Maria Mallaband Limited

Batley Hall Nursing and Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**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 of Batley Hall Nursing and Residential Home took place on 6 June 2016 and was unannounced. The previous inspection had taken place on 6 March 2014. The service was not in breach of the health and social care regulations at that time.

The home provides accommodation for up to 51 people who require nursing or personal care. Batley Hall is a 19th century building which has been modernised and refurbished. The home has gardens and a patio area for people to use. Accommodation is provided over three floors, which can be accessed using passenger lifts. There were 47 people living at the home at the time of the inspection.

The home had a registered manager 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 2008 and associated Regulations about how the service is run.

All of the people we asked told us they felt safe living at Batley Hall Nursing and Residential Home. Relatives we spoke with told us they felt their family members were safe.

Staff and the registered manager had a good understanding of different types of potential abuse and were aware of safeguarding reporting procedures.

Risks to people were assessed and risk reduction measures were in place to help minimise risks to people.

Some important information was missing from some people's care plans and a personal emergency evacuation plan. The meant some people's needs were not accurately recorded which placed those people at risk of harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff received training and support and regular supervision to in order to perform their duties effectively. Staff and the registered manager felt supported.

Care and support was provided in line with the principles of the Mental Capacity Act 2005, although some staff lacked knowledge in this area.

People received support to meet their nutrition and hydration needs.

Staff interactions with people were caring and people appeared at ease in staff presence. People and relatives told us staff were caring. Staff treated people with dignity and respect. People's cultural and religious needs were considered.

Care plans were person centred, enabling personalised care to be provided to people. Care needs were regularly reviewed and people were invited to be involved in reviewing their care needs.

The registered manager held regular meetings with staff and people who lived at the home. Feedback was sought and acted upon.

We found the registered manager to be open and receptive to feedback during the inspection. Audits took place but these were not sufficiently robust to identify some areas which needed addressing.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People told us they felt safe.

Robust recruitment practices were followed to ensure staff were suitable to work in the home.

Key information was missing from some people's care plans and a personal emergency evacuation plan, which could place people at risk of harm.

Is the service effective?

Good

The service was effective.

Staff knew the people who they were supporting well.

Staff received training and ongoing support in order to provide effective care.

People were given support to ensure their hydration and nutritional needs were met.

Is the service caring?

Good

The service was caring.

We observed positive interactions between staff and people who lived at the home.

People's privacy and dignity were respected.

The home had received an award for high quality of care provided for people in final years of life. People's end of life wishes were considered and respected.

Is the service responsive?

Good

The service was responsive.

Care plans reflected people's preferences and choices and plans

were tailored to each individual. This enabled personalised care to be provided by staff.

Care plans were evaluated regularly.

People's living spaces were personalised to their tastes.

We observed people making their own choices.

Is the service well-led?

Requires Improvement

The service was not always well led.

The registered manager held regular meetings with staff and people who lived at the home.

Community links were evident, for example with a local school.

Regular audits and quality checks took place, however, these required improvement to be fully effective in improving the service provision.

Batley Hall Nursing and Residential Home

Detailed findings

Background to this inspection

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

We inspected Batley Hall Nursing and Residential Home on 6 June 2016. The inspection was unannounced. The inspection team consisted of three adult social care inspectors.

The registered provider had been asked to complete a Provider Information Return (PIR) and had submitted this to us prior to the inspection. 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.

Prior to the inspection we reviewed information we held about the home and contacted the local authority commissioning and safeguarding teams and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During the inspection we spoke with eight people who lived at the home, three visitors who were friends or relatives of people who lived at the home, a member of catering staff, four care staff, a senior carer, a registered nurse, an activities coordinator and the registered manager. Following the inspection we spoke with the registered provider's project manager, responsible for the implementation of the electronic care planning system.

We looked at eight people's care records and daily communication logs, four staff files including recruitment, supervision and training data, as well as records relating to the management of the service and maintenance of the home.

Requires Improvement

Is the service safe?

Our findings

We asked people whether they felt safe living at Batley Hall Nursing and Residential Home. A person we asked said, "Yes, I do." Another said, "Yes, I feel safe." A relative told us, "My [name of relative] is safe and happy here."

