Linden Care Homes Limited

Linden Grange

Inspection report

14-16 Grange Road
Hartshill
Nuneaton
Warwickshire
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Tel: 01827899227

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13 July 2016

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

Summary of findings

Overall summary

The inspection took place on 12 and 13 July 2016. The visit was unannounced on 12 July 2016 and we informed the provider we would return on 13 July 2016.

Linden Grange provides accommodation and personal care for up to 35 older people. The home has two floors; the ground floor provides residential care to up to 23 older people. The first floor has 12 beds, and the provider has a contract with the local Clinical Commissioning Group (CCG) for ten of these beds on a 'discharge to assess' plan from a local hospital. These beds are used by older people, discharged from hospital, on a short residential care stay of up to six weeks during which time they will be assessed, by healthcare professionals visiting the home, as to any future care support they may need. At the time of the inspection 33 people lived at the home.

The home is required to have 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 and associated Regulations about how the service is run. At the time of this inspection the home had a registered manager in post.

Linden Grange opened in 2014 and this is their first inspection since their registration with us.

People felt safe living at the home because staff were there to support them when needed. Staff were trained to know what abuse was and how to report any concerns to the registered manager. People were supported to take their prescribed medicines by trained staff. Some risks were assessed but actions were not always put into place to reduce the risk of harm of injury to people. Staff did not have the information available to refer to, if needed, to know how to keep people safe from identified risks.

Staff were trained and had the skills the needed to deliver care and support to people. Staff worked within the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. People had choices offered to them about what they wanted to eat and drink and were supported to maintain their health and, when needed, were referred to health professionals.

People said staff were kind to them and involved them in making decisions about their day to day care and how they spent their time. People said they received care in a way they wanted and everyone had a care plan that gave staff key information about people. There were planned group activities for people to take part in if they wished to do so, access to gardens and a kitchenette people and their relatives could use.

Some systems were in place to assess the quality of the service provided but audits were not always effective. Some people and relatives were asked for their feedback on their experiences of using the service. However, this had not been analysed and actions to improve, where needed, had not been implemented. The provider's Statement of Purpose did not reflect the range of people living at the home; to include

people on a 'discharge to assess' plan.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.
Risks were not consistently managed, some risks associated with people's care were assessed, however, actions were not always put into place to reduce the risk of harm. People had their prescribed medicines available to them and were supported to take these by trained staff. People were protected against the risk of abuse because staff were trained and knew how to raise concerns and the provider completed checks to ensure staff were of good character.

Is the service effective?

Good

The service was effective.
Staff had undertaken training to deliver care and support and people felt staff had the skills they needed. Staff worked within the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. People were offered choices and given the support they needed to eat and drink. People were supported to maintain their health and were referred to health professionals when needed.

Is the service caring?

Good

The service was caring.
People and their relatives told us that staff were kind and caring towards them or their family member. People were involved in decisions about their day to day care and supported to express their views about what they wanted to do and how they spent their time.

Is the service responsive?

Good

The service was responsive.
People received care in a way they wanted and staff involved them in their care. Care plans gave staff key information about people. There were planned group activities for people to take part in if they wished to do so.

Is the service well-led?

Requires Improvement

The service was not consistently well led.
The provider had some systems in place to monitor the quality of

the service provided but had not ensured these were effective. This meant opportunities to identify where action was required to implement improvement were missed. Staff told us they felt supported by the registered manager.

Linden Grange

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.

The inspection took place on 12 and 13 July 2016. The visit was unannounced on 12 July 2016 and we and we told the provider we would return on 13 July 2016. One inspector undertook the first day and they returned on the second day with an 'expert by experience.' An expert by experience is a person who has personal experiences of using or caring for someone who uses this type of care service.

The provider completed a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed the information we held about the service. This included information shared with us by the local authority commissioners. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority. We reviewed statutory notifications sent to us from the provider. A statutory notification is information about important events which the provider is required to send us by law.

We spoke with 12 people who lived at the home and four relatives who told us about their experiences of using the service. We spoke with staff on duty including five care staff, two team leaders, one care supervisor, two kitchen assistant staff, the head of housekeeping, the registered manager and deputy manager of care. We spoke with four visiting healthcare professionals. We spent time with and observed care staff offering care and support in communal areas of the home.

