, recommended by the Isle of Wight Fire and Rescue Service, had been completed. This included training staff in the use of evacuation equipment and installing additional fire doors. Further work, to increase the number of zones on the fire alarm system, was planned to be completed shortly after the inspection.

Other risks to people were managed effectively. For example, two people had fallen out of bed; in each case, staff had examined the possible cause and taken action to reduce the likelihood of further falls. This included making referrals to the falls clinic and asking doctors to review people's medicines. A contributory factor with one person's falls had been their clothing and staff had supported the person to wear clothing made of more suitable fabric. The person had also fallen in the bathroom and additional equipment had been provided to reduce this risk. Bedrails had been used to prevent another person from falling out of bed, but these had not been suitable. As a safer alternative, staff had obtained a new bed that could be lowered to the floor, together with a 'crash mat' next to the bed. This reduced the likelihood of injury if the person fell out of bed again. However, the measures taken to reduce risks to people were not always documented in their care records, so there was a risk they would not be applied consistently by all staff.

Staff knew how to minimise risks to people, although this was not always supported by information recorded in people's care plans, which was sometimes contradictory. For example, one person's care plan stated they were not at risk of developing pressure injuries, yet a tool used to formally assess this showed they were at high risk. We discussed risk management with the registered manager who showed us new care planning records they had started to introduce that would document risks, and the actions taken to reduce them, more consistently in the future.

An appropriate system was in place to assess and analyse accidents and incidents across the home and action was taken to learn lessons from them. For example, a wardrobe had fallen on to a person as it was not secured to the wall; the provider had checked all the home's furniture and secured wardrobes to walls where necessary. The registered manager had identified that lighting levels in some areas of the home were poor, and had taken action to improve this to make it easier for people to identify hazards in corridors and stairways.

People felt safe living at the home. One person told us, "At night, [staff] have a quick peep at us. It's nice to know there's someone looking after you; it makes you feel safe." Staff knew how to identify safeguarding concerns and acted on these to keep people safe. Most staff had received appropriate training and were aware of people who were at particular risk of abuse. A care staff member said, "If I thought some was [being abused], I'd go to the office; they'd want you to tell them and would take action." However, non-care staff, such as housekeepers and cleaners had not received training in safeguarding people from abuse. The registered manager agreed this was an area that could be improved.

An effective system was in place for obtaining, storing, administering and disposing of medicines received into the home. We observed part of the medicines round and saw staff followed best practice guidance by administering and recording medicines to people individually. One person self-administered their medicines; an appropriate risk assessment had been completed and they had been given a lockable cupboard to store their medicines safely. There was a clear process in place to help ensure topical creams were not used beyond their safe 'use-by' date. However, the use of topical creams was not always recorded by staff, so the provider was unable to confirm that these were always applied when needed. Also, some hand-written entries in the medication administration records (MAR) had not been double-checked by a second member of staff to make sure they were accurate; this was contrary to guidance issued by the national institute for Health and Clinical Excellence (NICE) and could lead to medicine errors.

People were supported by sufficient staff with the right skills and knowledge to meet their individual needs. One person told us, "Staff come as quickly as possible if I press my bell." Staffing levels were determined by the number of people using the service and their needs, together with feedback from people and staff. The registered manager told us people's needs had increased over the past year, so they had increased the staffing levels accordingly. An overlap between shifts was built in to the duty system to allow staff to hand over important information about people and to complete daily records of the care and support provided to people.

Clear recruitment procedures were in place to help ensure staff were suitable to work at the home. These included reference checks from previous employers and a criminal record check with the Disclosure and Barring Service (DBS). The DBS helps employers to make safer recruitment decisions. Staff confirmed this process was followed before they started working at the home.

There were arrangements in place to keep people safe in an emergency; staff understood these and knew where to access the information. Personal evacuation plans were available for all people; they included details of the support each person would need if they had to be evacuated and were kept in an accessible place. Reciprocal arrangements were in place with a neighbouring home which could be used to shelter people in an emergency.

Requires Improvement

Is the service effective?

Our findings

Most people living at the home were able to make informed decisions about the care and support they received. These people had given verbal consent, or had signed consent forms, indicating their agreement to the care and support they received. However, when people lacked the capacity to make certain decisions, staff did not always follow the Mental Capacity Act, 2005 (MCA). 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. 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 decisions made on their behalf must be in their best interests and as least restrictive as possible.

