

Eldercare (Halifax) Limited

St Lukes 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 

Summary of findings

Overall summary

This inspection took place on 25 October 2016 and was unannounced. We carried out our last inspection in May 2015 when we found the registered provider had breached regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which related to the premises. At this inspection we found improvements had been made in this area.

St Luke's Care Home provides accommodation for up to 34 people. The home is on one level and provides 22 single bedrooms and six double bedrooms.

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

Staffing levels were not sufficient to meet the needs of people living in the home. A dependency tool was in place, although we found this had not accurately assessed people's needs. People, relatives and staff told us there were not enough staff on shift. Following our inspection, the registered manager informed us staff levels had increased.

Systems to ensure the safe management of medicines were not fully effective. We identified gaps as the service did not have protocols for 'as and when' (PRN) required medicines and staff did not receive medication competency checks. Following our inspection we saw evidence which showed staff had their competency checked and PRN protocols were also introduced. Medicines were stored correctly and MAR charts showed people received their medicines as prescribed.

Care plans lacked person-centred detail and were not consistent with the care provided by staff. There was limited evidence of involvement from people and families in care planning. Since our inspection, the registered manager had put steps in place to address our concerns which they had identified before our inspection.

Staff knew about people's likes and dislikes and how they wanted to receive their care. Concerns were identified regarding the level of stimulation people received as activities were not regularly taking place. Following our inspection, a full schedule of activities has been introduced.

Recruitment procedures followed were found to be safe as relevant background checks had been carried out. Most risks to people had been identified, assessed and reviewed, although we found some gaps which we discussed with the registered manager. Mental capacity assessments had been completed, although these varied in quality and Deprivation of Liberty Safeguards (DoLS) authorisations and applications were monitored.

Relatives were able to visit their family members at all times and they spoke positively about the care provided by staff. Staff received support through their induction and supervisions. Staff appraisals were scheduled to take place in January 2017. We found gaps in staff training, although the registered manager had already booked staff on to courses to fulfil training needs. Team meetings had started since the registered manager joined the service and staff felt they could approach the registered manager and senior operations manager.

A number of quality management systems had been introduced by the registered manager which we found were effective as they contained evidence of actions which had been completed. Feedback through meetings and surveys was acted on. People and relatives were aware how they could complain if they were dissatisfied and systems were in place to record and respond to any concerns.

Relatives and staff felt people living in the home were safe and protected from harm. The privacy and dignity of people was well managed by staff. Relatives and staff told us people's privacy and dignity was respected.

The living environment was clean and all maintenance certificates were up-to-date. Fire safety was well managed with evidence of staff training, regular checks of equipment and personal emergency evacuation plans.

Prior to our inspection concerns had been raised about the quality of food, although during our inspection people were satisfied with their meals. Healthcare professionals were complimentary about staff who ensured people had access to healthcare when they needed this.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Staffing levels in the home were not sufficient to meet people's care needs in a timely way. The environment and cleanliness in the service had improved. Infection control was well managed.

Some gaps in the management of medicines were identified. PRN protocols and staff competency checks had not been completed. Pain assessments were not completed.

People felt safe and safeguarding notifications had been submitted. Recruitment processes were found to be safe. Risks assessments were in place and were reviewed, although some gaps were identified.

Requires Improvement 

Is the service effective?

The service was not always effective.

Staff received an appropriate induction and supervisions had taken place. Appraisals were due in January 2017. Staff training was not up-to-date, although a programme of training had been booked to address gaps.

Mental capacity assessments in care plans were of variable quality. Mental Capacity Act (MCA) training had been booked. People told us staff ensured they were given choices about their care.

People were supported to access healthcare services. Healthcare professionals were complimentary about the service. People spoke positively about the food.

Requires Improvement 

Is the service caring?

The service was caring.

Staff demonstrated they had the necessary attitudes and values to provide kind, compassionate care. Staff were familiar with people's care preferences.

Good 

Staff knew how to protect people's privacy and dignity and relatives confirmed this happened.

Is the service responsive?

The service was not always responsive.

People did not receive regular stimulation through the registered provider's programme of activities. Staff did not have enough time to provide this support.

People's care plans were not person-centred and were not always consistent with people's care needs. There was a lack of evidence to show people had been involved in care planning.

