Care Quality Commission

Sainthill House Ltd

Sainthill House Care Home

Inspection report

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

The inspection took place on 23 and 26 October 2015 and was unannounced.

Sainthill House is registered to provide accommodation for 17 people who require nursing or personal care. The service provides care and support for up to 12 older people who may have physical and/or mental health needs at Sainthill House. The service also comprises Sainthill Cottage, attached to Sainthill House, which provides care and accommodation for up to five younger people who have a learning disability. At the time of the inspection there were five people in the cottage and 13 people in the main house, including two people attending day care.

There was a new manager in post. A registered manager application had been submitted to the Care Quality Commission but the registration process was still in progress. 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

Summary of findings

meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. Everyone was positive about the new manager, and felt they were approachable, caring, and committed to the service and the well-being of people there. Staff commented on the improvements he had made at the service and told us," "It's amazing the things that have changed for the better".

People were not always safe because the service was not consistently following safe practice around recording when giving people their prescribed creams, and staff did not always understand their role and responsibilities in relation to infection control.

The service was not fully meeting its requirements in relation to protecting people's human rights, where people lacked the mental capacity to make certain decisions about their care and welfare.

The service did not notify the Care Quality Commission of all significant events which had occurred, in line with their legal responsibilities. This meant that the Commission was unable to monitor whether the service had responded to these incidents appropriately.

People received care and support in line with their individual care plans; however some people told us they had not been involved in their development. We have made a recommendation about routinely and meaningfully involving people in decisions about their care and ensuring their details are recorded accurately.

We saw that staff promoted people's independence and treated people with dignity and respect. Written feedback from one person said," I cannot speak more highly of the care and attention I am receiving at Sainthill House; I certainly recommend it to everyone". A relative told us, "The staff couldn't look after [the person] any better. This is a home from home".

People's relatives said they were made welcome and encouraged to visit the home as often as they wished. They said the service was good at keeping them informed and involving them in decisions about their relatives care.

Staff were well supported by the provider and manager. They were undertaking a new comprehensive training programme to help them meet people's mental and physical health needs.

There were enough staff deployed to meet the diverse needs of people at the service and to care for them safely. People were engaged in a variety of activities within the home and in the community and there were sufficient numbers of staff to support people to go out regularly if they wanted to. This ensured people experienced a good quality of life.

The provider actively sought the views of people, their relatives and staff through staff and residents meetings and an 'on line' questionnaire to continuously improve the service.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

We made a recommendation about the service routinely and meaningfully involving people and their advocates in developing care plans, and ensuring their details are recorded accurately.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Some aspects of the service were not safe.

Risks were not always identified and managed in ways which kept people safe.

People were protected from abuse and avoidable harm.

There were sufficient numbers of staff to keep people safe and meet each person's individual needs.

Requires improvement

Is the service effective?

The service was not always effective.

People's rights were not always protected, because where people lacked the mental capacity to consent to aspects of their care or treatment, the service did not always act in line with current legislation and guidance.

People received effective care and support from staff with the skills to support their diverse needs.

People had access to healthcare services and received ongoing healthcare support.

Requires improvement

Is the service caring?

The service was caring.

People were treated with kindness, dignity and respect.

Staff were committed to promoting people's independence and supporting them to make choices.

People and their relatives were supported to maintain strong family relationships.

Good

Is the service responsive?

The service was not always responsive.

We have made a recommendation that people and their advocates should be routinely and meaningfully involved in developing care plans. People's details should be recorded accurately.

Care plans and risk assessments contained clear and up to date information for staff about how to understand and support people's individual needs.

People were engaged in a variety of activities within the home and in the community and there were sufficient numbers of staff to support people to go out regularly if they wanted to.

Requires improvement

Summary of findings

Is the service well-led?

Some aspects of the service were not well led.

The service did not notify the Care Quality Commission of all significant events which had occurred, in line with their legal responsibilities.

Quality Assurance systems did not always identify risks and areas for improvement.

The manager was committed to developing and improving the service for the benefit of people and staff working there.

The manager and staff at the service were well supported by the provider.

