Care Quality Commission

Central & Cecil Housing Trust

Link House

Inspection report

15 Blenheim Road
London SW20 9BA
Tel: 020 8545 4920
Website: www.ccht.org.uk

Date of inspection visit: 14 October 2014
Date of publication: 06/03/2015

Ratings

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

Overall summary

This inspection took place on 14 October 2014 and was unannounced. At our last inspection on 24 July 2013, the service was judged to be compliant with all of the regulations that we inspected.

Link House is a care home providing accommodation and nursing care for up to 52 people. The home is split across three floors providing residential care, nursing care and care for people living with dementia. At the time of our visit, there were 49 people using the service.

The service requires a registered manager to be in place. 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 our visit, the service did not have a registered manager in place. There was a manager in post who had not yet completed the registration process and we will check to make sure this is done. This manager had recently returned from a four-month period of absence, during which other managers employed by the same provider had been covering the role.

We found there were not always enough staff to ensure people's needs were met and the home used a high level of agency staff, which put people at risk of being cared for

Summary of findings

by staff who did not know them well enough to meet their individual needs. However, there were safe recruitment processes to protect people from the risks of being cared for by unsuitable staff.

The provider shared information on good practice with staff through meetings, memos and other communications. However, in the months before our visit staff had not received adequate support such as supervision and specialised training to help them meet people's individual needs.

People had choices about what to eat and drink and the service catered for different nutritional needs. However, there was a lack of monitoring of food and fluid intake for people who were at risk of malnutrition.

People were not always involved in decisions about their care and their views were not taken into account when care was planned. However, people fed back that staff were kind, caring and compassionate although they did not always have time to engage people in meaningful conversations. Staff delivered care in such a way as to respect people's privacy and dignity

We found at least one person was receiving care without a full assessment of their needs or a care plan, which meant they were at risk of receiving unsafe or inappropriate care. However, other people's care was planned in response to a full assessment of their needs and this was regularly reviewed.

The service had clear processes for responding to complaints. However, people did not know how they could discuss their care and have their say and relatives agreed. The service was not carrying out any surveys, meetings or other methods of involving people in decision making about the way the service was provided.

Staff knew about their responsibilities in terms of the Mental Capacity Act and the Deprivation of Liberty Safeguards (DoLS). A number of applications to deprive people of their liberty were waiting to be made, but at the time of our visit the local authority had not yet been able to process these.

There were risk assessments in place and staff were aware of how to manage people's individual risks. The provider had a system to monitor accidents, incidents and environmental risks. There were policies, procedures and systems in place for the safe storage and administration of medicines.

People had access to healthcare professionals to meet their needs when required.

Some people engaged in activities that were meaningful to them, although we found this area was lacking in terms of support for people living with dementia. People and their families said they would like more activities to be offered.

We recommend that the provider consider relevant guidance, such as that produced by the National Institute for Health and Care Excellence (NICE), about cognitive stimulation for people living with dementia.

There were systems in place to assess and monitor the quality of the service. Records showed that improvements had been made in several areas over the last year. Managers were aware of the shortfalls that we found and had an action plan to rectify them.

You can see what action we told the provider to take at the back of the full version of the report.

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

The service was not safe. There were not enough staff to ensure people's needs were met at all times.

People's individual risks, and those relating to the premises, were assessed and managed. There were policies and procedures to protect people from discrimination and abuse.

There were policies, procedures and systems in place for the safe storage and administration of medicines.

Is the service effective?

Requires Improvement

The service was not effective. Staff did not receive the support they needed to carry out their jobs effectively. People at risk of malnutrition did not always receive adequate monitoring of their dietary intake.

People were able to choose from a variety of nutritious food and were able to access healthcare support when they needed it.

Staff were aware of their roles and responsibilities around the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). Appropriate applications were made to the relevant authorities when people needed to be deprived of their liberty.

Is the service caring?

Requires Improvement

The service was not consistently caring. Although staff spoke to people in a kind and respectful manner, they did not always have time to engage people in meaningful conversations.

People and their relatives were not involved in the planning of their care and their views were not always taken into account.

Staff worked to ensure that people's privacy, dignity and independence were respected.

Is the service responsive?

Requires Improvement

The service was not consistently responsive. Not everyone who used the service had their needs properly assessed to make sure they were receiving the right care for them. Other people's care was planned to take their needs into account and care plans were reviewed so they were up to date.

People fed back that they did not have enough activities or community involvement. This was particularly true for people who were less able to engage themselves in activities.