The registered manager and staff had received training and were clear about safeguarding reporting procedures and were able to outline different types of abuse and the potential signs to look for, which may indicate if someone was at risk of harm or being abused. Appropriate referrals had been made, for example to the local authority and the care quality commission (CQC) and the registered manager had sought advice when necessary. Staff were aware of the whistleblowing policy. A member of staff told us they would have, "No qualms," about whistleblowing if they felt they needed to, to protect people from abuse or harm. This showed people were protected from abuse and improper treatment because staff had received relevant training and the registered provider had procedures and processes in place to protect people.

The registered manager told us risk assessments were in place in relation to the building, environment and also in relation to risks to individuals associated with falling, use of bed rails, and moving and handling for example. We saw door key risk assessments had been completed and personal preferences had been considered regarding whether people wished to have their doors open or closed. Risk assessments had been evaluated and updated regularly. This helped to ensure staff were aware of who was at risk and what actions to take to reduce risks.

A member of staff we spoke with told us, "We evaluate everything. Check if there's a risk to the resident or to myself." Another staff member said, "Everything is risk assessed. Moving and handling. It's in the care plan so we know what's best for each person."

Prior to the inspection, we had been notified by the registered manager that a person had fallen, resulting in a laceration to their head. It was documented in the person's care plan that the person refused the use of walking aids and wished to remain independent. We found appropriate incident reports had been completed and action had been taken. The person's falls risk assessment had been updated the person's care plan had been updated accordingly. Falls risk reduction measures had been put into place and the person had been referred to a falls clinic. This showed the registered manager took steps to reduce risks whilst respecting people's wishes to remain independent.

One person was sat outside for some of the day during the inspection. We heard staff communicate to ensure the person had a call bell with them, so they could request assistance if required. This helped to ensure the person's safety.

Personal emergency evacuation plans were in place. These plans took into account whether people's needs were low, medium or high and the equipment and number of staff required to assist each person, in the case of an evacuation. However, in one of the plans we sampled the person's significant individual physical disability was not recorded. Furthermore, the plan stated the incorrect room number in relation to the

person's bedroom. We shared this with the registered manager, who advised they were unsure how to add the person's individual disability to the record due to the complexity of the electronic system. This meant, although plans were in place, people may not be evacuated safely in an emergency because incorrect information had been recorded. We spoke with the company's project manager of the new electronic system following the inspection and we were advised the system was capable of recording such information but accepted staff at Batley Hall Nursing and Residential home may benefit from further training in order to ensure all relevant information was recorded.

We found some care plans were lacking information in order for safe care and treatment to be provided. For example, one of the care plans we sampled showed the person was at risk of choking with thin liquids. We asked the registered manager what actions staff should take to reduce the risk of the person choking and we were told staff used a food thickener to reduce the risk. However, this information was not documented in the person's care plan. This meant the person could be at risk of choking, because their needs were not recorded or documented in the person's care plan. Another person required a specific mattress to manage pressure care because the person was at risk of developing pressure ulcers. The care plan did not indicate the setting that was required for the mattress, which meant there was a risk the assessed need was not met. Some people's care plans stated they required assistance from two staff to use a hoist in order to assist the person to move. However, there was no guidance included to assist staff to safely secure the hoist to move people. The registered manager contacted us following the inspection to confirm this information had been updated immediately following the inspection.

We observed a person trying to climb over their bed rails. A member of the inspection team called a member of staff to assist the person. We looked at the person's risk assessment in relation to the bed rails. The assessment stated, 'Does not try to get out of bed.' We felt this needed immediate attention and advised the registered manager. We were contacted by the registered manager following the inspection and assured the person's needs had very recently changed and had been reassessed and the rails were no longer in use but other risk reduction measures were in place.

The above examples demonstrated a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because risks were not always appropriately assessed and key information in some care plans was missing, resulting in people being at risk of harm.

The registered manager kept records of fire safety checks. We saw risk assessments were in place in the event of an emergency evacuation. These risk assessments took into account risks such as electrical hazards for example, and considered risk reduction measures such as emergency lighting, signage, escape routes and practice drills. The fire evacuation procedure was displayed on the wall in communal areas. We saw evidence fire drills had taken place regularly and any lessons learned were shared and discussed with staff.

We saw an emergency folder was in place with a 'grab bag' which contained items that may be useful in an emergency, such as high visibility vests, a torch, wrist bands, blankets, a mobile phone, energy sweets and contacts numbers. This was checked weekly to ensure information was up to date and all contents were present. This demonstrated measures were in place to help ensure the safety of people in the event of an emergency.