Complaints were appropriately managed.

Requires Improvement ●

Is the service well-led?

The service not always well-led.

The registered manager had introduced several audits which were effective. Feedback through meetings and surveys was acted on.

Staff were complimentary about the registered manager and acknowledged improvements had been made since they arrived.

Requires Improvement ●

St Lukes 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 25 October 2016 and was unannounced. The inspection team consisted of two adult social care inspectors and an expert by experience with a background in care for 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.

At the time of this inspection there were 23 people living at St Luke's. We spoke with eight people who used the service, six relatives, eight members of staff, two visiting health professionals, the registered manager and the senior operations manager. During the inspection we reviewed a range of records that related to people's care and support and the management of the home. We looked at four people's care plans.

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 all the information we held about the service. This included any statutory notifications which had been sent to us. We contacted the local authority and Healthwatch. The local authority shared findings from a recent contract monitoring visit and Healthwatch stated they had no information about St Luke's Care Home. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

Is the service safe?

Our findings

At our last inspection in May 2015, we rated this key area as 'requires improvement'. We found communal areas; bedrooms, bathrooms toilets and the kitchen were not clean in all areas we looked. At this inspection we found sufficient improvements had been made in these areas, although we identified concerns regarding medication and staffing levels.

The registered provider had a dependency tool in place to determine staffing levels based on people's needs. However, based on feedback from people, relatives, staff and our observations, we found the dependency tool did not accurately reflect people's care needs.

During the morning we observed a period of 25 minutes in the lounge area where the only member of staff in this area was the registered manager who entered on two occasions. During this time, staff were busy elsewhere with a number of people who needed two staff to meet their care needs.

Staff we spoke with felt more staff were needed. We asked if there were sufficient numbers of staff providing cover and were told, "No, the residents we've got are high dependency." Another staff member commented, "We have quite a lot of doubles and hoisting, assisting people with eating. There's no time for anyone in the lounge." Another staff member said, "Not with their needs." We were told by staff there were occasions where senior care cover was not provided, whilst some shifts had more than one senior care staff member.

Comments from people about staffing cover included; "There is a staff shortage during the night", "Sometimes during the day we have to wait for staff for a while before going to the toilet and it is very difficult to wait" and "When staff say they will be with you in a little while, you know they will be back." Relative's comments about staffing levels included; "They always seem to be short staffed", "You can tell they're stretched. They don't have any time to spend with anybody" and "I am not aware they are short staffed." We saw details of a complaint dated September 2016 when concerns about staffing levels and agency usage had been highlighted to the registered manager.

The registered provider used agency staff, although the registered manager told us, "We try and get it consistent with who's been here before." One agency member of staff we met had worked in the home for 18 months and was transferring to become a permanent member of staff. One person told us, "There can be some improvement on staff, to ensure that we don't see as many agency staff."

We concluded this was a breach of Regulation 18 (1) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection, the registered manager informed us staffing levels had been reviewed and with immediate effect, an extra member of staff would be on shift during the day.

We looked at the management of medicines and found the systems to ensure this was safe were not always robust.

We found the registered provider did not have protocols in place for the use of 'as and when required' (PRN) medicines. Without this guidance, staff may not know when to offer these medicines. Pain assessment tools were not in place for four people. One member of staff told us they thought it would be difficult for an agency member of staff to identify whether one person needed pain relief without this information. Pain charts for one person known to experience pain had not been completed. Following our inspection, the registered provider put these assessments in place.

We saw one staff member responsible for administering medicines was wearing nail polish and a watch. The National Institute for Health and Care Excellence (NICE) guidance states 'healthcare workers should ensure that their hands can be decontaminated throughout the duration of clinical work by being bare below the elbow when delivering direct patient care. This should be managed by removing wrist and hand jewellery and making sure that fingernails are short, clean and free of nail polish'. The registered provider took appropriate action in response to this feedback.

Staff who were responsible for administering medicines had received training, although their competency had not been formally assessed. Following our inspection, the registered manager provided evidence to show they had since formally assessed the competency of these staff in safely handling medicines.