There were clear complaints procedures and the service responded appropriately to complaints.

Summary of findings

Is the service well-led?

The service was not well-led at the time of our visit, although the manager had recently returned from absence and had a plan in place to carry out improvements they had identified.

The service had not asked people or their relatives for their views about how the service was run during the manager's absence.

The provider was aware that they needed to take action. They carried out regular audits, which had identified areas for improvement. Some of these had been completed and others were in progress as part of the action plan.

Requires Improvement 

Link House

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 checked 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.

Before the inspection, we reviewed the information we held about the provider. This included a provider information return, which was information we asked the provider to send to us about their service. We looked at previous inspection reports, reports from the local Dignity in Care project and notifications of events which the provider is required by law to inform us about. We also spoke with commissioners from the local authority.

This inspection took place on 14 October 2014 and was unannounced. It was carried out by an inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We talked with 11 people who used the service and four relatives or friends of people who used the service. We also spoke with two visiting healthcare professionals, two members of nursing staff and eight care workers. We reviewed four people's care records, three staff files and other information relating to the management of the service, such as records of complaints and incidents.

Requires Improvement

Is the service safe?

Our findings

There were not enough experienced and skilled staff to meet people's needs. One person who used the service told us, "There isn't enough staff on duty, there is never enough staff" and we observed that staff had difficulty providing individual support for people who needed it, particularly during lunchtime. For example, we observed one person for 36 minutes during lunchtime and saw they struggled to use the cutlery they had been given and appeared distressed, saying, "I can't manage" and, "I wish someone would help me" several times. Staff interacted with the person nine times during the 36-minute period, but never for more than two minutes at one time. This meant that for most of the lunch period, the person was left without support to eat despite appearing distressed. This also impacted negatively on the person's dignity as the lack of support caused them to spill food onto their clothes several times. Staff and visiting professionals also told us there were not enough staff working at the home, although rotas showed the home's set minimum staffing levels were met. This demonstrated that the service's minimum staffing levels were not sufficient to meet people's needs.

Local reports and staff told us, and rotas confirmed, that the service relied on a large number of agency staff due to a shortage of permanent staff. In one week a month before our visit, the service had used an average of seven agency staff on each day, which meant approximately a third of shifts were being covered by agency staff. Staff and visiting professionals expressed concern about the level of agency staff being used by the home. Staff told us they often had to work with agency staff who did not know people well, which meant they were not able to provide the right level of care to people.

These issues were a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Managers were aware of this problem and a recruitment programme was underway.

We saw that several large objects were being stored in a stairwell that was a main fire escape route from the first floor. Also, objects were blocking access to the evacuation slide that would be needed for people who were unable to walk down stairs. When we pointed this out to the manager, they immediately located the home's handyman and made sure the escape route was cleared. We also found some large objects such as a carpet steamer stored in a communal bathroom. This reduced the bathroom's floor space and had the potential to cause injury to people who might trip or fall on the equipment. We also found no evidence that risk assessments or equipment checks were carried out to ensure that smaller pieces of equipment, such as bed rails, wheelchairs and walking frames, were safe for people to use. This showed that the provider did not have adequate systems in place to identify and monitor risks to people's safety. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

However, we saw evidence of some precautions the provider had taken to ensure that the premises were safe. Fire evacuation procedures were displayed on walls. Fire extinguishers were available and within their service dates. We saw records showing that lifts, hoists and electrical equipment were regularly checked and serviced and there was an annual water hygiene risk assessment. The provider carried out an annual risk assessment of the premises and safety issues identified in November 2013 had been addressed.

The service had a policy on preventing discrimination. Staff told us they challenged any discrimination they saw. The manager told us they had disciplined staff in the past for using language that could be seen as mocking or discriminating against people. We saw that keeping safe and challenging discrimination was included on the agenda for residents' and relatives' meetings. Staff told us they would talk with people in private if they noticed significant changes in their behaviour, such as withdrawal, that might indicate bullying or abuse. They had received training in safeguarding people from abuse and were aware of the provider's recording and reporting procedures for suspected abuse.

The manager told us they minimised risks to people's safety by conducting an assessment before admission to ensure people were appropriately placed and the home was able to meet their needs safely. Each person had a risk assessment, which included specific risks arising from the person's history, any behaviour likely to challenge the service and challenges the person had experienced in the past. Staff told us the service worked closely with the local challenging behaviour team and social workers. We saw evidence of this in people's records. Staff confirmed they received training in managing behaviour that challenged.

Requires Improvement

Is the service safe?