Requires improvement

Sainthill House Care 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 23 and 26 October 2015 and was unannounced. It was carried out by two inspectors and an expert-by-experience with expertise in the care of people with physical and mental health needs. 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 we reviewed the information we held about the service. This included previous inspection reports, statutory notifications (issues providers are legally required to notify us about) other data and enquiries. At the last inspection on 7 July 2014 the service was meeting essential standards of quality and safety, although it was noted that the recording of the use of prescribed creams was inconsistent.

We looked at a range of records related to the running of the service. These included staff rotas, supervision and training records, medicine records and quality monitoring audits.

We looked at the care provided to 17 people, observing how they were supported, looking at their care records and speaking with 12 of them to help us understand their experiences. We also spoke with three visitors and five staff including care staff, the manager and cleaner. Following the inspection we telephoned two people's relatives, and five health and social care professionals who supported people at Sainthill House, to ask for their views about the service and received feedback.

Requires improvement

Is the service safe?

Our findings

People at the service were not always safe. During the inspection we passed a member of staff in the corridor, carrying the uncovered bowl from a commode. This contained urine and they had no protective clothing on other than gloves. This shows that this member of staff did not understand their role in relation to infection control and hygiene, and that people were therefore at risk. The manager was aware that the prevention and control of infection was a learning need for staff. He had completed an infection control audit, organised training, identified two members of staff with responsibility for 'infection control', and provided gloves and aprons for staff to use when giving personal care.

Both the cottage and main house looked generally clean, and the cleaner talked us through the cleaning routine. We saw however, that the bath chair in an upstairs bathroom was dirty. The manager told us he was working to improve cleanliness at the home, and had recently introduced a new cleaning programme, which included tasks for the night staff. He had given them clear written guidance which stated," The night cleaning checklist is mandatory and part of the job responsibility". A health professional told us, "It's always clean".

Medicines administration records (MAR) for the application of creams and topical medication were not always being signed by staff. This meant that it was not possible to tell whether people had received this medication, or if it was effective in treating their condition.

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

The manager was working to achieve safe medicines management at the service. He had begun a comprehensive monthly audit of medication, in order to identify where improvements were needed and develop an action plan. There was a comprehensive medication management policy. Care plans supported staff to give medicines safely, for example describing what the medication looked like and what possible side effects there might be. All staff were undergoing training to be competent in administering and receiving medication. They could not give medicines until this had been completed. Two members of staff, one from the cottage and one from the main house, had been given the task of ordering and receiving medication, completing the returns, stock checks and audits. The manager gave them dedicated time for this task, which meant they could do it thoroughly with no distractions.

In the main house, staff gave people their medicine from a locked cupboard in their room, to minimise the risk of medication errors. Medicines which required additional security were kept in a locked cupboard in the office. We looked at the medicines administration records (MAR) and saw that all, apart from the MAR sheets for topical medicines, had been correctly completed with two staff signatures on the MAR sheet for controlled drugs. People confirmed they received their medication at the correct time and had access to pain relief if they needed it.

People living in the cottage had personal protection evacuation plans, which clearly described each person's risk in an emergency, such as a fire, and how to manage the situation as safely as possible. However in the main house individual fire evacuation risk assessments were on file, but unclear as to people's individual mobility and communication needs. There were photographs of people with their names and room numbers on the wall in the staff office, but no other easily accessible record. This meant, in the event of a fire, staff and the emergency services may not easily be able to find information about where people were, the safest way to move them quickly and evacuate them safely. Immediately following the inspection the manager reviewed the fire evacuation risk assessments and plans and confirmed that the information was now clear and easily accessible.

People at the service and their relatives, told us they felt safe. One person told us they felt happy and safe living in the home and all staff were really nice and caring. They told us if they weren't happy about anything, "they would soon tell the staff and they would sort it out". We observed staff spoke to people in a friendly and respectful manner and they were gentle and helpful when assisting them.

