Family Star Limited

Shirley View Nursing Home

Inspection report

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Sutton
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13 January 2017

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 11 and 13 January 2017 and was unannounced.

Shirley View is registered to provide accommodation, nursing and personal care for up to 22 people. At the time of our inspection there were 15 people using the service. There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our last comprehensive inspection on 26 January 2016 we found three breaches of regulations in relation to staffing, good governance and notifications of incidents. We carried out a follow-up inspection on 5 and 8 July 2016 and found these problems had been resolved. However, we also found the provider was in breach of the regulation in relation to safe care and treatment because fire doors were not closing properly and medicines were not always stored securely.

At this inspection, we found the provider had resolved the issue with the fire doors. However, there were still problems with medicines management. Cupboards and refrigerators used to store medicines were not kept locked, although these were kept in a lockable room. There were not always sufficient instructions for staff about when to give people certain medicines or what to do if people declined to take their medicines.

We also found that some risks were not managed adequately, including some risks presented by the home environment and some risks that were specific to individuals, such as the use of bed rails. However, there were detailed risk management plans to help staff protect people from other risks, such as those of falling or developing pressure ulcers.

The provider had checks and audits to help them monitor and improve the quality of the service, but these were not sufficiently robust as they had not identified the issues described above.

We found two breaches of regulations. We have served a requirement notice for the breach of regulations in relation to good governance. We are taking further action against the provider for a repeated failure to meet the regulation in relation to safe care and treatment. Full information about our regulatory response is added to reports after any representations and appeals have been concluded.

People had care plans covering areas where they needed care and support. However, these were not always sufficiently personalised and did not contain information on people's likes, dislikes and preferences about how they wanted their care delivered, or about how to meet people's emotional and psychological needs. Although the staff we observed appeared to know people well and we saw staff supporting people appropriately, there was still a risk that new or temporary staff would not have the information they needed to respond to people's needs.

The provider had appropriate policies and procedures in place for reporting alleged or suspected abuse. Staff were familiar with how to recognise and report abuse and people and their relatives felt they were safe at the home. There were enough staff to keep people safe and the provider carried out appropriate checks when recruiting staff to help ensure they were suitable to care for people.

Staff received the training and support they needed to do their jobs well, including specialist support in caring for people living with dementia. Staff had opportunities to learn about specific health conditions people had and to discuss good practice as a team.

Staff were aware of their duties in relation to the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). This is legislation intended to ensure that where people are unable to consent to the care and treatment they need, this is only provided in their best interests and in such a way as to ensure their rights are not compromised. Where people were able to consent, staff obtained their consent before providing care.

People received enough nutritious food and fluids to meet their needs. Staff were aware of people's specific dietary requirements. People received the support they needed to access healthcare services, including specialist healthcare providers as required. Staff monitored people's health closely to ensure they received healthcare support when they needed it. The home worked with local healthcare providers to help reduce the frequency and length of hospital admissions.

Staff spoke to people kindly and respectfully. They took time to get to know people including what was important to them. Staff helped ensure people were comfortable living in the home and provided emotional support and reassurance when people needed it.

Staff provided people with the information they needed to make choices about their care, although we recommend that the provider seek advice on how to make some information more accessible as it was written in a style that some people might find difficult to read. Staff respected people's privacy and dignity.

The provider was working to improve the provision of activities at the service. A range of culturally appropriate activities was offered to people and staff worked to protect people from the risks of social isolation and boredom.

The service had an appropriate complaints procedure and this was displayed where people could see it. The registered manager encouraged people and relatives to raise concerns and give feedback and they acted on these promptly.

There were systems in place to help ensure smooth transitions when people moved between services, particularly between the home and hospital. Staff kept up regular communication with the other service and with people's relatives to ensure information was shared as required for the benefit of the person.

The service had an open and supportive culture where people, staff and relatives felt enabled to voice their opinions and raise concerns. The provider carried out surveys and meetings to gather the views of people and their relatives and used these to help improve the service. Staff kept records and communications to a high standard, meaning information was passed efficiently within the staff team. The registered manager and staff had a good relationship with the other providers and attended regular meetings with them to discuss joint working and to share relevant information.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. The provider did not have robust enough processes to ensure medicines were stored and administered safely and some risks to people were not appropriately managed.

Staff followed appropriate procedures to keep people safe from abuse and avoidable harm.

There were enough suitable staff to care for people safely.

Is the service effective?