Staff had several ways of sharing information about risks. A communication book used for this purpose contained information such as alerts about recent incidents. The manager told us they discussed incidents with all staff who were involved, including conversations on how they could be managed differently or prevented from happening in future. A visiting healthcare professional told us they felt the service was safe because staff were aware of risks and how to manage them. We observed staff making sure people were aware of risks to them. For example, we saw a member of staff telling one person their drink was very hot and they should let it cool before drinking it.

We looked at records of accidents and incidents kept by the service. There was a reporting and investigation flowchart so staff at all levels were aware of their responsibilities. Reports noted actions that had been taken, further action to be taken and who was responsible. An example of this was when a person had displayed aggressive behaviour and staff had discussed this and noticed a changed pattern in their behaviour. They made sure the person was supported to access medical professionals to check for urinary tract infections as this can often cause people to behave aggressively. Each report had been signed off by a manager and entered into a quarterly summary, which managers told us they used to look for any trends that might indicate increased risks to people or the service. This showed that information from incidents was discussed, monitored and acted on appropriately to help keep people safe.

Recruitment records showed that new staff were required to submit evidence such as criminal record checks, proof of qualifications, two references from previous employers and proof of identity, before commencing work. This helped to protect people from the risks of being cared for by unsuitable staff.

The provider had policies and procedures in relation to the safe storage, handling, administration and disposal of medicines. These included specific information about controlled drugs. We saw that controlled drugs were kept inside a cupboard that complied with relevant legislation to keep them secure and that only the registered nurse on shift had access to the keys. There was a stock control book for controlled drugs and an entry had been made and signed for by two nurses each time medicines were received or removed from the controlled drugs supply. This helped protect people from the risks associated with inappropriate handling of potentially dangerous medicines.

Each person who took medicines had a medicine administration record (MAR) supplied by the pharmacy. We saw that these had been completed daily and if people had not taken medicines, the reasons for this were recorded. Where medicines were to be given only when required (PRN), staff had information about the form, dosage and maximum frequency of the medicines to help them ensure that medicines were given to people safely. The pharmacy carried out medicines management audits at the home, which included storage and administration of all medicines and the management of controlled drugs. The manager held copies of the audits, which they used to identify improvements that were needed.

Requires Improvement

Is the service effective?

Our findings

The home manager told us they regularly sought guidance about best practice, such as by visiting other services and exchanging ideas. They told us there were regular meetings for staff to discuss information on good practice. We saw evidence that staff meetings and memos sent to staff covered topics such as assisting people with eating, referrals to healthcare professionals for people who needed them and best practice in positive risk-taking. This helped to ensure that staff were kept informed about good practice.

However, staff told us that during the five months in which the manager had been absent, they had not received regular supervision. This was confirmed by a supervision record, which showed that more than half of the staff had not received supervision in the two months before our visit. We also found that because some staff training was out of date according to the dates on the certificates, such as training on the Mental Capacity Act, the provider had not ensured that staff were fully up to date with the relevant training. Eight of the 11 staff we spoke with said they had not received training in supporting people living with dementia but felt they needed it. This meant that people were at risk of receiving care or support from staff who were not adequately supported to carry out their roles effectively. This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People's dietary needs and preferences, including ethnic and cultural requirements, were assessed and recorded before admission. Each person had a nutrition care plan, which took this information into account. However, we found that people's food and fluid intake was not being sufficiently monitored where people were at risk of malnutrition. For example, one person was assessed at medium risk due to their medical history. Records showed they had been admitted to hospital four months before our visit and received a specific diagnosis that indicated they were at risk of malnutrition. However, their care plan had not been updated to reflect needs arising from this. There was no evidence of any systems in place to manage associated risks or to monitor whether the person was eating and drinking enough, although the person had lost almost a quarter (23%) of their body weight after returning from hospital. There was no evidence that the provider had followed guidance about nutritional support for people who lose large amounts of weight in short time periods.

Records showed the person had been weighed monthly since their hospital admission but there was no information about what a healthy weight would be for that person or any information about how staff should monitor the person's recovery. Staff confirmed they did not have food and fluid monitoring in place and daily notes contained no information about the amount or type of food eaten. We did not see evidence that the person had been referred for specialist input to support their nutrition. This meant that the person was not adequately protected from the risk of becoming malnourished or losing weight. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

In other cases, we found people had access to healthcare support. People confirmed that they saw the doctor, optician, podiatrist and dentist when they needed to and records confirmed this. During our visit, we saw a GP, a district nurse and a hospice worker tending to people. Some people had been referred to specialist services when required, including continence and pain management services. Information from appointments was logged in people's personal files. This meant that, in most cases, staff had access to specialist advice to help them understand the day-to-day care people needed.

