Newco Southport Limited

Fleetwood Hall

Inspection report

100 Fleetwood Road
Southport
Merseyside
PR9 9QN

Tel: 01704544242
Website: www.fleetwoodhall.com

Date of inspection visit:
22 January 2018
25 January 2018

Date of publication:
07 March 2018

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

This inspection took place on 22 & 25 January 2018.

Fleetwood Hall is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Fleetwood Hall accommodates 53 people across five separate units, each of which had separate adapted facilities. One of the units specialises in providing care to people living with dementia, and is split into a male and female side. The other unit specialises in supporting people with mental health needs, and is also split into male and female sides.

At the time of our inspection there were 43 people living in the home.

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

The home had a focused inspection in June 2017 to follow up on breaches from the previous comprehensive inspection. We found that the home had met the breaches however was still rated requires improvement. Following this inspection the home was rated as Requires Improvement overall.

This is the second consecutive time the service has been rated Requires Improvement.

Systems relating to governance arrangements were not always robust. We saw numerous incident forms and audits across the service provision which required further action to be taken which were not fully completed. This meant we could not always be sure who was responsible for overseeing that action plans were adhered to. We did see a new auditing system which had just been introduced which was more robust, however, that had not been implemented yet. Therefore, we could not check its effectiveness at this inspection. We spoke at length to the registered manager and director about this during our inspection.

There was a process in place to document, analyse and review incidents and accidents. We saw that the records were not always clear in relation to incidents and accidents and some of the information was missing. This made it difficult to see if patterns and trends had been identified. We have made a recommendation regarding this.

We saw that all checks on the environment were being completed. We did however receive a concern during our inspection that the key coded gate was not locked as it should be. On the second day of our inspection we saw that the gate was unlocked, so we raised this with the registered manager who took immediate

action to rectify the problem.

Staff were able to describe the process they would follow to ensure that people were protected from harm and abuse. All staff had completed safeguarding training, some were due refreshers which were being booked. There was information around the home which described what people should do if they felt they needed to report a concern.

We discussed some recent safeguarding concerns with the registered manager to ensure that improvements had been made as a result of concerns raised. We saw some evidence that lessons had been learnt as a result of these.

Risk assessments were in place and were reviewed every month or when there was a change in people's needs. We saw risk assessments in place to manage people's mobility needs, falls, pressure areas, personal care and mental health and behaviour. Risk assessments were linked to an accompanying plan of care which was informative and fully described how staff were required to support the person.

We saw that rotas were fully staffed; however there was a heavy reliance on agency staff. The registered manager had a process in place to recruit new staff and we saw that some new staff were due to start working at the home. Most of the agency staff were used regularly. This meant that they were familiar with the service.

Medication was managed, administered and stored securely by registered nurses on each unit. Each person had a medication file in place which contained information about them and their preferences for taking medication.

There were domestic staff around the home ensuing that rooms and bathrooms were kept clean. There was hand gel available around the home and personal protective equipment (PPE) for staff to use to prevent the spread of infection.

People's needs and choices were assessed prior to them being admitted to the home.

The training matrix showed that staff were trained in all subjects which were mandatory to their role, and as stated in the provider's training policy. We saw however, that the provider had introduced so much new training at once and not separated it from the mandatory training. This meant that it affected the overall percentage of staff trained as some staff had not been able to complete these additional training courses yet.

Staff received regular supervision and appraisal.

People were supported to eat and drink in accordance with their needs. People, who were assessed as at risk of weight loss, had appropriate documentation in place to monitor their food and fluid intake. Where specialist diets were needed for some people, the chef had good knowledge of this.

The service worked in conjunction with physiotherapists, registered mental health nurses (RMN')s psychiatrists and tissue viability nurses to ensure people had effective care and treatment.

Everyone had records in their files relating to external appointments with healthcare professionals such as GP's, opticians or chiropodists. The outcome of these appointments was recorded in people's records.