Some people living at the home had a cognitive impairment and care records showed they were not able to give valid consent to certain decisions, including the delivery of personal care, the administration of medicines, the use of bedrails and the use of alert mats to monitor their movements. Staff had therefore made these decisions on behalf of people. However, they had not documented their assessments of people's capacity to make these decisions or consultations with relevant people, such as family members, to make sure the decisions were in people's best interests. One person's relative had signed to agree to the person's care, including the use of bed rails. The person's care record stated the relative had the legal authority to make these decisions; however, the registered manager had not sought confirmation of this. Therefore, the provider was unable to show that decisions made on behalf of people had been made in their best interests.

The failure to follow the Mental Capacity Act, 2005 was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and found it was not. The registered manager had not made any applications for DoLS for people. Some people were subject to continuous supervision, for example their whereabouts was monitored throughout the day, alarm mats were in place for some people to alert staff if they moved from their chairs or their beds, and they were checked hourly at night. One person told us they would like to go for a walk outside but said staff "won't allow that". Care records showed that some people lacked the capacity to consent to these restrictions. Staff confirmed that people were not able to leave the home unaccompanied, as they said they would not be safe. They were not clear whether any DoLS authorisations were in place; some staff thought they were in place for some people, whilst other staff thought none were in place. Consequently, people were not protected from the risk of being deprived of their liberty unlawfully.

The failure to ensure people were not deprived of their liberty without lawful authority was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received mixed views from people about the quality of the food. Whilst some people were satisfied,

others said meals were not always warm or of a good quality. One person told us, "The quality of the food isn't always very good; it's too hard and dry sometimes." Another person said of the pasta bake they had at lunchtime "It wasn't cooked right." They ate very little of it, as did two other people sat at their table, but none of them was offered an alternative meal. Three other people, who chose beef casserole, told us it "tasted lovely" and said the beef was "very tender"; they each ate all of their meals. A family member told us they brought special food in for their relative when they were receiving end of life care, which was kept separately and cooked for them individually when they wanted it. Responses to a survey conducted by the provider identified on-going dissatisfaction with the food. The provider planned to address this by enlarging the dining room and introducing a food warmer to help ensure people's food was served hot.

Most people received appropriate support to eat and drink. People who needed full support to eat received their meals first and were supported on a one-to-one basis by staff that engaged with them. However, on the first day of the inspection, staffing arrangements at lunchtime were disorganised. Some people waited up to 20 minutes for their meals, which they said was "not unusual". The staff member supporting a person on a one-to-one basis was called away twice to support another person or to answer the front door, which was disruptive for the person they were supporting. Two people received their desserts around 10 minutes after finishing their main course, by which time the ice cream had half-melted and the hot dessert had started to cool.

On the second day of the inspection, staff were better organised and the atmosphere was calm. People told us they enjoyed their meals and people who needed one-to-one support received it without interruption. The family member of a person who was cared for in bed told us staff supported their relative to eat well. They said, "My relative had to be turned regularly. At mealtimes, they were always in the right position [to eat], so staff didn't have to move them more often than needed. It was absolutely outstanding how they managed it." The registered manager told us of plans to enlarge the dining room and to introduce a heated trolley to help keep meals warm and enhance the mealtime experience for people.

Drinks were available throughout the day and staff prompted people to drink often. Some people had requested, and received, alcoholic drinks at lunchtime which they clearly enjoyed. Staff monitored the food and fluid intake of people and took appropriate action if people started to lose weight. However, records were not always accurate; for example a person who ate very little of their lunch was recorded as having eaten it all and some records were not completed fully. The amount people drank was not totalled at the end of each day, so it was not always easy for staff to assess whether people had drunk enough.

People told us they received effective care and support. One person said of the staff, "They look after us very well; I've got no complaints." Another told us, "The way I'm looked after, I cannot criticise." A family member told us staff researched a particular condition their relative had in order to gain a better understanding of their care needs. They said, "The care was absolutely excellent."

Staff were knowledgeable about the needs of people and how to care for them effectively. New staff received induction training, which followed the Care Certificate. This is awarded to staff who complete a learning programme designed to enable them to provide safe and compassionate care to people. They worked alongside a more experienced member of staff until they had been assessed as competent to work unsupervised. Training for experienced staff was refreshed regularly and we saw training dates had already been set for the coming year. Most staff had obtained vocational qualifications relevant to their role or were working towards these.