There were sufficient numbers of staff deployed to meet people's needs and to keep them safe. People told us that the call bell response time varied from, "Instantly", to, "Between five to ten minutes or less", with no difference day or night. One person was aware that they had a pressure pad beside their bed and said, "When I get out of

Requires improvement

Is the service safe?

bed the carers come instantly". Another person said, "If the carers are busy when I call they will come and tell me how long it will be before they can get to me, so I am kept informed of delays and never feel neglected".

The manager told us agency staff were never used, as bank staff were available, and he would step in and cover a shift if required. This meant that there was consistency for people living at the home, with care being provided by staff who knew them well. Health professionals were satisfied there were enough staff at the service to meet the needs of the people there.

Risks of abuse to people were minimised because the manager ensured all new staff were thoroughly checked to make sure they were suitable to work at the home. Staff recruitment records showed appropriate checks were undertaken before staff began work. Disclosure and Barring Service checks (DBS) had been requested and were present in all records. The DBS checks people's criminal history and their suitability to work with vulnerable people.

The service protected people from the risk of abuse through the provision of policies, procedures and staff training. Staff knew about the different forms of abuse, how to recognise the signs of abuse and how to report any concerns. They were aware of the service's whistleblowing policy and told us they would feel confident to use it. Staff had safeguarding training, which was updated every year. This allowed them to maintain their knowledge and awareness. The service had staff disciplinary procedures in place, and there were no disciplinary processes underway at the time of the inspection. The manager told us, "All the staff are fantastic", and that he had been able to manage any practice issues in supervision.

Care plans and risk assessments supported staff to provide safe care. For example, one person had a falls risk assessment completed. They were assessed as at medium risk of falls. Further information was then provided about how to reduce the risks such as support when using the stairs, supervision when in the kitchen and the bedroom to be kept free of clutter. When asked, staff knew about the risk and how to manage it. The care plan of someone living with dementia, who became distressed, guided staff to, "Be patient and smile. Please do not challenge [the person] and treat them with dignity and respect. When [the person] escalates, please give them time to calm down and do not attempt any care intervention".

Staff had a good understanding of the policy and procedures related to accident and incident reporting. Records were clear and showed appropriate actions had been taken. The manager audited these records, noting details like where the incident had happened, when and who was involved. This allowed them to understand any causes and identify wider risks, trends and preventative actions that might be needed to keep people safe.

There were systems in place to make sure that the premises and equipment were safe for people. Staff had received training in fire safety, and fire checks and drills were carried out in accordance with fire regulations.

The laundry was done on the premises by staff and there were systems in place to keep soiled items separate from clean laundry, which minimised the risk of cross contamination. There was a regular clinical waste collection.

Requires improvement

Is the service effective?

Our findings

The service was not always effective. People's rights were not being protected in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. (DoLS.) The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. A Supreme Court judgement on 19 March 2014 widened and clarified the definition of deprivation of liberty. If a person is subject to continuous supervision and control, is not free to leave, and lacks capacity to consent to these arrangements, they are deprived of their liberty. Some people had been referred for an assessment, but others, who met these criteria, had not yet been referred. A health professional told us that an urgent application had been made appropriately for one person, but this was out of date when they visited and the service had required prompting to re-refer. The service was therefore not meeting its requirements.

The Mental Capacity Act 2005 (MCA) provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. This ensures that their human rights are protected. The service had a detailed MCA policy, containing clear guidance for staff, however the staff we spoke with did not have an understanding of the MCA or how to apply the principles in practice.

Care plans contained consent forms related to decisions about support and care and the sharing of personal information. However, people's capacity to make these decisions had not always been assessed and documented, there was contradictory information about whether the person had the capacity to make the decision, and it was not always documented that the person and their family had been involved in the decision making process. Some people at the service had listening devices in their rooms to enable staff to monitor them because of certain risks. No formal decisions had been made that the use of these devices was in their best interests. This meant restrictive practices were in place without ensuring people's human and legal rights had been protected, although this had been rectified by the second day of the inspection.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding service users from abuse and improper treatment.

Staff had the experience, skills and attitudes to support the people living at the service. Written feedback posted on 'carehome.co.uk' said," I cannot speak more highly of the care and attention I am receiving at Sainthill House; I certainly recommend it to everyone". A relative told us, "The staff couldn't look after [the person] any better. This is a home from home".