We reviewed a range of records, these included care records for six people and four people's medicine administration records. We looked at quality assurance audits and feedback from people.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at the home. One person said, "I knew I was no longer safe to live at home by myself, I feel safe here because the staff are around to help me when needed. It's a safe and secure home." Another person told us, "I feel safe here, the staff check on me."

Staff told us they had received training on how to protect people from abuse and how to recognise concerns. One staff member told us, "I've never had any concerns about abuse here. If I had, I'd report straightaway to the manager. I'd go further if needed." Another staff member said, "The manager would listen to any concerns about abuse, they would report it further and deal with it." The registered manager understood their responsibilities in informing the local authority and us of any safeguarding concerns. Some assessments were in place to identify where people were at risk but these did not record actions to be taken, by staff, to minimise the identified risks. For example, some people were identified as being at high risk of falls but no information was available to tell staff how to minimise the risk of harm or injury. One staff member told us, "I've worked in care for a long time and know the importance of making sure people can't trip over things and to support them when needed." Another staff member said, "We get to know people well on the ground floor and how to keep them safe, but on the first floor with the 'discharge to assess' beds, people change all the time." We discussed people's risk assessments with the registered manager and deputy manager for care and they told us actions to minimise identified risks would be added to people's assessments so staff had the information to refer to, when needed. On the second day of our inspection, the deputy manager for care showed us one person's falls risk assessment. They had reviewed the assessment and included actions for staff to follow so that the risk of further falls was reduced. This included a pressure sensor mat next to the person's bed so staff were alerted when this person got up and could offer support to them. The deputy manager for care informed us they would ensure everyone's risk assessments were detailed and contained the information staff needed to ensure risks were managed consistently.

One staff member informed us, "One person smokes and we lock away their matches and cigarettes for safety, but when they want a cigarette staff always support them outside." We found there was no risk assessment identifying the risks to show why this person's smoking items had been removed from them or how staff should safely support them when they smoked. The day after our visit, we were sent a copy of a risk assessment and management plan that had been implemented for this person. This meant that staff had the information they needed to safely support the person to store their smoking materials and smoke.

Another person had a health condition, but potential risks posed, by this to their wellbeing had not been assessed. However, staff were able to tell us how they would recognise if this person was unwell and what they would do about it. Some people were identified as becoming 'anxious' or 'agitated' but we found no care plan to tell staff how to safely and consistently manage people's anxiety. The deputy manager for care told us they would spend the next week, following our visit, supporting the registered manager to review identified risks to ensure staff had the information they needed to refer to, so people's health conditions were consistently managed.

Some people had Malnutrition Universal Screening Tool (MUST) assessments. (MUST) is a management plan

for people who are malnourished or at risk of malnutrition. One person was identified as being 'high risk' and actions to reduce the risk of this person becoming malnourished included them having high calorie snacks and being weighed each week. However, we found high calorie snacks, between meals, were not offered to people by staff and this person's weight was not being checked as planned for. We discussed this with the registered manager and deputy manager for care and they informed us this person was offered biscuits as a snack. We asked staff to check this person's weight and they informed us of a small weight loss. The deputy manager for care told us, "All meals have extra calories added, such as butter and cream being used with potato, but we will ensure high calorie snacks are made available to people."

Some people identified at risk of malnutrition or who had poor appetites had food charts so that staff could monitor what people had eaten. Two people's food charts had not been completed for the previous day. One staff member told us, "Staff must have forgotten to complete them, they are meant to filled in at the end of the shift." On the second day of our visit, we observed staff completed people's food charts but one staff member was not able to recall what people had eaten earlier in the day and were asking one another staff member if they could remember what a person had eaten for breakfast. The deputy manager for care told us they would implement a clearer recording chart and staff said they would complete charts after each meal rather than at the end of the shift so that an accurate record was kept and cold be referred to if needed.