Health and safety checks took place regularly. For example, records showed water temperatures in baths and showers were regularly checked and these were found to be within acceptable parameters. Electrical portable appliance testing (PAT) had been carried out and was up to date. This helped to keep the premises and equipment safe.

There was an evacuation mat available for use in an emergency, which was stored in the corridor. A sign had been placed next to this piece of equipment, stating, 'Access needed to evacuation mat at all times. Do not block access with hoists, wheelchairs or other equipment.' However, between 11.30am and 4.00pm on the day of our inspection, access to the mat was blocked by a hoist. We highlighted this to the registered manager who agreed to address this.

We looked at accident and incident records. We saw that analysis took place. The day, time and circumstances were considered and this helped to identify any trends. We saw the analysis included information such as, 'details of remedial action, by whom and when.' The form prompted staff to consider whether and what risk reduction measures were in place. This helped to identify patterns of risk and reduce risks to people.

A dependency tool was used to help determine staffing levels. This took into account the level of people's need. Staff numbers were planned to include an additional 15 – 20% in order to cover for staff sickness or holidays.

A person told us, "If I press the buzzer, they are busy, but they come pretty quick." A family member told us they felt there were enough staff. Some staff we spoke with told us they felt there were enough staff. However, one staff member told us they felt there were not enough staff. They said, "We can't just sit and chat to people." Another member of staff said, "I suppose you could say we could do with extra staff on a morning. We can't interact as much as we want. We talk as we are doing. We can't just stop and chat."

We observed people's needs being met by staff. We looked at a random sample of the times it took to answer nurse calls and we found calls were answered in a timely manner.

We looked at four staff files and found safe recruitment practices had been followed. For example, the registered manager ensured that references had been obtained, identity checks had been completed and Disclosure and Barring Service (DBS) checks had been carried out. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups.

We looked at whether medicines were managed and administered safely. The nurse administered medicines for people who required nursing care and a senior carer administered medicines for people who required residential care. We saw records to show staff responsible for administering medicines had received appropriate training. Furthermore, competency had been assessed following the training to ensure they were safe to administer medication. The competency assessment considered skills such as preparation, safe administration, recording and storage of medicines.

There was an electronic medication administration record (MAR) system in place. Each staff member accessed the electronic system with a unique identification. This meant records showed which member of staff had been responsible for administering medicines. The system displayed a photograph of each person and notified the staff member if a person had not been recorded as receiving their medicines. This reduced the risks associated with medicines being given to the wrong person or being missed. Despite this, however, on one of the records we viewed we found the medication administration record showed there should have been 30 doses of medicine remaining, but there were 29. The member of staff told us the medicine was given but not recorded.

The storage of medicines was safe and temperatures were recorded to ensure medicines were stored within safe temperature parameters. We saw dates of opening had been recorded on medicines which helped to ensure only medicines that were in date were administered.

We checked the controlled drugs, which are prescription medicines that are controlled under Misuse of Drugs legislation. We saw weekly stock checks were completed and the controlled drugs register was up to date and signed by two members of staff. This demonstrated controlled drugs were managed safely and appropriately.

We found the home to be clean with a pleasant odour. We saw anti-bacterial hand sanitizer was placed around the home and we observed staff to use these. Staff told us they had access to personal protective equipment (PPE) and we observed staff wearing these. This helped to prevent and control the possible spread of infection.

Good

Is the service effective?

Our findings

We asked a person their views about the quality of food and were told, "The food is quite good."

Staff had received induction and training to enable them to provide effective care and support to people. In one of the files we sampled we saw discussion had taken place at the end of an employee's probationary period, to address any areas which required further training. We saw staff had received training in areas such as safe moving and handling, fire safety, emergency first aid, food safety, infection prevention and control, dementia awareness and safeguarding.

The registered manager told us staff received one to one supervision six times per year and had an annual appraisal. In the four staff files we sampled we saw supervision contracts were in place. These outlined how often staff would receive supervision and outlined the 'ground rules' for supervision such as confidentiality, timekeeping and willingness to reflect on skills. We saw evidence staff received regular supervision. Discussions took place during supervision in relation to learning, culture and work environment, objectives and how to achieve them. A member of staff confirmed they had supervision six times a year and said, "It feels like a lot." A further staff member told us they felt supervision was, "Helpful." This showed staff received regular support and management supervision to monitor their performance and development needs.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. The registered manager told us they and staff had completed MCA training. The registered manager demonstrated a sound understanding of the MCA. Although the registered manager told us, and we saw records which showed staff had received training in this area, we found some staff knowledge to be lacking. When asked, some staff were unsure whether they had received training in relation to the MCA.

