The Autumncare Group Limited

Northlands Care Home (Northumberland)

Inspection report

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Ratings

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

Overall summary

This inspection was unannounced and took place on the 22 and 24 October and 3 November 2014.

Northlands Care Home (Northumberland) is registered to provide accommodation for up to 35 people with either personal, nursing or dementia care needs. Accommodation is split over three floors and at the time of our inspection there were 33 people living at the home.

The home had a registered manager who had been registered with the Care Quality Commission to manage the service since October 2011. 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.

Summary of findings

People told us they felt safe living at Northlands Care Home (Northumberland). There were systems in place to protect people from abuse and channels through which staff could raise concerns. We saw that safeguarding matters that had arisen within the last 12 months had been handled appropriately and referred on to the local authority safeguarding team for investigation.

A process was in place to assess people's needs and the risks they were exposed to in their daily lives. Care records were regularly reviewed, however, we found contradictory information in these records and as a result there was a risk that people may receive inappropriate care or treatment. Medicines were not administered safely. We saw nursing staff left medicines in front of people without observing they had taken them safely. Regular health and safety checks were carried out on the premises and on equipment. Recruitment processes were thorough and included checks to ensure that staff employed were of good character. Staffing levels were determined by people's needs. The registered manager told us she had experienced difficulties in recruiting and retaining staff in recent months, which had led to some usage of agency and bank staff.

Staff records showed staff received regular training that was up to date. Supervisions and appraisals for staff were conducted regularly and staff confirmed they could feedback their views during these meetings with their manager. The environment did not reflect best practice guidance in relation to attaining the best possible health and quality of life outcomes for people living with dementia.

CQC monitors the operation of Deprivation of Liberty Safeguards (DoLS). DoLS are part of the Mental Capacity Act (2005). These safeguards exist to make sure people are looked after in a way that does not inappropriately restrict their freedom. We saw the registered manager had applied for, and had been granted DoLS for a number of people living in the home. In addition, people's ability to make informed decisions had been assessed, but this was not always fully documented.

People told us, and records confirmed that their general healthcare needs were met. We saw people's general practitioners were called where there were concerns about their welfare and other healthcare professionals such as dentists and chiropodists. People told us they were very happy with the food they were served. We saw that people's nutritional needs were considered specialist advice sought where necessary.

Our observations confirmed people experienced care and treatment that protected and promoted their privacy and dignity. Staff displayed caring and compassionate attitudes towards people and people spoke highly of the staff team. People had individualised care plans and risk assessments and staff were aware of people's individual needs. People told us, and our own observations confirmed that regular activities took place within the home.

Systems such as audits were in place to monitor the service provided and care delivered. Where issues were identified, action plans were drafted and improvements made. We received positive feedback about the leadership and management of the home.

The registered manager had not notified the Care Quality Commission (CQC) of approved DoLS applications and other safeguarding and/or serious injury incidents that had occurred within the last twelve months. This is a breach of the Care Quality Commission (Registration) Regulations 2009 and we are dealing with this outside of the inspection process.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These were related to the management of medicines and records. You can see what action we told the provider to take at the back of the full version of this report. We will make sure action is taken and we will report on this when it is complete.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Not all aspects of the service were safe.

People told us they felt safe and staff were aware of their personal responsibilities to protect people from harm or abuse and report any such matters. Staffing levels were maintained, although there was a reliance on agency and bank staff. Recruitment procedures were robust and ensured staff were suitably qualified and fit to carry out their role.

Risks to people in terms of both care delivery and activities of daily living were assessed and reviewed. Risks associated with the building were generally well managed although some improvement was needed in areas.

We found that medicines were not well managed. People were at risk because staff did not follow company policies and procedures and best practice guidelines when administering people's medicines.

Is the service effective?

Requires Improvement

Not all aspects of the service were effective.

People told us and we saw that staff met their needs. Records showed that staff received training specific to the needs of the people that they cared for. Supervisions and appraisals were carried out regularly.