There were procedures for staff to follow when people were at risk of skin damage. Staff informed us some people had special mattresses on their bed to reduce the risk of their skin becoming sore. One staff member said, "One person has a pressure area and we reposition them every two hours." Another staff member said, "We don't do any wound or skin dressings, but the district nurses visit this home every day. If we had concerns about someone, we would tell the manager and the district nurse." A visiting student nurse told us, "Staff here always follow the guidance given and use the equipment correctly to reduce the risks of people's skin becoming damaged." The district nurse added, "A few people have pressure areas, wounds or ulcerated legs that we come and check and dress each day. I have no concerns about the staff managing pressure care here, they follow our guidance."

We observed safe moving and handling practices by staff. For example, staff explained to one person that they were going to support them to transfer to a wheelchair. Reassurance was given to the person and staff followed training they had been given when supporting the person to stand.

The provider's recruitment process ensured, as far as possible, that staff were of good character and safe to work with the people who lived in the home. Two staff members told us they had started working at the home over the past year. One staff member said, "I applied here and the manager interviewed me. I started once they had received my references and had completed a criminal record check on me."

Most people told us there were enough staff on shift to keep them safe. However, a few people said more staff were needed at times. One person told us, "I still feel safe, but sometimes they need more staff on because the girls (staff) are so busy." Staff told us that most of the time they felt there were enough staff. One staff member said, "I'd say 80% of the time we have enough staff, it's just when staff are on holiday or off sick we might be a bit short. The manager tries to get cover but staff also need their days off." Over the course of our two day inspection, we observed there were enough staff to keep people safe.

Staff told us they felt they had the skills to deal with emergencies that might arise from time to time. People had personal emergency evacuation plans (PEEPS) to tell staff the level of support they needed in to keep them safe the event of a fire. Staff told us they would call an ambulance if someone had an injury or became unwell and most staff were able to tell us what safe first aid treatment they would give if someone had a fall.

The registered manager and deputy manager for care shared their plans with us to offer staff a refresher on first aid if needed.

Most medicines were safely stored in the home. However, we found one person's eye drops and 11 prescribed supplements were stored in a kitchenette fridge used for food storage. The registered manager removed the prescribed items from this fridge, to place them in the designated medicines fridge, and told us they would remind staff of the correct storage.

Trained staff managed people's medicines and supported them to take their medicines when needed. One person told us, "Staff always give me my pills on time when I need them." Staff told us they had received training to administer peoples' medicines. One staff member told us, "If I'm unsure what a medicine is for, I can check in the medicine book (British National Formulary) or ask the manager." We saw one staff member take medicines to people and support them to safely take their tablets. We looked at four people's medicine administration record (MAR). These showed people had received the medicines prescribed to them.

Some people had medicines 'as required' such as for pain relief. Information was available to staff to tell them when people's 'as required' medicines should be given. This ensured people received these medicines consistently. We observed staff offered these medicines to people and ensured the dosage given was recorded on the MAR.

Good

Is the service effective?

Our findings

People felt staff had the skills they needed to effectively support them. One person told us, "I can't fault the staff, they are very good. They know me well and know what they are doing."

Staff told us they received an induction when they started work at the home. One staff member told us, "I had a staff mentor and felt my induction was good here." Another staff member said, "We have updates in our training to refresh our knowledge when needed." Staff told us they attended team meetings and received one to one supervision meetings. Staff felt well supported by other staff within the team and the registered manager. One staff member said, "I'd say team work is good here."

Staff understood the importance of gaining people's consent and worked within the principles of the Mental Capacity Act. One staff member told us, "We always explain to people what we are doing. We don't force people to do things." Most staff told us they had completed training on the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act 2005 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.

The registered manager understood their responsibilities under the Act when people had restrictions on their liberty. They informed us that three people were deprived of their liberty and they had submitted referrals for a further four people whose mental capacity was to be assessed for a DoLS. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards. Most staff could not recall which people had a DoLs in place, but told us they would check with the registered manager. The registered manager showed us information in the office that staff could refer to if needed.

People told us they enjoyed their meals. One person told us, "The girls (staff) come around in the mornings and tell me what is for lunch and I can choose what I want to have." We observed kitchen assistant staff members asking people their choice. One kitchen assistant told us, "We ask people what they'd like, so that we have an idea on quantities to cook, but we always cook extra of both choices in case people change their minds." One relative told us, "I'm always offered a meal when I visit my family member, it's good to be able to sit and eat together, and we enjoy that."