The registered manager had identified some people living at the home lacked capacity and were potentially being deprived of their liberty. Applications had been submitted to the local authority in order for this to be authorised. One application had been authorised and the others were awaiting a decision.

We saw evidence consent to care was sought. In one of the files we sampled we saw a document which stated, "I have read, understood and discussed my plan of care and risk assessments with [Member of staff].

I agree to its content and consent to the care prescribed.' This was signed by the person receiving the care. We also saw consent forms had been signed in relation to the use of equipment, whether the person wished to have their door open or closed or having photographs taken. In another file we sampled we saw the person's relative had signed the documentation and there was a record the person had consented to their relative signing the documentation on their behalf.

We found, where a person lacked capacity to give consent to care and treatment for example, appropriate mental capacity assessments were recorded and a decision had been made in the person's best interest.

People's nutritional and hydration needs were being met throughout the day of the inspection. There was a water cooler in the lounge area. Some people chose to stay in their rooms and we saw jugs and cups of water in people's rooms. The inspection took place on a warm day and, throughout the day, we heard people being encouraged to drink fluids and people were offered different flavoured ice lollies.

Catering staff were aware of people's specific dietary requirements. The cook told us they were, "very happy with the quality and quantity of ingredients and food." The most recent food hygiene rating was five, which equates to, 'Very good.'

We observed a mealtime experience. People were offered support to eat their meals. Staff could be heard saying phrases such as, "Can you manage?" and, "Do you want me to cut it up?"

A person had not eaten their meal and we heard staff say, "Do you want something else?" People were asked whether they had finished eating or whether they wanted more food before plates were taken away. Staff offered choices of drinks, meals and desserts to people and asked about preferences in relation to portion sizes. We heard a person say, "Well, it's a nice dinner." This showed people were given support to ensure their nutritional needs were met.

People had access to health care and we saw referrals were made to other agencies or professionals. For example, we saw referrals had been made to a general practitioner, speech and language therapist, district nurse and a falls clinic. This showed people using the service received additional support when required for meeting their care and treatment needs.

Batley Hall Nursing and Residential Home had a fresh, homely feel. There were photographs placed around the home. Communal bathrooms had been made to feel homely, for example by including pictures on walls. The design of the home meant people could access quieter areas as well as the main lounge. There was a patio area, directly accessible from the communal lounge area and there were well maintained gardens with seating areas.

Good

Is the service caring?

Our findings

A person who lived at Batley Hall Nursing and Residential Home told us, "The staff are very nice. Some nice girls."

Another person told us, "Staff are nice, yes. I like it."

A relative of a person living at the home said, "The carers. They are angels. It's a lovely place. I have not got a bad word to say about any of them." We were also told, "They [the carers] will do anything for these people."

A member of staff told us they felt, "Satisfaction when we see people come in unwell and then with the care here their health improves."

Another member of staff told us, "I love it working here. It's a nice environment. I just love it."

Throughout the day of the inspection, we observed people being given choices and being treated with dignity and respect.

We saw a member of staff observed a person to be seated in an uncomfortable position. The member of staff asked the person if they could make them more comfortable by using another cushion.

We observed a new member of care staff to be assisting a person to eat their meal. The carer sat with the person and chatted quietly whilst assisting the person to eat their meal. The person looked comfortable in the presence of the staff member and with the support they were being given and was enjoying their meal.

Staff were able to explain how they would protect people's privacy and dignity. A member of staff told us they would, "Shut doors and curtains. Do things [the person]'s way. Keep the person covered."

We observed staff assisting a person to move with the use of hoisting equipment. Staff put the person at ease and explained to the person what was happening throughout the manoeuvre. The person appeared relaxed at what could otherwise be a stressful situation.

We observed staff asking people, as they walked passed them, if they were ok and whether they wanted anything. On occasion, the person did not hear the member of staff, so the staff member stopped, repeated their question and took time to listen to the person's answer. All the staff we observed demonstrated a patient and caring attitude. The atmosphere in the home felt calm and relaxed.