This was a breach of Regulation 12 (2)(g) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's medicines were generally administered from a 'monitored dosage system' which meant the medicine was prepared by a pharmacist. The registered manager told us this meant the medication round took an hour less than using the previous system. We found people who had been prescribed medicines to be taken at a time before the morning medication round started had received these at the time stated on the medication administration record (MAR).

We looked at the medication records for four people and also looked at the recording of controlled drugs (medicines liable to misuse). We saw this was well managed with two staff signatures and stock matched the controlled drugs register. We saw all MARs were fully completed and no gaps were noted. Temperature checks for the medication room and fridge were recorded.

We found cream charts had been introduced shortly before our inspection. We saw the cream chart for one person did not say how often the prescribed cream should be applied. Body maps showed where to apply creams and staff had made notes when these products had been administered.

We found examples of risk assessments for falls, mobility and nutrition which were calculated on a monthly basis. We also saw fire risk assessments in people's care plans. We looked at the care plan for one person who was at risk whilst being showered due to their moving and handling needs, although this had not been identified. We discussed this with the registered manager and following our inspection they informed us that external support had been arranged through a nurse practitioner to help assess this person's needs. We were informed that appropriate equipment was being sourced and the unsafe method of showering had stopped until a safe system was in place.

We found the home was clean and there were no odours. One relative said, "Someone is always cleaning the home, that includes on Christmas day as well." We saw some of the décor, fixtures and fittings looked worn. One relative told us, "The home could do with a little 'tlc' both inside and outside." We discussed this with the registered manager who told us they were awaiting approval from the registered provider to carry out works as part of a refurbishment programme.

The registered provider had recruited a member of staff responsible for maintenance shortly before our inspection. We saw a list of maintenance tasks had been created and equipment needed to carry out some of these works had already been purchased. Where one person's nurse call buzzer was not working we found the registered manager had taken appropriate action to have this repaired on the same day. As rooms became vacant they were being redecorated. The registered manager told us, "I know there's a lot of outstanding maintenance issues here."

We looked at the building maintenance records and saw regular environmental checks had been completed. For example, water temperatures had been checked and up-to-date maintenance certification for electricity and gas was in place.

We saw personal emergency evacuation plans (PEEPS) were in place which rated people's moving and handling needs. Staff we spoke with knew what to do in the event of a fire. Weekly fire alarm testing was carried out and emergency lighting was checked. The last fire evacuation took place in April 2016 and the next was due in October 2016. The registered manager told us they would hold unannounced fire practices on both days and nights to ensure staff followed the correct procedures.

People and relatives we spoke with told us they felt safe. One person said, "We are under lock and key. That's why I believe we are safe." One relative told us, "We couldn't have asked for a nicer, safer place for [name of person]." Staff we spoke with told us people were well cared for and kept safe. One staff member told us, "I feel I keep them safe."

The training records we looked at showed some staff had not received up-to-date safeguarding training. Following our inspection, the registered manager contacted us to advise they had booked this training with the local authority which was scheduled to take place in November and December 2016.

Staff we spoke with were able to describe different types of abuse and how they would identify a person was being harmed. They told us they were confident appropriate action would take place if they reported abuse and knew how to contact external agencies to report abuse. The registered provider had a whistleblowing policy which we found staff were aware of. 'Whistleblowing' is when a worker reports suspected wrongdoing at work.

We looked at safeguarding records and found appropriate referrals had been made to the local safeguarding authority and to the Care Quality Commission.

We looked at three staff files and found the recruitment procedures were safe. We saw relevant checks had been completed, which included identity checks, a disclosure and barring service check (DBS) and two references obtained before staff began work. The DBS is a national agency that holds information about criminal records. This helped to ensure people who received this service were protected from individuals who had been identified as unsuitable to work with vulnerable people.

Is the service effective?

Our findings

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). DoLS requires care homes to make applications to the local authority where they suspect they are depriving people of their liberty.

People we spoke with confirmed they were able to make choices about their care and lifestyle. One person said, "If I don't want to get up, I don't have to." Another person said, "I get reasonable choices, like when to go to bed or wake up or sit on my chair." One staff member told us, "I'd ask them what they want for breakfast. If they couldn't tell me, I'd show them options." During the staff handover a new admission to the home was discussed. The person's capacity was discussed and as they were able to make their own decisions, the staff were told this person would let them know when they required a specific medication. This meant people were supported to make decisions about their own care and treatment.