Good

The service was effective. Staff received adequate training and support and had opportunities to discuss current best practice in relation to their work.

Staff were aware of their duties around the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) and adhered to these.

People received a variety of nutritious food and adequate fluids to meet their needs. People were able to access healthcare services appropriate to their needs and the service worked with local healthcare providers to help avoid hospital admissions.

Is the service caring?

Good

The service was caring. Staff knew people well and treated them with kindness, compassion and respect.

Staff provided people with the information they needed to make choices about their care, although some was not as accessible as it could be.

Staff respected people's privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive. Some care plans were not sufficiently personalised to ensure that staff, particularly those who were new to the service, had the information they

needed to support people appropriately. Other care plans were more person-centred.

The provider had an appropriate complaints policy in place and encouraged people and their relatives to feed back any concerns they had.

There were systems in place to help ensure smooth transitions when people moved between services.

Is the service well-led?

Requires Improvement

The service was not always well-led. The provider used a number of checks and audits to monitor the quality of the service, but these had not identified the shortfalls in safety that we found during our inspection.

The provider actively sought feedback from people, their relatives and staff to help them monitor and improve the quality of the service. They maintained a high standard of record keeping and communication.

The service worked well with other providers and took time to discuss joint working and share relevant information with them.

Shirley View Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 11 and 13 January 2017 and was unannounced. It was carried out by one inspector. Before the inspection, we reviewed the information we held about the service. This included previous inspection reports and statutory notifications. Statutory notifications contain information the provider is required by law to send to us about significant events that take place within the service. We also reviewed the 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.

During the inspection, we spoke with three people who used the service, two relatives of people who used the service, six members of staff and two visiting healthcare professionals. We observed staff providing care to people and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We looked at three people's care plans, four staff files and other documentation relevant to the management of the service, such as maintenance records and surveys.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in July 2016 we found a breach of the regulation in relation to safe care and treatment. This was because fire doors did not close properly, putting people at risk in the event of a fire, and because medicines were not always stored securely in locked cupboards.

At this inspection, we found that the provider had arranged for all fire doors to be replaced with new doors which met relevant safety standards. However, there were still some problems with medicines management. For some people, there were no clear guidelines about when they should take certain medicines or what staff should do if they declined to take them. One person was prescribed two tablets to take each night, but records showed the person often took one tablet or none at all, with records indicating the medicine was not required. Staff explained that they monitored a specific aspect of the person's presentation to determine whether they needed the medicine and how much each night. However, there were no written guidelines to support this and as the pharmacy label for the medicine indicated only that two tablets should be taken at night, we could not be sure the person received their medicine as prescribed or that staff made consistent decisions about when they should offer it. In addition, where people were prescribed medicines to take 'as required,' there were no protocols to tell staff when they should offer the medicines.

Another person was prescribed two medicines for breathing difficulties and records showed although they took one of these medicines daily, they consistently refused the other. There was no evidence that this had been discussed with the prescriber or pharmacist to ensure it was safe for the person to miss this medicine and there were no written guidelines about what to do if the person refused their medicines.

We saw that a refrigerator and cupboard used to store medicines were left unlocked. Although these were kept in a secure clinical room, it is best practice to keep individual cupboards and refrigerators locked as this limits the number of people who are able to access them.

Staff recorded the temperatures of areas where medicines were stored daily. On the day of our inspection, a room temperature of 27°C was recorded but staff had not taken any action. Medicines should not be stored above 25°C because this can reduce or alter their effects. When we pointed this out, the member of staff administering medicines switched on a fan and recorded the action they took.

Nurses told us the registered manager assessed their competency to administer medicines through supervision and informal observations. The registered manager told us they also looked at medicines administration records (MARS) on a daily basis to check for discrepancies. We saw evidence that where staff had signed for a medicine on the wrong date, the manager had noted this and the error was corrected. However, we also found that a tablet due to be given that morning had been signed for even though it had not been given. Staff were unable to explain this discrepancy. This meant there was a risk that medicines records were not always accurate and persons checking them might believe people had taken their medicines when they had not.

We checked water temperatures from several outlets around the home. Most fell within acceptable ranges

but one shower ran cold despite being turned on full for more than five minutes. Another shower was hot enough to exceed the maximum 50°C reading on the thermometer we used. This put people at risk of serious injury from scalding. However, the registered manager arranged for a plumber to repair a faulty thermostat and the water from both outlets was running at a safe maximum temperature of 42°C by the second day of our inspection.