There were pictorial menus available in communal areas to help people understand their meal choices. There was a four-weekly menu, which was available on a seasonal basis, and each main meal included a vegetarian option. The service employed a chef manager, who told us how they made sure each person's dietary requirements were met. For example, they received an order sheet for each floor of the home with details about what each person wanted, and any special requirements such as for people who had diabetes, allergies or special preferences and those who required food supplements. We observed staff offering people a choice of drinks at times throughout the day and when one person said they did not like some of the food on their plate, staff offered the person an alternative.

The manager and relevant staff were aware of their responsibilities around the Deprivation of Liberty Safeguards (DoLS) and when to apply these. The manager told us they were trying to cut out barriers to people's

Requires Improvement

Is the service effective?

freedom. For example, if someone wished to go out, the manager instructed staff to prioritise supporting that person rather than completing any paperwork that could be finished later on. However, we saw in one person's records that they had tried to leave the home six days before our visit and had become agitated when staff prevented this, saying they felt "locked up," but no recorded attempt had been made since then to support the person to leave the building, except for a medical appointment.

Some applications had been made to deprive people of their liberty and these had been authorised for some people. However, at the time of our visit not everybody who required a DoLS application had had one. This included the person who wished to leave the home the week before our visit and another person whose bed had bed rails that were designed to manage the risk of them falling but which may also have prevented them from getting up when they wished. The manager told us this was because the local authority did not have capacity to deal with the number required and had asked them to send no more than two applications per week. People could not spontaneously leave one floor of the house because the exit was controlled via a keypad that only staff could activate. Staff told us they would open the door if people wished to move between floors. They explained the system was in place because the needs of people on this floor meant they were prone to becoming disorientated. The use of the keypad meant staff would be aware of which floor people were on in case of fire or any other emergency where people needed to be accounted for. The manager was aware the use of the keypad could be depriving people of their liberty and told us all the people living on that floor were included in the DoLS applications being made.

We noted that the service had taken steps to make the premises accessible to people living with dementia and those who required support for their mobility. For example, communal rooms had pictures on the doors to indicate their function and aid orientation. Bedroom doors were painted different colours to help people identify their own doors and so they contrasted with the walls to make them more visible. Some bathrooms were newly refurbished with sinks whose height could be adjusted to suit the individual, including those using wheelchairs.

Requires Improvement

Is the service caring?

Our findings

Care plans showed little evidence that people or their relatives had been involved consistently in planning care, or that their views had been taken into account. When we asked four people and two relatives about care planning and reviews, they told us they were not aware that these existed although they had been involved in conversations about care. They said they would like to be given opportunities to be more involved. One person's care plan stated that they did not like to be disturbed at night but that staff were to check on them anyway. There was no rationale, such as a risk management plan, given for checking on the person and no evidence that the provider had considered ways of mitigating any risks without disturbing the person's privacy. Another person's care plan stated that they appeared as if they preferred not to socialise with others. However, the person was deemed capable of expressing their views verbally, but there was no evidence that they had been asked whether or how they liked to socialise. This meant there was a risk that people were not being supported or cared for in ways that they were happy or comfortable with because they had not been fully involved and consulted about their care. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People told us the staff were kind and compassionate. One person said, "I am very well looked after." Another person's relative told us, "I think they're wonderful. I feel so much better being so far away and knowing [my relative] is in good hands."

We saw evidence that staff worked to gather information about people's personal preferences and life histories. The information included people's marital status and family situation, ethnicity, religion and food preferences. We looked at the file of one person who had recently moved into the home and saw that staff had talked to them about their life history. Staff told us the person's first language was not English but one member of staff spoke the same first language as the person and their family. We observed a member of staff speaking to the person's family in their native language on the telephone. These practices helped staff to build positive caring relationships with people who used the service and those important to them.

We observed that when people appeared upset or disorientated, staff attempted to reassure them. However, staff often did not have time to reassure people fully or explore the cause of their distress. For example, one person said, "I don't know where I am" and a member of staff responded, "You are in Link House" before walking away. After the staff member had left, the person said, "I don't know what that is. What house?" This showed that on that occasion staff did not spend enough time with a person to reassure them and to allay their anxieties.