Staff training was effective. For example, we saw staff supporting people to move around the home using appropriate techniques, and staff were able to communicate with people appropriately. A family member

told us, "[Staff] wanted to know the little things and the expressions that [my relative] would understand and that she would respond to. They used these and it gave her confidence." One staff member told us, "The key to dementia care is knowing the person and treating them as an individual." Another said, "People with dementia can't always express their needs, but you gradually build up a picture of them; you get to know their likes, their dislikes; how they like to dress and how they like their hair."

People were cared for by staff who were appropriately supported in their work. Staff received a range of supervisions with a manager. Supervisions provide an opportunity for managers to meet with staff, feedback on their performance, identify any concerns, offer support, and discuss training needs. The registered manager told us supervisions varied, and included group and individual sessions of supervision, depending on the need. For example, group supervisions were held to remind staff about infection control procedures following an outbreak of infection. Individual supervisions included observations of the staff member providing care to people, to check they were working in a compassionate and effective way. Staff told us they felt "supported" and "valued" by the management. One staff member said, "[Managers] ask what we think and listen to us. They tell you if you're doing something wrong, or if there's a better way to do it." All staff said they felt able to approach the registered manager for support and guidance at any time.

People were supported to access other healthcare services when needed and they were seen regularly by doctors, nurses, dentists, opticians and chiropodists. One person told us, "If you're not well, they get you a doctor." People were supported to attend outpatient appointments and clinics. A family member confirmed this and said, "If I couldn't get [my relative] to an appointment, [staff] would take her and arrange to meet me there. It worked really well." A visiting doctor told us staff had "done some amazing end of life care" and said they enjoyed "good working relationships" with staff which had enabled them to develop "excellent anticipatory care plans" for people. A community nurse told us they were satisfied with the care provided to people, and said staff were "very proactive in referring and requesting help".

Good

Is the service caring?

Our findings

People were cared for with kindness and compassion. One person said of the staff, "They're very nice; very attentive." A family member told us staff often gave their relative a kiss, which they described as "a lovely touch". Responses to a survey conducted by the provider confirmed that people felt staff were caring. Comments included: "Many caring staff at all levels"; and "Staff always appear caring, respectful, calm and friendly".

All the interactions we observed between people and staff were positive and people told us staff knew them very well. When medicines were being given, staff checked people were happy to receive them and explained what they were for. One person was eating at the time of the medicines round and the staff member offered to return later, after the person had finished their meal. A family member told us they had seen staff "singing and dancing" with their relative to a DVD. They said, "It was those little touches that made the home so good." Care plans contained information about people's backgrounds and family history. Staff used this knowledge to strike up meaningful conversations with people and helped them to reminisce.

We heard good-natured banter between people and staff, for example about the clothes they were wearing. They were clearly relaxed and comfortable in each other's company and knew how to relate to each other in a positive way. During a visit by an optician, a person was happy to try new spectacles on in the dining room. Staff helped by getting a hand mirror for the person to use and there were many comments about the colour and accessorizing of the spectacles, which other people contributed to. The person clearly enjoyed the process and the interactions with staff and other people living at the home.

Staff did not rush when providing care. When people wished to self-mobilise around the home, staff encouraged them to travel slowly and at the own pace. When using equipment to support people to move, staff checked people were ready to move, gently reminded them to lift their feet up and made sure they were comfortable throughout the process. When people were sat in arm chairs, staff knelt down to engage with them at eye level and used touch appropriately to reassure them when they became anxious.

Staff formed positive caring relationships with people. A family member told us that when their relative died, "staff knew I had no family to support me, so supported me well". They said seven members of staff attended their relative's funeral, which was "wonderful". They added: "I considered them friends as well as care providers. I miss going there." One person was often reluctant to leave their room due to a lack of confidence. When a staff member saw them in the dining room, they said, "Hello [person's name]; it's nice to see you out." They saw that the person's petticoat was showing and said, "I'll sort that out for you". The staff member placed the person at a table with people they knew and made them comfortable in their chair. The person clearly enjoyed the attention; the staff member told us they hoped this would encourage the person to socialise more often. Another staff member said, "It feels good knowing that [people] are happy."

Staff supported people to build positive relationships. Several people had formed close relationships with others living in the home. Staff were aware of these and made arrangements for these people to sit together at meal times, or engage in activities together. One person told us, they appreciated this and said, "The

same crowd go on trips [in the home's minibus], which is rather nice."