Where people refused to consent to care, staff told us they would respect people's choices, but would try again at a later time. If a person continued to refuse care, staff told us they would document this and report it to the registered manager.

Some staff we spoke with were unable to explain the MCA and DoLS and how this affected people. The registered manager told us they had identified this prior to our inspection. We saw they had made arrangements for staff to complete training in both MCA and DoLS to ensure all staff had a clear understanding. This training was scheduled to take place in October 2016.

We looked at the MCA assessments in people's care plans and found some were generalised and did not contain specific information about decisions people were unable to make, whilst others were decision specific assessments. For example, one person had a decision specific MCA assessment for the use of a peg feed and separate assessment for medication along with a best interest decision.

We identified one person who had communication difficulties. The registered manager had purchased communication cards for this person. The care plan for this person stated, 'It is believed that I understand what is said to me as I smile and laugh and respond to staff'. Staff had mixed views about this person's capacity and we saw this person's capacity had not been formally assessed. This meant staff may have made decisions on behalf of this person which they were able to make. Following our inspection, the registered manager informed us they had arranged for external support in assessing this person's communication needs and their capacity.

At the time of our inspection 11 DoLS applications had been submitted to the local authority and one authorisation was in place. The registered manager had a system for tracking this information which meant they knew about the status of DoLS applications.

Staff told us their induction included being shown around the home; shadowing experienced workers for a couple of weeks and attending training delivered over six days. Staff told us they completed tests at the end of each topic to ensure they were competent.

We looked at records of supervisions and found staff had received this support through a mix of group and one-to-one meetings. Staff we spoke with confirmed issues identified during supervision were acted on. As the registered manager had been in post for four months at the time of our inspection, they had scheduled staff appraisals for January 2017. They told us this was to ensure they had a sufficient period in which they would form a balanced view of each member of the staff team and areas for personal development.

Training records we looked at showed there were some gaps which the registered manager had started to address before our inspection. We saw a series of training sessions had taken place in October 2016 and further dates scheduled in November 2016 for staff to attend. These covered, for example, falls management, fire safety, moving and handling, dignity, choice and diversity and Dementia awareness. We saw nursing staff had received end of life training and had also received training in the use of peg feeds, syringe drivers and catheter care.

Care plans we looked at demonstrated people were supported to access healthcare services when this was needed. Every week a nurse from a local medical centre visited the home to address specific healthcare needs. On a monthly basis, the nurse carried out a 'ward round' and met each person. We saw the chiropodists visited every six weeks and on site opticians were scheduled to visit on 31 October 2016.

One person commented, "I told the manager that I need physio for my shoulder." Staff confirmed a referral to the GP had been made for this person. One health professional we spoke with about staff told us, "They always seem really competent. They never seem to sit on things. I've always been quite impressed." Another health professional told us one person identified as being at risk of weight loss had increased their weight as staff had followed their instructions.

We attended the staff handover meeting and found this was effective in ensuring staff coming on to the shift had relevant information about people's health and wellbeing. For example, a GP was needed for one person for their pain patch. We saw later in the day this appointment had been arranged. The registered manager attended the handover meeting which meant they also had an understanding of people changing healthcare needs.

At the time of our inspection a new chef had been recruited who was in the process of completing their induction. We were made aware that prior to this, agency staff had worked in the kitchen preparing meals which had affected quality. The registered manager told us, "We've had a lot of complaints about food." However, people we spoke with on the day of our inspection were complimentary about the food.

People told us; "Food is lovely, it's getting a lot better", "Food is great, they give you a shandy at mealtimes" and "If I need a snack or a natter, day or night, I only have to buzz." One relative told us, "The food has been good since they had a new cook. Before that, it was hit and miss." A staff member who commented on the quality of food told us, "It's got better."

We observed the lunchtime experience and found the atmosphere was relaxed. The meals served were as

advertised and we saw these were well presented and served warm. People were given two options at mealtimes, whilst snacks, fruit and fluids were available in the lounge. We saw records in the kitchen which noted special dietary requirements and where meals needed to be fortified.

Is the service caring?

Our findings

People and their relatives felt staff were very respectful, caring, good listeners and offered people choices about their care.