There was evidence that assessments were undertaken in relation to the Mental Capacity Act (2005) to determine the level of people's ability to make informed choices, although these were not always well documented. Applications had been made to the local safeguarding team to ensure that no person had their freedom inappropriately restricted.

People told us that they were happy with the food they received. We saw that people's nutritional needs were documented and, where necessary, their food and fluid intake was monitored. People had input into their care from external healthcare professionals.

Is the service caring?

Good

The service was caring

Staff treated people with dignity and respect and we saw many pleasant engagements. Staff displayed caring and courteous attitudes towards people.

The care we saw being delivered promoted people's right to privacy and independence. People told us they were given choices and we saw that this was the case when we carried out observations of care delivery within the home.

Summary of findings

There were plans in place for end of life care where people had the capacity to express their wishes. Where people needed an advocate to act on their behalf, we saw that the registered manager had procedures in place to arrange this.

Is the service responsive?

Requires Improvement

Not all aspects of the service were responsive

People told us that staff were aware of their individual needs and how to meet them. Individualised care plans and risk assessments were in place however, we found contradictions in some care records which placed people at risk of receiving inappropriate care or treatment.

External healthcare professionals told us that the service worked well with them and people and their relatives told us that the registered manager responded well when action needed to be taken.

Activities were available for those people who wished to be involved. The registered provider had a complaints policy and procedure in place and we saw that complaints were handled appropriately. Feedback was obtained and analysed by the registered manager at regular intervals.

Is the service well-led?

Requires Improvement

Not all aspects of the service were well led

People reported a positive atmosphere within the home and said that it was well led and they had everything they needed. We saw there were effective systems in place to monitor care delivery and to identify were there were shortfalls that may need to be addressed.

The manager did not notify us about all matters that she should have in line with the requirements of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Northlands Care Home (Northumberland)

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.

We visited the home on three separate dates; 22 and 24 October 2014 and 3 November 2014. This inspection was unannounced.

The inspection team consisted of two inspectors and an expert by experience with experience of older people's care services. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Prior to the inspection, the provider completed a Provider Information Return (PIR). This is a form which asks the provider to give some key information about the service, highlighting what the service does well, and identifying where and how improvements are to be made. We reviewed the information returned to us by the provider in the PIR, alongside information held by the Commission (CQC) about the home. This included reviewing statutory notifications and safeguarding information that the provider had sent us within the last 12 months. In addition, we contacted the commissioners of the service, the local authority safeguarding team, Northumberland Clinical Commissioning Group, Healthwatch (Northumberland) and the community matron for nursing homes. We also attempted to contact four healthcare professionals including a GP, chiropodist and a continence nurse in order to obtain their views about the care provided in the home. We did not get a response from all of the people we contacted. However, where we did, we used the information that they provided us with to inform the planning of our inspection.

During the visit we spoke with 15 people living at the home, seven people's relatives, three nurses, six care staff, the registered manager and the nominated individual. We walked around each floor of the home, looked in people's bedrooms, and all communal areas such as lounges and dining rooms. We observed the care and support people received within these communal areas. We reviewed a range of records related to people's care and the management of the service. These included six people's care records, six staff recruitment, training and induction records, 18 people's medication administration records (MARs) and records related to quality assurance audits and utility supplies certifications .

We also used the Short Observational Framework for Inspection (SOFI). SOFI is a tool used to observe care which helps us understand the experience of people who were unable to communicate their views and feelings to us verbally. We reviewed all the information that we gathered prior to the inspection, and at the inspection, to form the basis of our judgements and this report.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at the home. One person said, "When I first came in I was afraid to be left on my own but I am alright now." A second person told us, "I have no cause for concern at all." Other comments made were; "They (staff) are kind and I am full of admiration for the way they treat everybody"; "They (staff) are very good to me"; and "I feel safe here". None of the relatives we spoke with had any concerns about the safety of their relations.

We observed care being delivered in communal areas of the home and saw that the practices staff followed were safe. For example, the moving and handling manuovers we observed followed current best practice guidelines.