People's privacy was protected in most cases. Before entering people's rooms, staff knocked, waited for a response and sought permission from the person before going in. A quiet area was available where people could meet and talk to visitors in private. Confidential care records were kept securely and only accessed by staff authorised to view them. However, some personal information was found in communal areas, which could compromise people's privacy. For example, records of medicines people were receiving were left on top of the medicines trolley in the main corridor and details of people's nutrition and hydration needs were on a notice board in the dining room. We brought this to the attention of the registered manager who agreed to address it.

Staff treated people with dignity and respect. For example, they described practical steps they took to preserve people's dignity when providing personal care. A person confirmed this and said of the staff, "They're very discreet; they close the curtains and the door and keep me covered up."

Staff took a personalised approach to encouraging people to remain as independent as possible. For example, staff asked people where they wished to take their meals, where they wanted their drinks, and where they wished to spend their time. Two people told us they were encouraged to dress and wash themselves and that when they used the bathroom staff waited outside in case they needed help. A family member told us their relative was always asked which clothes they wanted to wear so that the colours matched.

When people moved to the home, they (and their families where appropriate) were involved in assessing, planning and agreeing the care and support they received. A family member told us, "We were always involved in discussions and reviews of [my relative's] care. When [staff] suggested they move to a room with more space for the hoist, we were consulted as to whether it would OK." Comments in care plans showed this process was on-going. Family members told us they were always kept up to date with any changes to the health of their relatives.

Requires Improvement

Is the service responsive?

Our findings

People said they received personalised care from staff who understood and met their needs well. One person told us "[Staff] know my routine. I have a call at six with a cup of tea and that starts the day. They don't immediately get you up; if you were asleep they'd leave you and if you wanted a lie-in you could have one. They give you all the help you need." A family member said, "I'm very happy with [the care] here. The activities are good and there's access to visit at any time; that's what I like."

When we spoke with staff, they demonstrated a good awareness of people's individual support needs and how they preferred to receive care and support. For example, they knew how often people liked to bathe, whether they preferred a bath or a shower, and what support they needed to dress; they knew what medicines people were taking, why they were taking them and how they liked to receive them; they understood people's individual dietary needs and where people liked to take their meals; they recognised when people's behaviour changed, for example if they became withdrawn, and knew how to respond to such changes.

However, care plans did not always support the delivery of individualised care. They provided a summary of people's needs, but did not provide comprehensive information about how each person's needs should be met and were not always up to date. For example, one person had been placed on bed rest and needed to be turned regularly to prevent pressure injuries, but this had not been documented in their care records. Staff told us the person was doubly incontinent, but a care plan was not in place for this to help make sure their continence needs were supported in an appropriate and consistent way. Other people's care plans specified the number of staff the person needed to support them with certain aspects of their care, such as mobilising, personal care or continence care, but did not explain what support was needed or how the person wished to receive it. Consequently, there was a risk people would not receive care in a consistent, personalised way. We discussed this with the registered manager who showed us a new care planning system they had started to introduce. Once completed, this would better support the delivery of personalised care to people.

Staff sought feedback from people through the use of survey forms and 'residents meetings'. People who chose not to attend the meetings were consulted on a one-to-one basis to help make sure their views were also considered. Most feedback was acted on. For example, a person highlighted that not all staff were skilled in helping people adjust their hearing aids, and we saw additional training had been organised to address this. However, a solution to concerns raised by visitors, that they were not able to identify the person in charge had not been identified; and responses to the most recent survey showed two people felt their concerns were not always listened to.

The residents meetings were used to discuss activities, menus and other changes to the home. We saw changes to the menu, suggested by people at the last meeting, had been introduced. People had also been consulted about the proposed new extension to the dining room and its possible use. The extension was being built to provide more space for people to eat and to accommodate a food warmer that would help keep food hotter, in response to complaints from people about the temperature of some meals.

There was an appropriate complaints policy in place, which was advertised in the reception area of the home. Records showed no formal complaints had been received in the past year; the registered manager told us they resolved all minor concerns as and when they arose. People knew how to make a complaint and said they would talk to the registered manager. One person said, "I know how to complain and I would if I had to."

Staff supported people to make choices. At lunchtime, people were given the choice of transferring into a dining chair or remaining in a wheelchair. They were also offered a napkin; some people declined these and their wishes were respected. People could also choose when they got up, when they went to bed, where they spent their day and which activities they took part in.