New staff had a mentor who introduced them to people living in the home and the routines. During the first week they shadowed their mentor and completed a written induction programme covering essential areas like infection control, moving and handling, fire safety, and safeguarding. They read the home's policies and signed to say they had read and understood them. The induction period was extended if staff needed more time to complete it satisfactorily. New and existing staff were undertaking the new Care Certificate, to ensure they had the introductory skills, knowledge and behaviours needed to provide safe, high quality and compassionate care.

The manager had introduced a comprehensive mandatory training programme to help staff develop and maintain the knowledge and skills needed to support people at the service. At the time of the inspection they had recently completed medication training, and were part way through a course on safeguarding, which they told us was 'quite in depth'. Some staff were finding the amount of training a bit overwhelming, but recognised its importance in enabling them to understand and meet people's needs effectively. People at the service told us the staff were well trained and skilful when assisting them. A health professional commented, "There are some quite challenging people there at the moment. They need to be very sure that the people they have can be looked after by staff with the right skill set. Staff at the moment have the skill set to meet the needs of the people there".

Requires improvement

Is the service effective?

Staff had an annual appraisal and formal supervision every three months where they discussed their strengths, training needs and plans for the future. They told us this was very helpful.

People had sufficient to eat and drink and received a balanced diet. The menu for the week was on display on each dining table and a monthly menu was on display in some of the bedrooms visited. People were consulted to ensure that the menu reflected their likes and dislikes, and alternatives were available on the day if required. Comments included," "The food is very good, hot and tasty. I enjoy the food. I asked for a roast and we get it. If you want a snack you just have to go to the kitchen hatch and ask", and, "The food is excellent, sometimes we have fish and chips from the "chippy" and that's lovely, My other favourite is Spaghetti Bolognese and we have that. Also the puddings are lovely and we have loads of vegetables". Staff encouraged people to have sufficient fluids, and drinks were seen in all the bedrooms visited as well as in the lounge and dining room. Bowls of fresh fruit were available in both the lounge and the dining room for people to help themselves.

People said they could choose to eat in their bedrooms, the lounge or in the dining room.

We observed practice in the dining room during the lunch time period, in both the cottage and the main house. The atmosphere in both was relaxed. One person required specialist seating and equipment to enable them to eat independently. This was provided. Staff provided calm reassurance and support, asking before giving assistance, "Shall I cut up your fish?"

People were weighed every month and their nutritional status monitored regularly. The manager audited the results, which meant that any risks around nutrition could be identified and action taken. Some people with swallowing difficulties had been referred for assessment by a speech and language therapist. Staff followed the recommendations made about the consistency of their food, which supported the people to receive adequate nutrition and minimised their risk of choking.

People's health needs were monitored regularly. Two people told us they saw their doctor when they were unwell and staff supported them to do this. Care plans recorded referrals, and visits from and to other professionals, such as a community psychiatric nurse, occupational therapist and GP. Staff reported good relationships with the surgery, and that the nurses and GP responded quickly. A health professional told us, "I've been consistently impressed. I was quite worried with the change in manager, but they have settled in pretty well. The residents are quite happy and well cared for. The service has contacted the surgery appropriately and guidance has been followed".

People at the service were supported to maintain their independence by the physical environment they lived in. For example the signage in the cottage was pictorial, so it could be easily understood by people. We saw people with sufficient mobility accessing the various parts of the cottage, main house and enclosed garden independently, or with staff if they needed support. Written feedback from somebody living at the home said, "I am an outdoor person…I now love the gardens here at Sainthill and love the inside courtyard". In the cottage there was a comfortable sensory space for people to relax in. A 'memory corner' was being developed in the main house, with pictures on the wall and items for reminiscence.

Good

Is the service caring?

Our findings

People told us the service was caring. Comments included, "I can't find any faults. I don't want to go back to my flat. The girls are very kind and I am very happy here", and, "All the carers are very nice. This is a relaxed place. A good home". This view was shared by relatives, who told us, "I like the fact that I see [the person] laughing and smiling. The staff are just wonderful". One said, "The care workers are wonderful, they couldn't be any better. The manager is lovely… I am able to join them on trips out from here. All the carers are nice". A health professional agreed that the staff were, "All very nice and caring."