We observed the support people were offered from staff during lunchtime meals. Staff offered people choices of food and drink and where they wished to eat their meal. Staff prompted and supported people to eat when needed. One staff member told us, "We always sit and eat a meal with people, it's a good way to encourage people to eat because they can see we are enjoying eating our meal." Staff sat with people and had quiet conversations over the mealtime that was unrushed and relaxed.

People said they felt staff would arrange for them to see a doctor if needed. Staff told us if they had any concerns about a person's health, they would inform the registered manager. One staff member said, "If a person is not well, we'll tell the manager and they will arrange the person's doctor to visit if needed." Another staff member said, "Some people need to have their blood tested so we know what dosage of their medicine to give them and the local hospital blood testing nurse (phlebotomist) visits people here." People's care records recorded that GP and other healthcare professional visits, such as chiropody and optician visits had taken place. Referrals to dieticians and speech and language therapists were made for people when needed.

People receiving a short stay at the home on a 'discharge to assess' plan were visited by healthcare professionals, such a physiotherapists and occupational therapists. These professionals completed planned assessments, such as washing and dressing or walking up and down stairs, with people as a part of their agreed assessment support.

Good

Is the service caring?

Our findings

People told us staff were kind and caring toward them and they had no complaints about their care. One person told us, "If I needed something, staff would go out of their way to get it for me." Another person said, "I have a laugh and a joke with the staff, they haven't spoken with me about my care, but I know what is happening." Relatives felt staff had a caring attitude toward people. One relative said, "Staff are caring, I can't think of anything they need to do to improve the care here."

We observed kind and friendly interactions between staff and people living in the home. We heard one person ask for a tissue and saw a staff member give this to the person and gently ask them if they needed any help.

Some staff had worked at the home since it had opened; in 2014, and knew the people on the ground floor well and how they liked to be cared for. One staff member told us, "We get to know people well and how they like things done. It's a bit harder upstairs because people are changing all the time (discharge to assess beds), but I believe we always do our best for people here."

People told us staff involved them in making day to day decisions about their care. One person told us, "Staff will ask me if I want a shower or what I want to do." Another person told us, "Staff ask me where I want to spend my time, I prefer my bedroom but can go in the lounge if I want to."

Staff knew how to respect people and maintain their dignity and gave us examples of how they would do this. During our visit, we saw examples of this happen, such as closing people's bedroom doors if the person wished this. However, we identified a few examples of when opportunities to respect people and promote their dignity was not always taken. For example, we saw people receiving a short stay at the home on a 'discharge to assess' plan, did not have their names on their bedroom doors. The registered manager informed us this was because people were not staying long. We discussed this with the registered manager and explained this did not promoted people's dignity or give them 'ownership' for their bedroom. The registered manager took immediate action to place people's names on their bedroom doors and said, "We will ensure this happens from now on." We found visiting healthcare professionals stuck appointment labels to people's bedroom doors, to remind people and staff of a planned assessment visit. Following a discussion, the registered manager agreed appointment labels would be placed inside people's bedrooms so that information was private and their dignity was respected. The registered manager informed us they would advise visiting healthcare professionals of this change so that people's dignity was respected.

Relatives told us they were able to visit people at any time and there were no restrictions placed on them. One relative said, "We come and visit when we can and have never been told there is a specific time." Another relative told us, "I visit most days and am always made welcome by staff." The registered manager told us, "There is a kitchenette where relatives can make drinks for themselves and their family member if they wish to. There are also lots of quiet areas to sit, if people want a change from their bedroom or the main lounge." One person said they liked dogs and used to enjoy walking with their dogs, the registered manager said, "Relatives or friends can bring in well behaved pets to visit people." This person had enjoyed visits from

various friends accompanied by their dogs.

Good

Is the service responsive?

Our findings

We received mixed feedback from people when we asked if they received care that was personalised to their needs. People living on the ground floor, where Linden Grange was their home, felt involved in their care. However, people living on the first floor, on a short 'discharge to assess' stay did not feel fully involved because some decisions were made by healthcare professionals on their behalf.