People's cultural and religious preferences were considered. Staff ensured people who had specific dietary requirements due to their religious faith were able to maintain this. The registered manager told us holy communion took place monthly and this took place within the person's own room if they preferred.

The home had been awarded a Quality Hallmark Award in care for people in final years of life. This certified

the home met the Gold Standard Framework for high quality of care provided. This award was valid from September 2013 to September 2016.

A red sticker was placed in a visible place in the files of people who had a 'do not attempt cardio pulmonary resuscitation' (DNACPR) order in place. In some of the care plans we sampled we saw details such as who the person would like contacting if they became near the end of their life and whether they would wish for a religious person to visit. This helped to ensure staff were aware of people's wishes in relation to end of life.

Good

Is the service responsive?

Our findings

One person told us, in relation to food and meals, "There is no choice. You have to have what they put out." This person told us, in relation to activities, "Nothing. Only sit."

A relative told us, "[Name] likes to stay in their room. Staff come and talk to [name] when they can. They go to bed when they want.

Care records consisted of a file relating to each person in the nurses office which stored essential information and consent forms, a file in the person's room with information such as food and fluid intake and an electronic care plan, which staff accessed using secure electronic devices.

We sampled eight care plans. Care plans were person centred and included a photograph of the person to whom the information related. The person's preferences, likes and dislikes were recorded. For example, we saw information recorded such as, 'Likes wearing a watch every day,' and, 'Does not like deodorant or perfume,' and, 'Prefers the window closed at night.' We observed the person to be wearing their watch. This helped to ensure staff were aware of people's preferences so they were able to offer personalised care and support to people.

Care plans recorded people's background and interests and hobbies. We saw these were specific to the person. For example, one plan stated, '[Name] likes netball and football' and '[Name] is afraid of ghosts' and '[Name] enjoys crosswords.' This person told us they enjoyed crosswords and we saw they had some on their bed. We saw plans provided information relating to the person's personal history and background. This further helped staff to be able to offer appropriate, personalised support.

Each care plan contained information relating to the support the person required in relation to nutrition and hydration, skin integrity, personal care, continence management, mobility and communication for example.

The registered manager told us care plans were reviewed monthly, or more frequently if required, and we saw evidence of this. Care plans had recently moved to an electronic system. We saw notices had been placed in people's rooms which stated, 'Your care plan is now on the computer system. If you would like to look at it please ask nurse or care assistant. We welcome your input into planning your care.'

We saw people's rooms were personalised and contained personal items such as ornaments and photographs. The registered manager told us people could bring to the home, "Whatever they like." The registered manager said, "It's their home."

Throughout the day of the inspection we saw people being offered choices, for example in relation to food, drink and whether they participated in activities. A staff member told us, "It's not regimented. We all try to have a bit of fun."

One person told us, "I have a bath on a Saturday but if I miss or don't feel like it, they ask me on another day. You don't miss out. You can choose to have a bath or a shower." This showed people were given choice and control.

There was an activities coordinator at the home. Having a dedicated activities coordinator meant staff at the home were able to continue to deliver care whilst people participated in activities. We saw varied activities such as nail painting, quizzes, bingo, patio crafts, patio planting, sound bingo, films, holy communion, entertainers, baking, dominoes, puzzles, tea parties as well as trips outside of the home such as a boat trip. The activities coordinator told us they completed a monthly plan for activities and ensured they visited people who were nursed in bed. The activities coordinator said, "We encourage people to come out of their rooms to participate in activities." There was Royal display and a poster advertising the home was hosting a tea party to celebrate the Queen's birthday. There were newspapers and magazines which were accessible for people to read. Throughout the day we saw people appeared to be enjoying reading these.

The complaints procedure was displayed. A complaint had been received during March 2016. We saw the registered manager had addressed this and discussed expectations with the staff concerned. Action had been taken through individual supervision. We saw the complaint was acknowledged, investigated, actions taken and the complainant was responded to and offered an apology. This showed the registered manager took action in relation to complaints.

Requires Improvement

Is the service well-led?

Our findings

The registered manager had been registered with the CQC to manage the service since February 2012.

One person told us, "[Name of registered manager] is really nice."

A staff member told us, "Residents know all staff. It's their home. They need to know staff."