We noted that in some areas of the house, such as the main lounge area and a downstairs corridor, the linoleum floor covering was not adhering properly to the floor and was lumpy. This increased the risk of people tripping and falling. The registered manager told us the provider had already arranged to have the floor resurfaced and they managed the risk by making sure there were always staff available to support people.

We checked upstairs windows and found they were fitted with restrictors. However, these were not tamper-proof, were easy to disable and we found on two windows we checked that the restrictor had slipped off its catch so we were able to open the window wide enough for a person to exit from it. This meant the risk of people falling from height was not adequately managed.

We noted that where some risks were identified that were specific to individuals there were no management plans to help ensure staff knew how to reduce and manage the risks. For example, one person had an identified risk of presenting with aggressive behaviour and of refusing personal care or medicines, which could lead to neglect. There were no guidelines for staff about how they should respond to the person in these circumstances. Although we observed staff responding in a consistently calm and respectful manner to defuse the situation when the person was verbally aggressive, there was still a risk that new or temporary staff would not know how to respond because of the lack of written guidelines and this could cause the situation to escalate. We also noted that people who used bed rails did not have individual risk assessments around using these, which could mean people were at increased risk of coming to harm. This was despite records showing one person had sustained two minor injuries within a week that staff suspected were due to the person bumping their head on their bed rail. Although staff had ensured padding was later added for this person, other people who used bed rails may have continued to be at risk.

The above paragraphs show that the provider was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although some risk management plans were missing, we found that people had comprehensive management plans to protect them from the risk of developing pressure ulcers. The registered manager told us they had particular expertise in pressure ulcer management and wound care and that there had been no pressure ulcers reported at the home for some time. Staff confirmed this and demonstrated a thorough knowledge of pressure area care. People had falls risk assessments and moving and handling assessments, which were updated monthly so staff had up to date information about how to support the person to mobilise safely. We observed that staff followed these instructions when supporting people.

People and their relatives told us they had no concerns about safety. One person told us, "It feels safe here." A relative said, "[People are] very well looked after. I haven't seen anything bad." The home had policies and procedures for recognising and reporting signs of abuse and staff we spoke with were familiar with these. They used body maps to record any unexplained bruises or injuries so these could be monitored. This helped staff promptly identify and report possible abuse.

People, relatives and staff said there were enough staff to keep people safe. Rotas confirmed the home's current staffing levels were met for day and night shifts. Although the service was experiencing some

problems with staff sickness and absence, they had been able to manage this through the use of agency staff and were in the process of recruiting some new permanent staff. We observed staff interacting with people and saw there were enough staff to allow people to move freely around the communal areas of the home with staff always within easy reach. The provider operated robust recruitment procedures to help protect people from the risks of being cared for by unsuitable staff. These included criminal record checks, work history and references and proof of identification.

Good

Is the service effective?

Our findings

Staff received adequate training and support to do their jobs effectively. There was evidence that staff had one to one meetings with their supervisor every two months to discuss their progress, best practice and any training needs. Staff told us they were able to request any training they needed and there was evidence that all care staff received a variety of relevant training within the last year. We saw evidence that the home received visits from representatives from an organisation specialising in research and support for people living with dementia. This included a booklet called 'This is me' that was designed to help staff provide person-centred care to people living with dementia. The registered manager told us the organisation also provided advice, support and guidance about best practice in supporting people living with dementia. The home also had visits from an organisation specialising in education about end of life care, to provide relevant training to staff.

There was a noticeboard with information about long-term health conditions such as diabetes and dementia displayed so that staff, people and visitors were able to learn about these. We saw evidence that managers attended meetings with healthcare providers and others where they discussed best practice in nursing care, including current research, and this was passed on to staff via staff meetings.

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 home was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. People and their friends and relatives told us that staff obtained their consent before carrying out care tasks with them. One said, "[Person] sometimes refuses their medicine but staff understand they can't force anyone to take it." Relatives confirmed that the service carried out assessments to see if people had the capacity to make decisions for themselves. Staff were familiar with their duties and when to report any concerns about capacity and consent. There was evidence that processes were followed in line with the MCA and appropriate people were involved in decisions made about people's care on their behalf, such as whether an attempt should be made to resuscitate them in the event of cardiac arrest. We looked at DoLS authorisations for those who had them and found these were up to date and conditions were met.