We asked staff about safeguarding and found they were knowledgeable about what constituted abuse. All of the staff we spoke with were clear on their own personal responsibility to report potential harm. They confirmed that there were safeguarding and whistleblowing policies and procedures in place, and they quoted the steps they would follow should they need to report such an incident. We reviewed the safeguarding and whistleblowing policies and procedures and found them to be thorough and clear with the contact details for the local authority safeguarding team and emergency duty teams listed. Information about safeguarding and whistleblowing was also posted around the home. We reviewed a log of safeguarding incidents and potential safeguarding incidents that had occurred within the home in the last 12 months. These were all handled appropriately and referred to the relevant parties for investigation and input as necessary.

Records were held of accidents and incidents that had happened within the home. These detailed the nature and circumstances of the accident or incident, and plans put in place to prevent repeat events.

We reviewed people's care records and found that risks which people may be exposed to in their daily lives had been assessed for most people and instructions written for staff to follow when delivering care, to manage these risks. For example where people had skin integrity issues there were risk assessments in place for preventing pressure damage from developing. In addition, we saw risk assessments for falls, nutrition, medication, moving and handling and the use of bed safety rails. Care records, including risk assessments, were reviewed regularly.

We saw there was an emergency contingency plan in place which contained a list of emergency contact details for staff to use should this be necessary. We saw that in people's individual care records there was information about their level of mobility, but the nominated individual confirmed that no individual person specific emergency evacuation plans were in place. She advised us this matter would be addressed.

We looked at the management of risks within the building and found that regular fire and health and safety checks were carried out and documented. Equipment was serviced and maintained regularly and we saw safety checks were carried out on for example, electrical equipment, the electrical installation within the building and gas supplied equipment. We saw evidence that legionella control measures were in place to prevent the development of Legionella bacteria within the home's water systems. However, the registered provider confirmed that they had not carried out a legionella risk assessment of the building in line with their legal obligations under Health and Safety at Work legislation. They told us that they would arrange for this to be done as soon as possible.

Staff files showed that recruitment processes and procedures were thorough and appropriate checks were carried out, including identity checks and Disclosure and Barring Service (DBS) checks, before staff began work. There was evidence the registered provider had checked nurses employed were appropriately registered and that their registrations were current and valid. The registered provider had systems in place designed to ensure that people's health and welfare needs could be met by staff who were fit, appropriately qualified and physically and mentally able to do their job.

The registered manager told us that staffing levels were decided on the basis of people's dependency levels using a staffing tool. We reviewed staffing rotas and saw that there was high use of agency staff and bank staff linked to the home. The registered manager told us the company had struggled to recruit staff (particularly nurses) recently and this was the reason for the current reliance on temporary workers. We saw that there were usually two nurses on duty during the day with five or six care workers and one nurse and three care workers at night. People told us there were enough staff to meet their needs and we saw no evidence to dispute this during our inspection. One person

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Is the service safe?

said, “I am not short of anything so it must be alright.” A second person told us, “They keep taking more staff on.” Another comment made was, “Sometimes I have to wait for staff but they come as quick as they can.”

On one of the days of our inspection we saw on the upper floor, where people living with dementia were accommodated, both the nurse and senior care worker took their meal break at the same time. This left only two care workers to protect the safety of 12 people. We observed periods of time where up to five and six people were left unattended in the lounge, whilst the two care workers assisted other people in their rooms with personal care. We considered there was a risk to those people who were left unobserved. We discussed our concerns with the registered manager who gave assurances that senior staff were not allowed to go on their lunch breaks together, and this matter would be addressed. We saw the registered manager had tackled issues historically related to staff conduct and there was evidence that staff had been subject to disciplinary procedures where necessary.