Staff were responsive to people's changing needs. For example, one person had been referred to their GP after experiencing difficulties with their continence and had had a catheter fitted. Staff were aware of how to support the person with this by encouraging good fluid intake, monitoring their output and keeping the site of the catheter clean. Another person had a condition which meant they needed to restrict their fluid intake and staff helped them achieve this in an appropriate way. Staff were aware of a person who was prone to becoming depressed; they were able to describe the early signs of this and the support they provided to the person when this occurred. They had also identified that a person was not washing regularly, so had started to encourage and prompt them to do this more often. Staff recognised that people's needs varied from day to day. For example, a staff member told us, "[One person's] needs are very varied; sometimes they need full assistance and sometimes they don't need any. You have to assess them on the day."

People told us they had access to a wide range of activities, mainly organised by an activity coordinator on weekdays. These included chair exercises, memory games, arts and crafts, music and trips to local attractions in the home's minibus. Five people went on a trip on the second day of the inspection and were clearly stimulated by the experience; when they returned, they told staff and other people all about where they had been and what they had done. A staff member had taken their young child with them, who people enjoyed interacting with; people told us this had made the trip feel like a "family outing". Another group of people had decorated some muffins and enjoyed eating them together afterwards. Other people chose to spend time in their rooms engaging in individual activities, such as reading, knitting or doing puzzles and were supported on a one-to-one basis to do this.

Good

Is the service well-led?

Our findings

People liked living at the home and felt it was well-led. One person said of the management, "They're wonderful; everything is well-organised." A family member told us, "It's a very well run home."

A director of the provider's company told us their vision was to provide a high quality service in a small, homely setting. They said, "We try to deliver the best service we can; residents are our principle focus." They supported the registered manager by visiting daily, but gave them sufficient autonomy to manage the home effectively. They said, "I have absolute confidence in [the registered manager]." Their vision was understood and shared by the staff, who were committed to maintaining a relaxed environment and were attentive to people's individual needs. People told us they enjoyed the relaxed atmosphere at the home, which they described as "very homely". The registered manager told us they intended to keep below the maximum occupancy level as this helped make the home feel more homely and allowed staff to get to know people well.

People benefitted from staff who understood their roles, were motivated, and worked well as a team. A visiting doctor confirmed this and said, "There's great teamwork; they're a good team." Comments from staff included: "I love working here. Morale is good; everyone gets on"; and "There's a very good atmosphere; we all work well together". There was a clear management structure in place, consisting of an experienced registered manager, two trainee deputy managers and four senior care staff. The registered manager told us only experienced staff who had worked at the home for a minimum of two years were permitted to work at night, as they needed to be capable of working without supervision.

There was an open and transparent culture at the home. Communication between management and staff was relaxed and open. The registered manager had an open door policy and their office was located in the centre of the home, which made it easy for people and staff to pop in and discuss concerns. The provider notified CQC of all significant events; relatives could visit at any time and were made welcome. The registered manager was aware of the need for a duty of candour policy, had sought guidance and was in the process of developing this. In order to keep up to date with current practice, the registered manager attended meetings of the local care homes association and accessed circulars distributed by them and other trade bodies. They developed links with the community through families and friends; they also supported people to access local shops, cafes and community groups using the home's minibus.

The registered manager sought feedback from staff, including through staff meetings. Staff were encouraged to make suggestions about how the service could be improved. Comments included: "[The management] like you to speak up. They look into everything [staff raise]"; "We feel valued and listened to"; and "Everyone has their say; [the registered manager] is good like that".

Audits of key aspects of the service, including care planning, medicines, infection control and the environment were conducted regularly to assess, monitor and improve the quality of service. The audits had not identified that safety checks had not been conducted for over two months. However, they had identified other improvements that were needed. For example, the registered manager had recognised that the care

planning system needed to be enhanced to make it more personalised. They had researched different formats and identified one that was suitable for the home. They were in the process of completing new care plans for each person and had recruited two deputy managers to support this work. There was also a development plan in place to enhance the environment and provide additional communal areas for people.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Staff did not follow the Mental Capacity Act, 2005 when making decisions on behalf of people who lacked capacity. Regulation 11(1)&(3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Service users were not protected from the risk of being deprived of their liberty without lawful authority. Regulation 13(1)&(5)