One person said, "The food is quite good. You always get enough and plenty of drinks." Another person said, "The meals are good. I get as much to drink as I want." A relative told us the variety of food could be improved and that it occasionally came out cold, but also said "If [my relative] doesn't like something, [staff] will replace it with something else." Another told us, "They provide good meals and regular drinks." Staff gave examples of how they worked to meet people's different needs in terms of diet and nutrition. There

were sugar-free spreads and desserts for people with diabetes and the chef was aware of different food textures and consistencies that some people needed to reduce their risk of choking on food. We saw some people had drinks containing thickening agents to reduce their risk of choking on liquids. Staff recorded people's weight regularly to help ensure they noticed promptly if people were not getting enough to eat. We saw evidence that where people were not eating enough to maintain their health, or where they had lost significant amounts of weight, staff arranged referrals to appropriate services to support the person's health.

Relatives fed back that people had good access to healthcare and regularly saw doctors, dentists and other healthcare professionals. One relative said, "The doctor comes in quite quickly and they always notify us." They gave examples of how the service looked after their loved ones' long-term health conditions, for example ensuring that people with diabetes had regular foot checks and eye examinations. This was confirmed with documentary evidence and the registered manager kept a diary of healthcare visits and referrals to help ensure nobody was missed out.

The service was part of the Vanguard initiative in the London Borough of Sutton. This was a new approach to the provision of care for people in care homes designed to reduce hospital admissions, shorten hospital stays, facilitate joined-up healthcare, improve health outcomes for people and ease transitions between services. The provider was working with other health agencies to test the new approach. A visiting healthcare professional told us the care home's staff readily implemented the new model which had successfully reduced and shortened hospital admissions. Records showed that staff kept in touch with the hospital while a person was admitted, exchanged information regularly and followed the hospital's instructions for providing aftercare once the person was discharged. This included monitoring the person for pain and skin deterioration as they needed to spend more time resting than usual. Staff also recorded any changes in people's presentation that might indicate illness or ill-being, so that colleagues were aware and could monitor people's signs and symptoms.

We saw evidence that people had access to specialist healthcare providers for specific health conditions and that staff noted their advice and incorporated it into people's care plans so they received the care and support they needed. The service also used charts to record certain measures of people's health. This was a good visual aid to help staff identify if people's health and wellbeing was deteriorating and meant they were able to refer people to doctors or other healthcare professionals promptly when needed.

Good

Is the service caring?

Our findings

One person told us the home provided "good company and good care." Another said, "The staff treat us with respect. I never feel uncomfortable with them." A relative said, "Yes, [staff] treat people with respect. They have a good sense of humour." We saw throughout our inspection that staff took time to speak to people individually, often in a friendly and joking manner that helped create a pleasant atmosphere in the home. Although staff spoke to people politely and respectfully, we observed staff calling one person by their full first name despite their care plan stating that they preferred to be known by a shortened version of their name. We discussed this with the registered manager, who said they would remind staff to use people's preferred names.

There was information in people's care plans about their life history, religious beliefs and communication needs. This was designed to help staff build up positive relationships and rapport with people through an understanding of their background and how to communicate with them. We saw evidence that the registered manager spent time with relatives on a regular basis to gather information about what was important to people, to help staff build these relationships. Staff told us they felt knowing people well was an important part of providing high quality care and said they felt able to do this at the home.

Staff worked to help people feel comfortable and at home. A relative told us, "It's a homely environment, not clinical. This is like [my relative's] own house was." One person told us, "Yes, it's homely here." Another person was sitting with a realistic toy cat, which staff told us they found comforting. Staff allowed a visitor to bring a pet dog into the home, which they took round to a number of people in the communal lounge. People smiled and expressed joy when they saw the dog. We also observed staff chatting with one person and giving them the opportunity to reminisce about their late husband. The person looked happy and relaxed during the conversation.

Throughout our inspection we observed staff displaying patience and empathy in their interactions with people living with dementia, some of whom were repeating questions or presenting as disoriented in space or time. For example, we observed one person showing signs of anxiety and asking staff where they were. Staff explained calmly and kindly where they were and reminded the person that they lived here, which appeared to reassure the person. Staff told us how they knew if people were in pain, where they were not able to indicate this verbally, and told us how they responded by making them comfortable. We observed staff discreetly discussing whether one person might be in pain and what support they would offer them.