People living on the ground floor told us they were happy living at the home and felt their needs were met by staff. One person told us, "I'm not really aware of my care plan, but on a day to day basis, staff involve me and ask me what I want." Another person said, "Staff came in this morning at 6.30am to help me up, but I said I'd like a bit longer in bed and they told me, 'that's okay' and came back later when I wanted to get up." This showed staff provided people with personalised care that was responsive to their individual needs. A further person told us, "I'm very happy living here, it is always clean and staff always help me when needed."

People's care needs were assessed and they had care plans. One staff member told us, "The care plans are basic, but we get to know people and always ask them what they would like or how they want to be supported." We observed staff knew people well and how to respond to their needs.

People receiving a short stay at the home on a 'discharge to assess' plan did not always feel fully involved in planning and making decisions about their care. One person told us, "I've no complaints, but can't say I was very involved in my discharge from hospital to this home." One person's relative told us, "My family member was informed by hospital staff of the transfer here from the local hospital. We'd never visited here and were not really involved in the decision, but we understand it is just for a short assessment stay and we're happy with that." The registered manager informed us that people, and their relatives whenever possible, were involved in their initial assessment prior to admission to a 'discharge to assess' short stay bed at the home from hospital and records showed this. However, local hospital staff decided who may be appropriate for a 'discharge to assess' bed at the home.

One person receiving a short stay told us, "They haven't really spoken with me about my care, but they have done a good job in getting me right, so I feel ready to go home. I've spoken with the manager and am waiting for them to let me know. They look after me, I can't grumble about the place." Weekly multi-disciplinary team (MDT) meetings took place, involving health care professionals, to discuss people's progress and discharge plans. The registered manager explained to us that people were not invited to attend discussions about them at the MDT because of the time constraints of the numerous health care professionals involved. However, the registered manager told us people, and their relatives, had been informed they could speak to them (the registered manager) following the weekly MDT. The registered manager informed us they would display a poster to remind people and their relatives about this and inform them who to ask for updates about their care and support and future plans.

One staff member told us, "All of the staff team work shifts on both floors of the home. Depending on which floor we are on, we have a handover meeting about those people at the start of the shift." We observed one meeting and found staff shared information about individual needs that staff may need to focus on during

their shift.

We looked at how people spent their time in the home and saw some people independently pursued interests and hobbies. One person told us, "I like to spend time in my bedroom and am happy with my television." Another person said, "I've always enjoyed flowers and gardening. I can go out into the garden here and enjoy helping with the flowers and watering them." Two garden areas were accessible to people and one staff member told us, "One person enjoys using the small greenhouse, they've got some tomato plants growing."

During our visit, people told us they enjoyed the visiting ukulele band who were there on the day of our visit. One person told us, "These are really good, it's been a great afternoon." People said they enjoyed the planned group activities, one person told us, "I just wish we could have more like the band or some trips out." The registered manager told us, "We are working on improving the planned activities and one of our colleagues from another home is due to visit next week to help staff with this planning and ideas."

The provider supported people's faith needs. One person told us, "I used to go to church, but now someone from the church comes here to visit me and support me with Holy Communion. I'm happy they can visit me here."

We asked people and relatives about what they would do if they wanted to raise a concern or were unhappy about an aspect of the home. People and their relatives told us they would speak to staff or the manager if they felt they needed to. People told us they had no current concerns or complaints. One person told us, "I've never had to complain about anything here." Another person told us, "Staff ask me if I am okay and happy with everything." One staff member told us, "If someone said they were not happy about something, I would sort it out if I could and if not, then I would tell the manager so they could help the person."

The provider's complaints policy was shared with people and their relatives. Staff told us that if anyone had a complaint, they would share this with the manager so that it could be looked into. The registered manager informed us they had received three complaints and these had been resolved. They told us one complaint raised was the length of time it took staff to answer the phone and this had been resolved by giving staff mobile handsets that could be carried about so they could respond to incomings calls when administrative staff were not available, this had resolved the issue.

Requires Improvement

Is the service well-led?