Another member of staff told us, "Everyone is very good here. If you don't know, just ask and they help you." A further staff member said, "I think this is a good care home. It's a good organisation, yes. They seem to do a lot for the staff."

Staff we spoke with felt confident they could share any concerns with the registered manager and they felt they would be listened to.

A member of staff told us they felt the registered manager was visible throughout the day and the staff member felt they could take any concerns to the registered manager.

A staff member told us, "You can go into the office any time. Can go in and ask [registered manager] anything. This staff member told us they felt well supported and said, "We all help each other out." A stable staff team was evident with some staff having worked at the home for many years.

The registered manager told us resident and relatives' meetings were held every eight to nine weeks. We looked at minutes from the most recent residents' meeting. We saw people were reminded they could order magazines and newspapers to be delivered, people were asked whether they felt safe and opinions were sought in relation to the quality of meals. The cook had recently made some changes to the menu and people were asked, 'please let us know if you enjoy the changes.' People were also asked for suggestions and whether they had any complaints.

We saw minutes of a staff meeting held during February 2016. Staff were reminded of the importance of record keeping and reminded to read relevant policies and procedures. During a staff meeting held during March 2016 staff were reminded to ensure people had access to their call bell. This showed important information was shared with staff.

The registered manager told us quality surveys were sent annually to people and relatives. We looked at the quality surveys sent to people during June 2015 and they were due to be sent again in June 2016. Once the quality surveys were received, these were analysed and the results were shared with people. Following analysis of the surveys the registered manager shared with people the actions that resulted from the surveys. Positive comments included, 'I am very satisfied with Batley Hall,' and, 'I never have any concerns communicating with staff.' One person commented, 'The handyman is always willing to help with practical things and also communicative.' This showed the registered manager proactively sought feedback from people living at the home.

We saw there was a quality audit schedule in place. Audits were well planned and took place in relation to care plans, medication, health and safety and the kitchen and dining experience for example. We could see a medication audit highlighted staff required further training following the introduction of the electronic MAR system. Records showed this was then actioned and training was planned. Mattress audit records included information to show staff how to test whether the mattress or pillow needed replacing. Records showed that actions were taken when necessary.

We saw evidence of safety checks in relation to extractor fans, water temperatures, window restrictors and fire hazards. Call bells were tested monthly and we saw evidence action was taken in a timely manner when necessary. Bed rail safety checks took place monthly and action was taken where repairs were required. We saw records to show slings were checked for cleanliness and safety monthly. However, we found records stated, 'unable to locate' for every month for a period of four months in relation to one particular sling. The record of another sling stated, 'unable to locate,' for a period of three months. We shared this with the registered manager, who agreed to address this.

We also found records showed delays in some maintenance works. For example, although records showed water temperature checks had taken place monthly, the records stated, 'New TMV [thermostatic mixing valve] required' in relation to two different outlets for the months of April and May. The inspection took place in June and we could see no evidence of action being taken. We highlighted this to the registered manager.

Annual maintenance records were well organised and planned on a calendar. The registered manager was able to show us when items such as lifts, hoists, smoke detectors, gas safety were next due for service. This showed the registered manager had management oversight and helped to ensure the premises were regularly maintained and kept safe.

The registered manager told us they felt supported in their role. They had frequent visits from the quality assurance manager and the regional manager. The registered manager felt they were able to obtain the necessary resources to manage the home effectively.

The registered manager told us their vision was for the home to be hotel standard but homely at the same time. The registered manager said, "We work where the residents live. Not the residents live where we work."

The registered manager engaged with the local community. For example, they had delivered a talk to local students in relation to choosing care as a career. The local school had attended the home on special occasions such as Christmas and Easter.

Policies and procedures were in place in relation to safeguarding, whistleblowing, medication, MCA and DoLS for example. This helped to ensure staff were following the correct guidelines in order provide effective care and support and keep people safe.

The registered manager was receptive to the feedback given during the inspection and acted swiftly on areas which were identified as requiring attention. However, although systems for auditing were in place, these were not sufficiently robust for the registered manager to have identified the areas which required improvement through auditing, for example incorrect information in an emergency evacuation plan, lacking information in some care plans resulting in potential risks and some maintenance works not being followed up in a timely manner.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to the health and safety of service users were not always appropriately assessed and key information was missing from some care plans. Regulation 12(2)(a).