Comments from people about staff included, "With staff, it's like my family just got bigger. They are a good bunch, they give me everything I want, even if it is just a natter", "Permanent staff are alright. Some staff members bought me a nice comfy blanket, others sing along with me", "I do as I like, staff look after me well", "Staff are extremely friendly, open and approachable" and "Staff took me out for my daughter's wedding, and I was happy to be reunited with my family."

One relative told us, "I can only speak highly of this home. My relative is on end of life care. Staff have been brilliant and utterly lovely."

Staff told us they felt people received care which was safe, effective and compassionate. One staff member told us, "I love it, that's why I've been here so long. It's always relaxed, it's homely." Another staff member said, "I enjoy looking after the elderly. I like listening to their life histories." One member of staff told us they had visited the home the weekend before our inspection to spend some time with one person who was receiving end of life care. We found they had done this in an unpaid capacity whilst they were off shift. Staff told us they enjoyed working with older people and liked working at St Luke's Care Home.

We observed a member of staff who sat with one person at the piano to play for a short while. They encouraged the person and helped them select a piece of music. The other people in the lounge all listened and smiled. One person said, "She's good, isn't she?" People looked well cared for. They were tidy and clean in their appearance which was achieved through good standards of care. We saw dementia friendly signage and doors to people's rooms showed the name of the person who lived in the room and a comment about their likes and dislikes as well as a colourful decoration.

Staff we spoke with were part of an established team who were familiar with the care needs of people who lived in the home. Staff were able to demonstrate they knew about people's care preferences. One relative told us, "Staff know what [name of person] prefers, as far as I am concerned, they look after her well and that's all that matters to me." A health professional we spoke with told us staff had been helpful and commented on how well staff knew people living in the home.

During our inspection we observed staff knocking on doors before entering people's rooms. Although doors to people's rooms were open whilst they were asleep, people expressed this was their preference as they appreciated knowing staff were there if they needed them. Staff we spoke with told us about the importance of closing curtains and doors when providing personal care for people. Information on dignity challenges was seen on display. This meant people's privacy and dignity was being respected.

We saw information on advocacy was on display in the home. At the time of our inspection, one person was accessing advocacy services to assist them.

We saw a compliment in the service which read, 'Just wanted to thank you for all your kindness and compassion you've shown towards dad and myself'.

Is the service responsive?

Our findings

Before our inspection, the registered manager had identified care plans needed improvement. They told us, "I don't think care plans are up to standard at the moment." In response, a new style care plan had been introduced which had been completed for people newly admitted.

The care plans we looked at were not person-centred and lacked detail. For example, one person's food, nutrition and mealtimes care plan stated, 'I enjoy most foods', rather than stating what they liked and disliked. Daily records did not evidence people were being supported according to their care plans. For example, one person's care plan described stretches which staff were expected to assist the person with. We found staff were unaware of this requirement and it was later confirmed this support was provided at hospital.

Although staff could tell us about people who needed repositioning to avoid problems with pressure care, this was not formalised through clear documentation.

One person's daily records showed they could get physically aggressive with staff and staff confirmed this. We found they did not have a care plan for this. The safety care plan for the same person did not indicate they often walked around at night and actively tried to leave the building.

We saw some records were not dated, although monthly evaluations were evident. Some relatives told us they were actively involved in care planning, although we found limited evidence of this in care plans. One relative told us "Staff have given [name of person] a paper and a pen to comment on her care plan and I like it."

This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection the registered manager contacted us to advise that the programme of updating all care plans would be completed by the end of January 2017. They told us the clinical lead would be allocated two days a week to work with staff to ensure this target was met. We also saw staff training in care planning and person-centred care had been scheduled for November 2016.

We looked at the provision of activities in the home and found there was little stimulation for people on a day-to-day basis. An activities planner was on display in the home which covered the month of October 2016. We saw there were 11 weekdays when no activities were scheduled and saw hairdressing and chiropody listed as activities on other days.

Peoples' comments on activities included; "I am not bothered about anything, I am just here, I want to get up and about, see new things and not get stuck in here. Staff are nice, but there is not much to do", "We don't have a lot of things to do" and "I am usually bored, there is not much we can do, sometimes I like to sit in the conservatory, play cards and bingo."