Staff helped people make choices about their care. For example, the chef had a range of pictures of different foods that they could show to people and help them make choices about what to eat. One person's relative said, "They don't force [people] to get up if they want to stay in bed." They also told us their relative had told staff they did not like particular foods and staff always respected their choices. Staff were able to tell us how they supported different people to make choices, such as by using objects of reference or showing people the things they could choose between. However, we also noticed that some information displayed in the home, such as the activities timetable and list of staff on duty, was written in cursive (joined up) handwriting that may be difficult for some people to read. This meant that although people received help in some areas,

there was a risk that they did not always have the information they needed to make some choices about their care.

We recommend that the provider seek advice on how to make information about people's choices more accessible, particularly for people living with dementia or visual impairments.

People and their relatives told us staff respected their privacy and dignity. We observed that staff did not discuss people's private information in front of other people or visitors and saw that they closed doors when providing personal care to people to maintain their privacy.

Requires Improvement

Is the service responsive?

Our findings

People's relatives and friends told us people received care that met their needs. Each person had their needs assessed and staff created care plans using information from these. However, some areas such as personal care or eating and drinking were not personalised and did not take into account people's individual preferences, likes and dislikes about how they wanted their care delivered. Some care plans stated that staff should be aware of people's likes, dislikes and preferences but because they did not specify what these were, staff who were unfamiliar with people did not have the information they needed to provide personalised care to people.

One care plan stated that the person could be "noisy for no reason," sometimes crying. This did not take into account the person's own views and experiences or the support they needed at these times, which meant there was a risk that the person's emotional and psychological needs were not met. Another person's file contained a document from their GP that stated the person had a specific mental health condition. However, this was not mentioned anywhere in their care plan and there was no information for staff about how to support the person's mental health and help them manage the condition. The person was therefore at risk of not having their needs met in this area. We discussed this with the registered manager, who told us they would review care plans where necessary.

People had detailed care plans about some areas such as diabetes, continence and pain management. This included information such as how often people needed to use the toilet and types of continence wear that they used. One person had a detailed management plan to help them reduce their smoking and the associated risks. The registered manager told us about one person who had moved into the home with a severe pressure ulcer. We saw evidence showing how staff had used a wound management plan to aid the person's recovery and by the time of our visit the ulcer had healed. This showed how staff provided personalised care to meet people's needs in some areas.

The service worked with people and their families to meet their cultural and social needs. For example, staff organised parties for Christmas and for people's birthdays. One person's relative told us, "They had a lovely barbecue in July and a nice party at Christmas." The registered manager told us they discussed diverse needs with people and their families as part of the care planning process. One relative told us a priest came in on Sundays to see their relative, which was very important to them.

One person told us "I have things to do. I like reading books, watching TV." The home employed a full-time activities co-ordinator, who told us they tailored activities to people's current interests and moods. There was an activities timetable displayed in the main lounge. Although we did not see any of the planned activities happening, we noticed the activities co-ordinator engaging different people in individual and small group activities throughout our inspection. We saw evidence that people who remained in their bedrooms during the day had regular contact with staff to help protect them from the risk of social isolation. The activities co-ordinator confirmed that they were able to engage people in their rooms with activities like gentle exercise, massage and nail painting. Records confirmed that people took part in organised activities at least three or four times a week. We also saw that staff asked people at residents' meetings about any

extra activities they would like. One person's relative told us the activities on offer were not always suitable for everyone but staff did make an effort to spend time with people. We discussed this with the registered manager, who said they had already been working on providing a greater variety of activities to suit individual needs and abilities and would continue to improve this.

People and relatives told us staff and managers were responsive to any concerns they raised. One relative said, "I can always talk to them if I have concerns and can escalate it to the director if I need to. They are responsive and sort things quickly." The service had not received any formal complaints since our last inspection, although they had received five written compliments about the standard of care and the parties organised at the home. The registered manager told us the lack of complaints may have been because they routinely encouraged feedback from people and their relatives by having regular one-to-one meetings with them. This allowed them to become aware of and respond to minor concerns before they escalated into complaints. However, the service did have a formal complaints policy in place if people needed to use it and there was a simplified version displayed in a communal part of the house. This included information on what to do if the person complaining was not satisfied with the response.