Staff commented, "I love working here, it's so much better than where I was before. I look on all the residents as being part of my extended family". They told us they understood the importance of getting to know people and building good relationships with them, so that they could provide care according to their individual preferences. One member of staff told us how distressed one person had been, moving into the home and saying goodbye to their family. They had, "Made [the person] a cup of tea and sat with them. We spoke about their life and where it had taken them. It helped them to feel calmer".

Staff were respectful, understanding and patient when assisting people. For example, at lunchtime one person was worried about missing some visitors, who were waiting for them to finish their dinner. Staff saw the person was anxious and asked if they would like to have their pudding in their room with their visitors, instead of the dining room.

Staff respected people's dignity and privacy. People told us they knocked on bedroom and bathroom doors before entering, and ensured doors and curtains were closed while they were being supported with personal care. They gained people's permission before providing support, "Can I put your hearing aids in?", and, "Do you want me to bring your coffee into you?" They also explained to people what was happening, for example, "We're having lunch now", which was reassuring for people with memory loss who then knew where they needed to be and why.

Staff were committed to promoting people's independence and supporting them to make choices, and people told us their choices and preferences were respected. One member of staff said, "If I was ever to be assisted to get washed and dressed, I'd hate to have just anything put on me." They told us how they would help people to choose, for example, offering them two pairs of trousers. "I give them the choice… Let them get involved". They told us they would give people a flannel and a bowl of water so that they could wash themselves, rather than have a member of staff doing everything for them.

Staff told us how they actively promoted the development of friendships between people living at the service. One member of staff said "We are lucky with the residents as they all understand each other. They are a supportive lot together. We try to help people to communicate. There are some good little rapports between residents".

People were supported to maintain ongoing relationships with their families and could see them in private if they wished. Written feedback from one relative stated," Once [the person] had moved in we could visit at any time and were always assured of a warm welcome and a cup of tea". Relatives commented that the staff welcomed them and they were often invited to stay for lunch with their relative .

Requires improvement

Is the service responsive?

Our findings

The manager told us that people and their relatives were involved in developing their care plans. However, when people were asked about their involvement, the response was varied. In the cottage some people had signed their care plans and two people were able to confirm staff talked to them about their care and what was written about them. In the main house two people told us they were aware of their care plan, but nobody said they had been involved in developing it. Comments included, "I have heard of it but have not talked about it", and, "I'm vaguely aware of such a thing but I have not discussed it". One relative told us they had been involved, and another relative told us they hadn't.

In the cottage, people's care plans were kept in their rooms, on paper, and on an audio CD. They were written in the first person. However, these were not the words of the people we spoke with, who had limited communication skills. This meant that the care plans were not person centred, and did not accurately represent the views of the person. One care plan provided accurate information about the person, but in somebody else's name. Staff confirmed this was an error.

Before moving into the home, the manager completed an assessment with people to determine whether the service was right for them and able to meet their needs. He then completed a full care plan for the person if required, leaving a duplicate in the communication book for staff to see. He had recently introduced a new care planning system and was arranging training so that staff would be able to complete the care plans. He told us that this would be a more person centred document, which would require the key worker to sit with the person and their family to record details about their history, likes and dislikes and support needs. This would help them to get to know the person and vice versa.

Care plans were divided into sections covering specific areas such as mobility, personal care, communication, and managing moods, emotions and behaviours. Each section contained an assessment about the relevant need, and guidance to support staff in providing care for the person. For example, one care plan assessed the person's behaviour, at times, could be unpredictable. It described the signs and triggers and how to manage this. Staff were able to describe this need, and we saw how they supported the person effectively when a situation arose which was an identified trigger for them. Care plans were reviewed monthly with the person and their family and by the manager and team leader every six months. Relatives said that they were informed of changes in their relative's health and communication with the home was good.

Daily records and day to day care plans were kept in a separate folder so that staff could access and update information easily. There were communication books for staff in both the cottage and the main house where information shared at the staff handover was recorded, along with any changes in people's needs. This meant staff were kept up to date.