Each person we spoke with told us their medicine was brought to them but they all said that it was left for them to take and they were not observed whilst taking it. One person told us, “They don’t always stay, but they trust me to take them.” Our observations confirmed what people told us. We saw the administration of medicines was not safe as people were not always observed when their medicines were given to them to ensure they consumed them. On the middle floor several people were given their medicines whilst they were eating lunch and these were left on the table with them. This practice contradicted instructions in people’s care plans, risk assessments and the registered provider’s own medication policies and procedures which promoted that people should be observed whilst taking their medicines. In addition, this practice did not meet the minimum standards for medicines administration as issued by the Nursing and Midwifery Council.

We saw there were topical medicines in people’s rooms that were not dated when opened and we found one person had cream belonging to another person in their en-suite. The prescription label on some topical cream medicines was illegible and so was the expiry date. This meant that staff could not be sure the cream they applied was for the correct person and that it remained safe to use.

We reviewed a sample of people’s medication administration records (MARs) and found that these were well maintained. Medicines were stored appropriately and we saw systems were in place to account for medicines that were no longer required. There was evidence that GP’s reviewed people’s medicines on a regular basis but there was a lack of information and care planning related to medicines which were administered on an ‘as required’ basis. The management of medicines within the home did not fully reflect the National Institute for Health and Care Excellence (NICE) guidance related to managing medicines in care homes, which was published with the aim of improving health and social care.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Requires Improvement

Is the service effective?

Our findings

The people we spoke with told us they were happy with the care, support and attention they received. They said that staff met their needs, although sometimes they had to wait a short time for assistance if staff were busy. One person told us, "The staff seem very helpful and I haven't found yet that they don't know what to do. I don't have any trouble with the staff they are all very good." Another person told us, "Some of the staff are very good, but one day they tried to rush me too quickly." One person's relative told us, "I have been delighted with the care here. The staff have been excellent." Other relatives commented, "She couldn't be in a better place" and "He is always clean and comfortable".

Staff told us that they received regular training. One member of staff said, "We have so much training here!" Staff told us they received a thorough induction and then shadowed an experienced member of staff when they first started work. They confirmed they had completed training in areas such as, fire safety and moving and handling, and the staff files supported this. In addition, we saw staff had completed training specific to the needs of the people to whom they delivered care. For example, some staff files showed staff had received training in diabetes care, dementia awareness and Percutaneous Endoscopic Gastrostomy (PEG) feeding. PEG feeding is used where people cannot maintain adequate nutrition via oral intake. A feeding tube is passed through the abdominal wall into the stomach so that feed, water and medication can be given without swallowing.

When we observed staff delivering care, we saw they had the necessary skills to, for example, appropriately assist people with mobility and support people living with dementia. This showed they had practically applied the training they had completed. We saw the registered manager had a training matrix in place which she told us she used to monitor training requirements and request attendance on courses.

Staff told us and records confirmed they received regular supervision and appraisal. Staff said they felt supported by the registered manager. We saw that supervisions and appraisals were used as a two-way feedback tool through which the registered manager and individual staff could discuss work related issues, training needs and personal matters if necessary.

We looked at the environment within the home where people living with dementia were accommodated. We found most of the corridors and doors leading off them were painted in the same colour with only limited visible features to aid orientation. In addition, there were few tactile objects around to occupy people. The National Institute for Health and Care Excellence (NICE), The Alzheimer's Society and The Thomas Pocklington Trust have all issued guidance about how to create beneficial environments for people with dementia. We recommend the registered provider explores relevant guidance such as this, about how to make environments used by people living with dementia, more 'dementia friendly'.

Information in people's care records indicated some consideration had been given to people's levels of capacity and their ability to make their own choices and decisions in respect of the Mental Capacity Act 2005 (MCA). Assessments of people's ability to make day to day decisions about their care were evident in people's care records, but these were general overviews of their capacity (sometimes with repeated standard phrases between different people's care records) and not a measure of their ability to make specific decisions. There was some evidence that individual 'best interest decisions' had been made, for example about end of life care. However, records did not always fully explain who had been involved in the decision making process and what discussions had taken place.