The provider worked to maintain people's independence as far as possible, although there were shortfalls in this area. For example, each floor had a kitchenette where people and their visitors were able to make hot and cold drinks. However, one person told us they would like to be able to make tea for themselves or with staff help, but that staff always made their drinks for them. The manager told us that some people were able to move between the different floors of the house as they pleased, as long as staff knew their whereabouts. One person asked to accompany us to a different part of the house and we observed staff supporting them to return to their own floor when they were ready to do so. Staff told us some people were able to go out independently and this was facilitated wherever possible by means of ensuring foreseeable risks were properly managed. For example, staff would note what time people left the home and what they were wearing, in case they did not return within the expected time. Care plans described people's levels of independence and instructed staff about how to support people to do things for themselves where possible.

On several occasions during our visit, we observed staff referring to people who used the service by their room numbers rather than their names when speaking to other members of staff. This could be seen as disrespectful to the people being discussed. However, we did note that when staff were speaking with people directly, they used their preferred names and a respectful tone of voice. Visitors to the home told us they always saw staff treating people with respect. When addressing people we observed staff using language that was appropriate to people's level of understanding and age.

We witnessed staff knocking on people's doors, nearly all of which had knockers or bells and mail boxes. The manager told us this was to help give people a sense of ownership of their private space and "having their own front door." Some

Requires Improvement

Is the service caring?

front doors were due to be finished with knockers and mail boxes shortly. We saw that staff closed the doors if they were carrying out care or nursing tasks in people's bedrooms.

Requires Improvement

Is the service responsive?

Our findings

One person's file contained no record of any assessments of needs or risks. Staff told us this was because the person was admitted to the home less than three weeks before our visit and they did not yet know whether the move would be permanent. However, this meant that the person was at risk of receiving inappropriate or unsuitable care during their stay due to a lack of information about them. For example, there was no information or care plan detailing what support the person needed with personal care, but their daily notes showed that staff did support the person daily with personal care. This risk was increased due to the high proportion of agency staff used by the service, who may be less familiar with the person than permanent staff. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Other people's care plans were based on an initial assessment that covered their specific needs in various areas such as personal care and preferred activities. The assessments had been repeated at least annually to ensure people's changing needs were taken into account. This helped staff have a thorough knowledge of how to care for people in an individual way to suit their preferences and needs. The care plans were reviewed at least annually and contained goals for people to achieve, such as becoming more involved in activities to help prevent social isolation. This included information for staff about how to support people who might need encouragement to interact with their peers.

Records showed that staff discussed responding to people's needs at team meetings. Topics included updating care plans and communicating with colleagues when people's needs changed over time. We saw examples of this in people's care records, such as care plans being updated to include information about how a healthcare professional was to be involved in one person's care in response to a change in their healthcare needs.

We checked the service's complaints log, which showed how the provider responded to people's complaints and concerns. Each record showed that the complaint had been responded to and the action taken took into account the complainant's wishes as far as possible. The provider had a procedure for responding to complaints, including an initial response within one day of the complaint being made, and records showed that the procedure had been adhered to in all but one instance. The records for this particular complaint included an explanation for the longer response time. Leaflets and brochures about how to complain, including contact details, were available for people and their relatives to take. During our visit, one person told us they did not always feel listened to with regard to specific dietary preferences they had requested. We fed this back to the manager, who later met with the person to discuss how the service could meet their needs better and arranged a follow-up meeting with the person and their relative later in the week. The manager told us the initial meeting had been positive and that the person was happy with the outcome.

During our visit, we saw that some people were engaged in a variety of activities. In one communal area, one person was reading a newspaper, another was knitting and a third was receiving support from staff to engage in an arts activity. The person reading the newspaper told us it was important to them that they had their daily paper and that staff made sure they received it. There was a volunteer visiting the home, who engaged people in one to one activities such as a jigsaw puzzle. Assessments and care planning covered people's hobbies and preferred activities, including their preferred level of inclusion in social activities. However, we observed that several people were asleep during our visit or were not offered any activities. Some people told us they would like to go out to cafes or for walks. Two visitors felt that there was little stimulation for people who were less able to engage themselves in activities, particularly people with dementia. One relative told us, "There should be many more activities. [My relative] likes doing things. They could take her downstairs but she never gets taken… She likes going out."

We recommend that the provider consider relevant guidance, such as that produced by the National Institute for Health and Care Excellence (NICE), about cognitive stimulation for people living with dementia.

Requires Improvement

Is the service well-led?