Staff said they took time to speak with people and read their care plan, so they could understand their individual needs and how best to support them. This was essential when people were unable to communicate their needs themselves, for example due to dementia. They told us, "If someone is agitated and restless, it might mean that they need to go to the toilet. Staff will recognise this. I know that one person gets confused by the big bathroom downstairs as it has a bath and a sink as well, so not clear what it's for, so I take them to their own toilet. If you know somebody, you recognise that there is a trigger and a reason why someone is behaving in a certain way".

People told us how much they liked their bedrooms. They looked homely and comfortable, and were decorated according to the person's needs, tastes and preferences.

Activities were available at the home, planned according to people's interests and wish to participate. These included, reflexology, karaoke, 'tranquil moments', board games and jigsaw puzzles. Holy Communion was held every three weeks. There were regular trips out in the home's two minibuses, to the seaside and local places of interest, as well as for everyday activities, such as shopping for a Halloween party that was being planned. People could join in or pursue their own interests. Comments included," I like to see to the garden out the front and on Fridays I usually catch the bus to Age Concern for the day", "The staff do not impose any restrictions on me. I go out shopping whenever I like", and, "I think of myself as a "loner" but I'm encouraged to join in and I enjoy being with the other people then. I also go out with my family and hope to join the trips out".

On the afternoon of the inspection, staff were chatting with people in the lounge, playing board games with people

Requires improvement

Is the service responsive?

and giving a hand massage. One to one support was provided to people who didn't want to join in. People preferring to remain in their bedrooms said staff visited them "for a chat" from time to time as well as greeting them through their open doors when passing by. One person's activities record said, "[The person] chose to stay in their room for tranquil moments today, but I did get to have some one to one time talking with them, where they discussed what it is like to have other people doing things for them".

In the cottage, people helped with household tasks such as hoovering and taking the rubbish out. They all went out regularly, attended a social club once or twice a week and joined in with activities in the main house if they wanted to. One person did voluntary work. A relative told us, "For years [person's name] has been stuck in with no one talking to them. They are really happy there and go out most days. They tell me, "I've been here, I've been there". They love it".

The home had a clear written complaints policy and procedure directing people to contact external organisations if they were unhappy with the provider's response. People and their relatives told us they would speak to the manager, the provider or their key worker if they wanted to make a complaint, but had never done so. They were confident they would be taken seriously. Minutes of a staff meeting showed the manager had discussed a complaint raised by a member of the public, and given guidance to staff to prevent a similar situation happening again.

We recommend people and their advocates are routinely and meaningfully involved in developing care plans. People's details should be recorded accurately.

Requires improvement

Is the service well-led?

Our findings

At the time of the inspection the manager had been in post for eight weeks. He was waiting for the necessary checks to be completed so that he could be formally registered with the CQC.

The manager was working to improve the quality of care and had developed a comprehensive quality assurance system. Monthly audits were in place to monitor the care and environment at the service, looking at areas such as medication, infection control, clinical waste and end of life care. He had analysed the results and used the information to develop action plans. For example, the clinical waste audit identified a need for clinical pedal bins in the home, which were now in place. Some issues had not been picked up however, such as the lack of people's involvement in the development of care plans and the fact that medicines administration records (MAR) for the application of creams and topical medication were not always being signed by staff. We recognise that the new quality assurance system will take time to embed and anticipate that it will therefore become more effective over time.

All accidents and incidents which occurred in the home were recorded and audited; however, the service had not notified the Care Quality Commission of all significant events which had occurred, in line with their legal responsibilities. This meant that the Commission was unable to monitor whether the service had responded to these incidents correctly.

This is a breach of regulation 18 of the Health and Social Care Act 2008 (Registrations) Regulations 2009.

The manager and staff told us that the provider was very supportive and wanted the best for the home. He attended staff meetings and spent time talking with people at the service. The manager met with him every week to brief him about any developments and what action might be needed. He told us that the provider had done everything he asked for, "…like the provision of clinical bins, flooring being changed in one of the rooms, carpets washed, gardens tidied up, exterior building and windows painted. He hasn't said no to anything, I just need to explain why". However, despite this level of oversight, the provider had not recognised the issues identified during the inspection which were impacting on the effectiveness of the service.