There was evidence that some people's families had lasting power of attorney (LPA) over their financial affairs and/or health and care interests, but copies of these legal documents were not always held within people's care records. Staff told us that some people's relative's had power of attorney's in place for health and welfare decisions, however when we reviewed those people's care records, copies of these power of attorney's were not on file. In light of this, we were concerned that where people did not have the capacity to make their own decisions, decisions may be made about their health and welfare by a third party who did not have any legal right to make such a decision. The registered provider could not be certain they were acting in people's best interests and in line with the MCA.

We asked people if staff asked for their consent before they delivered care and they told us that they did. One person said, "They ask before attending to me or doing anything." Our observations supported this. For example, we saw staff

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Is the service effective?

asking people if they wanted to go to the toilet and when they refused, this decision was respected. We saw another person was asked where they wanted to eat their lunch and they were promptly relocated to the dining room, although staff told us this was not their usual preferred option.

Some staff told us they had completed training in the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). DoLS are part of the Mental Capacity Act 2005. They are a legal process which is followed to ensure that people are looked after in a way that does not inappropriately restrict their freedom. For example, a DoLS application would be necessary where a person with limited capacity needs to remain under constant supervision to protect their safety and wellbeing. These applications and decisions are made in people's best interests by the relevant local authority supervising body. The registered manager told us that 16 applications for DoLS had been made to the local authority and all relevant cases had been granted. We saw evidence of these granted applications in people's care records. We considered that whilst there was evidence elements of the MCA were applied, records needed to be improved to ensure that best interest decisions were appropriately evidenced in line with the requirements of this legislation.

We looked at how people's general healthcare needs were met and found evidence that healthcare professionals such as doctors, physiotherapists, speech and language therapists and psychiatrists were involved in people's care whenever necessary.

People told us the food they received was good. One person said, "It is good and hot. I enjoy it." Another person told us, "The food is very good actually and I really enjoy it." We sampled some of the food within the home and found it to be very tasty and filling. We saw that there was information about people's nutritional needs in their care records and people were weighed on a regular basis. Where food and fluid charts were in place we found these were completed to monitor people's consumption levels to ensure they remained as healthy as possible.

Good

Is the service caring?

Our findings

People gave us positive feedback when we asked them about the care they received, and this was supported by their relatives. One person told us, "I think the care is good here. I feel listened to and I think they act on what I say. Staff are friendly and chatty. I think they explain things to me. They asked me if I wanted a male or female carer." Another person told us, "I am definitely happy with the way they look after me." Other comments included; "The staff are always nice to me"; "They always ask if there is anything I need"; and "It's like being one of the family". One person's relative said, "We have been delighted with the care here. The staff have been excellent."

We observed care delivery and watched how staff interacted with people. We saw many pleasant interactions when staff were supporting people, for example when assisting them with meals or personal care. Staff engaged with people kindly and respectfully, and there was a calm, happy atmosphere within the home. People told us that they enjoyed good relationships with the staff who cared for them and we heard staff asking people how they were when passing.

We saw that people received care which promoted and protected their dignity, privacy and independence. For example we observed staff knocked on people's bedroom doors before entering and they gave them privacy within the bathroom wherever possible. One person told us, "They will shut the door and pull the curtains while they dress me. They treat me the way they would like to be treated themselves." We observed one person who had exited from their bedroom without being fully clothed. Staff immediately, gently and discreetly encouraged and supported this person to return to their room and assisted them to dress in a manner that maintained their dignity. On another occasion we saw people were asked discreetly if they needed the toilet. People moved around the home independently wherever possible, and we saw that staff encouraged them to do as much as they could for themselves.

We also observed that people were given choices and were involved in day to day decisions about their care. Staff explained in advance about the care that they were about to deliver. We observed one care worker asked a person where they wanted to eat their meal and then said to them, "I am just going to move this footplate on your wheelchair first." The care worker then asked the person if they were ready to be moved to the dining room before doing so. Staff displayed caring and compassionate attitudes towards people resulting in them experiencing positive care delivery.