Our findings

When we visited the home, we were told the manager had returned the previous day from a long-term absence. Staff spoke positively to us about the manager's return. One member of staff said they had struggled without a manager due to lack of organisation and direction but were confident this would improve. We noted that a common theme in audits carried out during the manager's absence was that staff were unsure of their responsibilities or where to find key documents relating to the management of the service. However, the manager was aware of these challenges and was able to tell us about a detailed plan for improving the service in terms of visible and accessible leadership.

The home manager and area manager told us they ran a 'residents' group' to discuss the running of the home, but only two people had been involved at the last meeting four months before our visit so they were currently planning ways to involve more people. However, people and relatives told us they were not aware of any meetings or ways in which they could be involved in the provision of the service. One relative said, "I've never been to a relatives'/residents' meeting, not since [my relative] was admitted. Let families know when things are happening and help." We did not find any evidence that people or their relatives were involved in the running of the service by any other means. This meant that the provider was not following their own diversity policy, which stated that they should use effective methods of collecting people's views such as surveys and meetings, to ensure their needs could be met. During our visit, people, their relatives and staff identified several changes they would like to make to the service but managers were not aware of these because they did not have effective mechanisms in place to seek and act on people's views or those of staff. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We discussed with the manager how they used current research and guidance to aid their delivery of high quality care. This included links with a research and training programme that provided training on caring for people living with dementia. The manager told us the programme had provided leadership training for managers and senior staff. The service also worked with the local authority and other local services providing specialist training on good practice, such as the challenging behaviour team.

The manager told us they used handovers to monitor the culture of the service, such as the language used when discussing people who used the service and their relatives. They said they had placed more emphasis on staff attitudes in the recruitment process and had introduced a tour of the home as part of the interview stage, during which they would monitor candidates' interactions with people who used the service. This helped them to make sure staff were aware of, and continued to uphold, the service's values of dignity and respect.

The manager explained systems that were in place to ensure high standards of care were maintained. Examples included checks to make sure records had been completed correctly and disciplinary action they took when staff did not meet the required standards in their work. We noted that a medicines handover form, which staff were asked to complete each shift to confirm that their colleagues had administered medicines according to care plans, had not been completed on seven days in September 2014. This omission had not been picked up by managers. However, records of previous quality checks showed that a large number of medicines errors and instances of poor practice had been identified earlier in 2014, and these had been addressed by the time of our visit, showing that the quality of medicines administration and recording was improving. The area manager was aware that there had been shortfalls in this area, and told us they had placed particular emphasis on medicines management in their plans to improve the service.

We spoke with the home manager and the area manager, who told us about the key challenges and achievements of the service. They told us they had identified a number of areas for improvement, which agreed with our findings at this inspection. This showed that the provider had an effective system for identifying risks to the service, although they had not yet made the necessary changes. We looked at two audit reports from June and August 2014. Although some issues identified in June had not been rectified by August, there was evidence that improvements had been made by the time we visited.

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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The registered person did not ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe, by means of the carrying out of an assessment of the needs of the service user. The planning and delivery of care was not carried out in such a way as to meet the service user's individual needs or reflect published research evidence and guidance issued by the appropriate professional and expert bodies as to good practice in relation to the nutritional needs of service users. Regulation 9 (1)(a)(b)(i)(ii)(iii)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers The registered person did not protect service users against the risks of inappropriate or unsafe care and treatment by means of the effective operation of systems designed to enable the registered person to regularly assess and monitor the quality of the services provided in the carrying on of the regulated activity. The registered person did not identify, assess and manage risks, relating to the health, welfare and safety of service users and others who may be at risk, arising from the physical environment. The registered person did not regularly seek the views of service users, persons acting on their behalf and persons who are employed for the purposes of the carrying on of the regulated activity. Regulation 10 (1)(a)(b)(e)

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **The registered person did not make suitable arrangements to ensure that service users were enabled to make, or participate in making, decisions relating to their care or treatment.** **The registered person did not encourage service users, or those acting on their behalf, to express their views as to what is important to them in relation to the care or treatment or, where necessary, assist service users, or those acting on their behalf, to express their views and, so far as appropriate and reasonably practicable, accommodate those views.** **The registered person did not provide appropriate opportunities, encouragement and support to service users in relation to promoting their community involvement. Regulation 17 (1)(b)(2)(c)(ii)(d)(f)(g)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **The registered person did not take appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity. Regulation 22.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **The registered person did not have suitable arrangements in place in order to ensure that persons employed for the purposes of carrying on the regulated activity were appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to service users safely and to an appropriate standard, including by receiving appropriate training, professional development, supervision and appraisal. Regulation 23 (1)(a)**