A staff member was appointed as an activities coordinator. Along with other staff members, they were expected to provide stimulation for people, although staff we spoke with told us they did not have enough time to provide activities for people. We asked one member of staff why activities had not consistently taken place. They told us this was due to, "Only having a certain amount of staff on." Another staff member said, "Personally, I don't see how we find the time. In the records we looked at we found limited recording of people's participation in activities. We concluded people had not received adequate stimulation."

This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw external entertainers had been booked to visit once or twice a month. For example a motivational therapist visited in October 2016. On the day of our inspection we saw an external activity provider engaging people in wartime memories with songs and visual prompts. One relative commented, "It was fun, relevant and suited to the residents age."

The registered manager had identified providing more stimulation was as an area of improvement. Following our inspection the registered manager sent us a copy of the November 2016 activity planner. We saw activities had been scheduled for every day of the week. There were no gaps in the schedule and new activities such as bun making, movie afternoons and reminiscence had been arranged.

There were systems in place to deal with concerns and complaints, which included providing people with information about the complaints process. People we spoke with told us they knew how to complain and felt appropriate action would take place. One person said, "We have seen four managers come and go and if we raised any concerns, they always acted on them." We looked at records of complaints and concerns received in the last 12 months and found details of timely responses given to people and relatives which included the remedial action taken.

Is the service well-led?

Our findings

At the time of our inspection the service had a registered manager who had been registered with the Care Quality Commission since September 2016. They had been in post as manager since June 2016. A senior operations manager visited the home at least once a week. Staff told us they felt they could approach the senior operations manager with any concerns. The registered manager told us they felt well supported in their role. One staff member told us, "I do think the home is well run."

Several governance systems we saw had recently been introduced following the arrival of the registered manager. We saw there been an improvement in the quality management systems used by the service.

The registered manager showed us a series of audits they were carrying out on either a monthly or quarterly basis. We saw audits covering; care plans, bedrails, weights, pressure care, mattresses, complaints, accidents and incidents. We saw audits were comprehensive and recorded action taken where needed. For example, following the July 2016 care plan audit, it was recorded that not all care plans contained up-to-date pictures of people. In response, the registered manager had purchased a camera and added these pictures.

We saw accidents and incidents were recorded. Following a recommendation from the local authority, the registered manager had introduced a template to identify themes relating to accidents and incidents. They had already planned to start using this tool following our inspection.

People and relatives were able to provide feedback at any time using the surveys available. Information on display stated, 'We are always looking for ways to improve our service'. Feedback was sought and acted on. For example, we found changes were planned to mealtimes and staff were wearing ID badges which had both been identified through feedback as concerns. Two people had provided feedback around poor access to chiropody. At our inspection we saw regular visits from the chiropodist had been arranged.

Prior to the registered manager joining, there was limited evidence of meetings for people, their relatives and staff. Since they started four months ago, two resident and relatives meetings had been held. One person told us, "We have contributed to a recent meeting." Notes from the most recent meeting were on display for people and relatives to see.

A staff meeting took place in July 2016 which provided guidance for staff around improving the mealtime experience for people, information on activities and a section of the meeting for staff to be able to raise their own concerns. This meeting focused on maintenance issues. Other staff meetings had since been held for care assistant and domestic staff in October 2016, which reflected on feedback from a recent resident meeting. A home managers meeting took place in October 2016 which covered, for example, expectations around completing staff supervisions and appraisals.

We asked staff about the registered manager and found they were approachable and staff felt sufficiently supported. One staff member said, "She's made a lot of changes which I feel are for the better, but you need

more staff to put them into practice." Another staff member commented, "I do get a lot of support from [name of registered manager]." A third staff member told us, "You can tell she's trying to make improvements."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Diagnostic and screening procedures	People's preferences were not achieved and their needs were not been met.
Treatment of disease, disorder or injury	Care plans were not person-centred and did not accurately identify people's care needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Diagnostic and screening procedures	PRN protocols were not in place and staff medication competency had not been assessed. Pain assessments had not been completed.
Treatment of disease, disorder or injury	

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing
Diagnostic and screening procedures	There were insufficient numbers of suitably qualified, competent, skilled and experienced staff deployed in the service.
Treatment of disease, disorder or injury	