People's diversity was considered and we saw a vicar was visiting people within the home on one of the days that we inspected. One person told us, "There is a lady comes from the church to see us quite regularly." We asked the registered manager if any person living at the home accessed advocacy services. She told us that usually people's relatives' acted on their behalf and that currently no person living at the home used the services of an advocate. The registered manager told us she was in the process of arranging an advocate to act on one person's behalf who lacked capacity and understanding in relation to their financial affairs.

We looked at end of life care provision within the home and found that effective care planning was in place. Where people had capacity to consent to discussions about their end of life wishes, this was documented within their care records. These care records were held confidentially.

Requires Improvement

Is the service responsive?

Our findings

People told us they felt involved in their care and that staff were aware of, and met their needs. One person commented, "They are very good to me. I don't have to ask, they seem to know what I like. For instance, I like black coffee and it just turns up!" We asked staff to tell us about the needs of some of the people they cared for and they demonstrated they knew people individually. One care worker said, "X likes a coffee and to sit in the corridor and watch what is going on. Y is quite independent but they need help with going to the toilet and getting dressed. Food wise they are on a soft food diet."

We looked at people's care records and found that care plans and risk assessments were in place that were person centred and individualised. Regular reviews of these care records took place, however, we could not always reflect on changes as previous documents were discarded once they were updated electronically. Assessments of need and dependency analysis tools were in place, which were reviewed on a monthly basis. Pre-admission assessments were undertaken before people moved into the home, although we noted that these would be more useful to initial care planning if they contained more detail.

We found that generally people received the care specified in their care records, although there were occasions where these care records did not reflect recent changes to their care and this led to confusion. For example, one person's care records showed contradictory information about how often their blood sugars should be monitored in different records held within their own care file and other monitoring tools in use within the home. One of the nursing staff team told us they followed what they believed to be the correct instructions, which they recalled from a conversation with a fellow nurse, who had discussed the matter with the person's GP. There was no record of this nurse's conversation with the GP and the resulting change in instructions related to the frequency of blood sugar monitoring in the person's care records.

Some care records stated that people's food and fluid intake was to be monitored, but we established this was in fact a historic instruction that no longer applied and records had not been updated. In one case we found an instruction in a communal area that a person should have two sugars in their tea, however, staff confirmed that this was not correct as the person was diabetic. Their care records supported what staff had told us. We were concerned there was a risk that people may receive inappropriate care or treatment due to inaccurate records.

This is a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

External healthcare professionals told us staff were responsive to their requests for information and they followed instructions that they gave about future care to be delivered. We saw that nursing staff had involved general practitioners and, for example, diabetes specialists in people's care, where they had become concerned about their health and welfare. One healthcare professional linked with the home told us, "The staff are always good and seem to know their residents well when I go into the home to work with certain people. The nurse always gives me information in advance and they have always been able to answer my questions."

People's relatives told us that they were happy the service was responsive to changes in their relations' needs. One relative said, "We are kept informed all the time, my relative had a problem with the feeding tube, it was dealt with immediately and we were informed." We saw another relative asking the registered manager for a chiropodist appointment to be arranged for her father and the manager immediately called the chiropodist.

We looked at the activity provision within the home and spoke with the activities co-ordinator who worked at the home four days a week. We observed people enjoying singing in the lounge and partaking in musical instrument sessions. In the afternoon of the first day of our inspection we saw a quiz taking place. One person told us, "We had a good singer in yesterday singing songs from the 1950's." People said they were happy with the activities that were on offer and they could choose if they wanted to be involved. Some people said they had enjoyed trips out into the community. This showed that the registered provider promoted people's wellbeing and social involvement.

People told us that they had not had any reason to complain. One person said, "I am quite comfortable and happy here. I haven't raised a complaint." Another person told us, "I can't complain about anything. I haven't needed to." People told us they were confident that they could raise any issues or concerns with staff or the registered manager. We observed one relative approach the manager with a low

Requires Improvement

Is the service responsive?

level complaint. The manager dealt with the situation calmly, professionally and offered to meet with the relative the following week to discuss and document their concerns in more detail.