Relatives told us the staff were good at communicating with them if people went to hospital. One said, "They ring and let me know straight away if [person] goes to hospital. They are good communicators." Staff told us there had been a marked improvement in the quality of people's transitions between different services as a result of the Vanguard project. This was especially true of hospital stays, according to staff and relatives. The project included use of a special 'red bag', standardised documentation and a checklist to ensure everything people needed in hospital went with them in the bag, including relevant paperwork and information, medicines, toiletries and personal items that were important to people. Staff told us this had noticeably reduced the number of telephone calls between the home and hospital during people's admissions and had made people's transitions easier for them as they had everything they needed and ambulance and hospital staff had enough information to ensure they provided people with the personalised care they needed. The bag also helped to ensure that people's possessions did not get lost in hospital. We saw examples of information the home had obtained from the hospital when a person was discharged, such as their current medicines, a management plan for their condition and a summary of the treatment they had received.

Requires Improvement

Is the service well-led?

Our findings

The provider and registered manager carried out a number of checks and audits to help them monitor and improve the quality of the service. This included daily checks of cleanliness, fire safety activities provision and other areas. There were weekly checks of medicines administration records and monthly checks of hygiene and housekeeping. However, the checks relating to safety were not sufficiently robust to identify the problems that we found such as the shortfalls in medicines management, individual risk management and risks presented by the home environment. People were at risk of coming to harm because the provider's checks had not identified these issues.

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

One person told us, "The manager is good. I can't complain." Staff told us the manager was supportive, colleagues were friendly and the home was a pleasant place to work. Some staff mentioned the home's 'no-blame' culture, which they said facilitated openness and made them feel comfortable reporting incidents and other problems. Staff told us they were able to express their views and discuss good practice at staff meetings or, if they were unable to attend, they had opportunities to speak with the registered manager directly. Minutes from staff meetings confirmed that the staff team discussed good practice and how to improve the service, for example around how to improve caring interactions with people.

The provider encouraged feedback from people, their relatives and staff to help them assess and improve the quality of the service. The registered manager told us they did not hold many group meetings for people and their relatives because relatives had fed back that they did not find these as useful as individual meetings. We saw records of individual meetings relatives had with the registered manager. These showed relatives had the opportunity to discuss any concerns or comments they had about their loved ones' health and wellbeing and that the manager followed these up appropriately.

The provider carried out an annual survey and one was in progress at the time of our inspection with questionnaires being sent out. We looked at the survey from the previous year and noted that although most comments were positive, the provider had taken action to make improvements suggested by people and their relatives. For example, one person had commented that they would like staff to wear identity badges and by the time of our visit all staff had these.

We noted that the standard of record keeping at the home was generally good, with staff documenting the care they provided in sufficient detail for the provider to be able to use the records in care audits. However, an exception to this was some records of what people ate and drank with staff often noting "lunch" or "pudding" rather than specifying what people ate. This meant the records were not sufficiently detailed to help staff identify any trends that might indicate food intolerances or dislikes. We discussed this with the registered manager, who told us they would ask staff to make these records more specific.

There were systems in place to ensure good levels of communication within the staff team. There was a

communication book and handover records to ensure all staff received any information about changes to people's care plans, appointments or health issues that needed monitoring. The registered manager checked these regularly to ensure they were followed up where necessary and also added any information they needed to communicate to staff. Staff told us this was a useful way of ensuring consistent working.

Relatives told us the service worked well with other providers, such as healthcare services and local authorities. The registered manager told us they had a good relationship with other providers who were involved in providing care to people living at the home. They told us about a workshop they attended with commissioners to discuss caring for people whose needs challenged the service and also told us that they were able to discuss such challenges with commissioners on an ongoing basis when they needed to. We saw evidence of multi-disciplinary meetings that managers attended including the local safeguarding team, healthcare providers and Deprivation of Liberty Safeguards (DoLS) assessors. We also saw evidence that the staff had worked with a specialist home care team to support a person's health condition and that they had co-ordinated care between this team, the person's GP and a physiotherapy service to ensure that information was shared on a need-to-know basis. The registered manager kept a diary of contacts with other providers, which helped them evaluate how well they were working together.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not effectively operate systems to assess, monitor and improve the quality and safety of the service. They did not effectively assess, monitor and mitigate risks relating to the health, safety and welfare of service users. Regulation 17 (1) (2)(a)(b)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not ensure care and treatment was provided in a safe way for service users. This included assessing the risks to the health and safety of service users of receiving the care or treatment, doing all that is reasonably practicable to mitigate any such risks, ensuring that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way and the proper and safe management of medicines. Regulation 12 (1) (2)(a)(b)(d)(g)

The enforcement action we took:

We have served a warning notice against the provider and they are required to be compliant with this regulation by 17 February 2017.