The service invited relatives and people using the service to provide feedback using an external website, 'carehome.co.uk'. At the time of the inspection four people had posted positive comments, including, "The home is very clean and the food is very nice", and, "The care from the staff was fantastic, [the person] was always treated with dignity and respect and if they felt there was a problem the manager and staff would always listen and try and sort it out as quickly as possible". The manager was in the process of arranging the first 'Residents and Relatives' meeting at the home, where people would be able to talk about any concerns and ideas for improving the service.

All residents and relatives we spoke with could name the new manager, and said they found him to be approachable. Comments included, "The manager is always around, he pops in to see me now and again…He is getting to grips with his job, he rushes around and seems to be in a hurry to change things. The manager is very friendly and helpful".

Staff said the manager was very good, with a focus on professional development, rather than just 'learning the job'. There had been a 'big drive on training', which was mandatory. He was supportive of them in their roles. For example he had acknowledged that staff had their own lives and families, and had changed the rota so they had regular shifts, allowing them to plan ahead. He had also allocated specific roles and responsibilities to staff, which included a 'dementia lead', an 'admission liaison' person to make the transition between home and care home as smooth as possible, and a mentor to support new staff. He told us this was better for staff because, "they are empowered and not so task focused".

Some members of staff did express concern about how quickly the manager wanted to change things, although they recognised the changes were improvements. They told us he listened, communicated well and was open to ideas. He met every morning with staff from the main house and the cottage, including the cook, cleaner, care staff and maintenance person. This meant that information was shared, and issues discussed and dealt with promptly. In addition there were monthly staff meetings, with a scheduled agenda.

Staff told us there was an 'open and transparent culture' at the service. They were able to speak freely and the manager was 'always open to suggestions'. They said, "I am absolutely supported by [the manager]. He is very

Requires improvement

Is the service well-led?

proactive. I feel I can go to him at any time of the day. I can go to him with an idea or a problem…or with worries or concerns. He is very supportive personally" and, "It's amazing the things that have changed for the better. Rooms have been decorated… Horrible carpets taken up and lino put down, so it's easy to keep clean. Before certain people were put to bed at certain times. Now if they don't want to get up in the morning they don't and if they don't want to go to bed they don't. We have two minibuses now so people go out more…Everything's wonderful at the moment!"

The people at the service had a diverse range of support needs, for example some people needed support due to physical health needs, some people were living with dementia and some were people with a learning disability. A health professional commented on this and the complex needs of new people moving in. They said, "Some people can manage homes like that, but it needs to be done quite well". The manager was aware of these issues and that they might impact on the people living there, for example, some people might not understand the behaviour of people with dementia, and be disturbed by it.

The manager told us his vision for the future was to develop a service for people with dementia. His aim was, "to provide better care than everybody else". He wanted Sainthill House to "shine out from the rest of the homes in terms of care provision, quality of environment, food, activities and staff". He said, "I want this place to be like a train station in terms of activities, with people coming and going all the time. Very lively. It is happening, but it's a process. I will put all of my energy into making sure I achieve that". We saw from the minutes of staff meetings that the manager shared his vision with staff, telling them, "I feel there is a fantastic team in the cottage and house…My vision is to…put safety, compassion, dignity and privacy at the heart of our care". Further developments to the home had been planned, including the provision of lifts and joining the buildings together to create a new lounge and a sunroom.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 12 HSCA (RA) Regulations 2014 Safe care and treatment 12(2)(g) Medicines were not always being managed safely. 12(2)(h) Staff were not acting to prevent the spread of infection.

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 13(4)(d) Where a person lacked mental capacity to consent to care and treatment, the service did not always follow a best interests process in accordance with the Mental Capacity Act 2005. 13(5) The service was depriving people of their liberty for the purpose of receiving care or treatment without lawful authority.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The registered person was not ensuring notifications were made to the commission without delay as required by their registration.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.