We reviewed the way complaints were handled and found that formal complaints on record were all dealt with appropriately and the complainant responded to. Documents were in place related to each complaint and any actions taken. An action plan was also drafted as a result of each complaint. The registered manager was proactive in dealing with complaints and we saw that she addressed issues raised via, for example feedback questionnaires, and she documented her actions.

The registered provider had systems in place to gather people's views to measure the standard of service delivered. The registered manager told us that she analysed this information and responded to any issues or concerns raised. We reviewed some of the feedback received from people's relatives in a recent survey. Some of their comments included; "Keep up the outstanding job that you do. The care, love and support has been outstanding"; "The carers are always very helpful and I appreciate how kind they are to mum"; and "The carers are lovely with X, for which I would like to pass my thanks on".

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection there was a registered manager in post. Our records showed that she had been formally registered with the Commission since October 2011. The registered manager was present on two of the three days that we inspected the home, and on the third day the nominated individual of the organisation was present.

We received feedback from people about the registered manager. One person said, "I know the manager is X. She came and saw me today but she doesn't normally." Another person told us, "Oh yes I know her". A third person said, "She comes around now and then." When we asked people if they thought the home was well led they all said they thought it was. The relatives we spoke with told us that they enjoyed a positive relationship with the registered manager and found the home to have a friendly atmosphere. Staff reported they found the manager approachable and good to work for.

We found the provider had an overall assurance system in place to ensure that staff delivered care appropriately. Monitoring tools such as positional change charts and charts recording food and fluid intake were in place. In addition, we saw the registered manager had a 'check system' in operation where staff had to check on people in their rooms in quieter areas of the home and sign to show that they had done so, on a sheet held communally.

The registered manager told us and records showed that a range of different audits and checks were carried out to monitor care delivery. These included medication audits, infection control audits, and health and safety audits. Staff meetings and meetings for people and their relatives took place on a quarterly basis. Minutes showed that issues such as health and safety, activities and improvements to the home were discussed. The registered manager told us and records showed that she did a weekly 'walk-around' where she looked at the condition of the premises and that care-based monitoring charts, such as food and fluid charts, were completed by staff. We saw that any issues identified in audits, meetings or from the manager's 'walk-around', were formulated into an action plan. The auditing systems in place identified issues that needed to be addressed and the registered manager used action plans to monitor standards and drive improvements.

Records showed the nominated individual visited the home on approximately monthly, and reviewed the premises, care records and interviewed a number of people and staff. An action plan was drafted at the back of each report for identifying issues that needed to be addressed and we saw the completion of these actions was monitored.

We reviewed the accident and incident records held within the home and saw that these were recorded individually and thoroughly analysed on a monthly basis in order to identify any important patterns and trends that may need to be addressed. For example, as the result of a falls analysis, specialist equipment had been arranged for one person and this was subsequently put in place to reduce their risk of unobserved falls. In each case the registered manager had recorded where actions had resulted, and where for example, risk assessments and care plans had been amended.

During our inspection we reviewed the home's log of safeguarding incidents, other serious incidents and DoLS applications that had been granted within the previous 12 months. We established that we had not been notified of several cases in line with the requirements of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. The registered manager acknowledged she had failed to make the necessary notifications and said this was due to a lack of understanding of the requirements of this regulation. She gave assurances that this would not happen again. We were satisfied the registered manager had notified us of deaths and the majority of other serious incidents that have occurred within the home over the last 12 months. Notifications are changes, events or incidents that the provider is legally obliged to tell us about. The submission of notifications is a requirement of the law. They enable us to monitor any trends or concerns within the service. We are dealing with this breach outside of this inspection process.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **People who use services and others were not protected against the risks associated with medicines because the administration of medicines was not safe and therefore the registered provider could not be sure that people got the medicines they required.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records People who used the service were not protected from the risk of unsafe or inappropriate care and treatment arising from a lack of proper information being held about them, as records were not appropriately maintained.