Our findings

There was a management structure in place to support the registered manager. The deputy manager for care informed us they had a regional role for three homes and visited Linden Grange on a weekly basis, and visits to the home were also undertaken by the general manager. The deputy manager for care said, "We are all very supportive of one another and have worked closely for years." The registered manager told us they felt supported by senior management and from their staff team, which included care supervisors and team leaders.

Staff told us they felt supported and worked well as a team. Staff knew the different roles of senior staff and said they felt they were approachable. One staff member told us, "We have team leaders that lead the shifts and tell us what needs doing. We also have care supervisors on most shifts and they help on the floor as well."

The registered manager showed us their Statement of Purpose that was dated 2016. This is a document that tells us and people using the service about the provider's mission statement and what services they offer. We identified the provider's update of their Statement of Purpose did not reflect the range of people living at the home. For example, we found no mention of the ten 'discharge to assess' short residential stay beds.

We saw the provider's Statement of Purpose referred to planned 'resident and relative' meetings to gain feedback from people. People and their relatives informed us that such meetings did not take place. One person told us, "We don't have resident meetings here, it might be good to have them so we can get together, but we can always speak with staff if we have anything we need to say. Staff always ask us how we are and if everything is okay." The registered manager said such meetings had not yet commenced since the home opened but it was something they hoped to implement by the end of 2016. Following our visit, the registered manager informed us they had made a 'comments and suggestions' box available for people and their relatives to use.

The registered manager told us they had sought feedback from people through questionnaires during January 2016, however, this feedback had not yet been analysed. We looked at completed questionnaires and saw, overall, people's feedback was positive. However, when asked about dental care on the questionnaire, two people had used this opportunity to say they would like a dental visit. We found no action had been taken to respond to these requests. This meant that whilst feedback had been sought from people, a timely analysis had not taken place and opportunities to implement improvement, where needed, had not always been actioned.

We found there was no process in place for gaining feedback from people using a 'discharge to assess' bed at the home. The provider's quality assurance policy had not given consideration as to how feedback would be sought from people who would not be included in the annual quality assurance survey.

Systems were in place to audit the quality of services. However, the deputy manager for care informed us, for example, that they completed a medicine audit every six months and other checks by the registered

manager were completed informally on a monthly basis. We found the registered manager's checks had not identified the issues we found. For example, one person kept an inhaler in their pocket and self-medicated this medicine when needed. However, we found this person's medicine administration record did not reflect this and recorded staff were administering this medicine. We also identified some people were prescribed medicine that was absorbed through their skin by way of a patch. We found no record was kept by staff to log the location of the patch on the body; to ensure the manufactures instructions were followed.

Care plan audits were not always effective because they had not identified issues we found. Whilst we found staff had the knowledge they needed from their previous care experience, they did not always have the information to refer to, if needed, in people's care records. For example, 'waterlow' assessments had been completed for people; this is a tool used to assess people's risk of skin damage. We found assessments identified some people at 'very high risk' but did not include information about actions staff should take to reduce the risks of people's skin becoming damaged. We found one person was identified as requiring help to manage their colostomy but had no care plan for this to inform staff what to do. Care plan information ensures staff take a consistent approach to meeting people's needs and audits of care records had not identified any need to include further information.

Accidents and incidents were recorded and analysis took place. However, we found the registered manager's analysis had not given consideration as to how to prevent a reoccurrence of accidents. For example, two people had fallen twice in May 2016 and three times in June 2016, but we found the accident analysis had not considered how to reduce the risk of these people having further falls. We found their falls risk assessments had not been reviewed. The registered manager and deputy manager for care informed us a more detailed analysis would be done and actions implemented when needed.

The registered manager told us they completed checks on staff and observations around the home to ensure people received a good service. We found these checks had not always identified where action was needed to make improvement. For example, the registered manager told us they were aware visiting healthcare professionals attached labels to people's bedroom doors but they had not challenged this practice.

Following our feedback, the registered manager and deputy manager for care informed us improvements would be made in areas we had identified to them. The following day we received an action plan telling us what action had been taken immediately and copies of reviewed risk assessments. Further improvement was planned and timescales were shared with us for implementing action.