Most areas of the home and some people's bedrooms had been refurbished to a high standard. The dementia unit had directional signage and there was additional refurbishment plans in place.

The service was operating in accordance with the principles of the Mental Capacity Act (MCA). Applications to deprive people of their liberty had been appropriately made following best interest decisions.

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

People were consulted with and involved in key decisions regarding their care and support.

Care plans were written in way which encompassed people's diverse needs, maintained their dignity and respected their right to choose.

There was information with regards to people's backgrounds, routines and preferences and this was all recorded in their plan of care. Care plans viewed demonstrated that people were getting the care which was right for them in accordance with their assessed needs.

Complaints were documented and responded to in line with the provider's complaints policy. People we spoke with told us they knew how to complain. The complaints procedure was displayed in the communal areas of the home.

People who required end of life care were supported at the home and staff had received training to enable them to care for people sensitively and with compassion.

The service worked closely with the local authorities and hospitals to support hospital discharges.

People were positive about the registered manager and the directors. Most incidents had been reported to CQC as required. However we saw that two incidents had not been reported appropriately. We spoke to the registered manager about this at the time of our inspection.

Feedback from staff and people who lived at the home was positive regarding the registered manager and the directors of the service. We saw there had been lots of improvements regarding the environment of the home, most of which were still on-going.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Incident and accidents were recorded, however some information was missing from forms and there was no remedial action recorded by the management in the forms viewed. We have made a recommendation about this.

Medication was managed safely and in line with best practice.

Staff recruitment was safe and there were comprehensive records kept in relation to each staff member.

Risk assessments were in place for people which supported all aspects of their care needs. Each risk assessment was linked to specific plan of care for the person.

Checks took place on the environment. There was a concern relating to the external gate which we addressed at inspection with the registered manager and director.

Is the service effective?

Good

The service was effective.

The staff had the correct training to reflect their roles, even though this was not always evidenced in the training matrix.

Staff received regular supervision and annual appraisals.

People were supported to eat and drink appropriately.

The service was working in accordance with the principles of the Mental Capacity Act and associated legislation.

Is the service caring?

Good

The service was caring.

We observed kind, caring and familiar interactions between staff and people who lived at the home.

Staff spoke about people with kindness and gave examples of how they respected people's privacy.

People had been involved in their care plans where possible.

Is the service responsive?

Good

The service was responsive.

People received care which right for them, which took into account their backgrounds, needs and wishes.

Complaints were appropriately responded to and documented in line with the service's policies and procedures.

People were supported sensitively with arrangements for end of life care.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Systems relating to governance were not always robust. When actions had been identified following audits, suitable action plans were not drawn up.

There was a registered manager in post. People spoke positively about the registered manager.

The culture of the home was friendly and relaxed.

Fleetwood Hall

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.

This inspection took place on 22 & 25 January 2018 and was unannounced.

The inspection team consisted of an adult social care 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. This expert had expertise of older people and care of people with dementia.

Before our inspection we reviewed the information we held about the home. This included the Provider Information Return (PIR). A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We had received a PIR for this service. We also looked at the intelligence the Care Quality Commission had received about the home. We gathered information about the service using a variety of methods. This included speaking to the local authority and looking at notifications we had been sent from the provider and also from the public or people living at the home. We used this information to form part of our inspection plan for Fleetwood Hall.

We spoke to four people who lived at the home and completed observations on the nursing and dementia units. We pathway tracked three people who lived at the home. This included looking at all of the records the service had in place about that person and speaking with them. We viewed three staff recruitment files, and spoke with 13 staff including the registered manager, quality manager, director, nurse in charge, seven support staff, the chef and the activities coordinator. We also spoke with a visiting healthcare professional.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at the home. We were not able to speak to many people on the day of our inspection, as some people did not wish to engage with us, or were unable to engage. However we received some comments which included, "Yes I feel okay here." and just "Yes" when we asked someone if they felt safe. We spoke with a visiting healthcare professional who did not raise any concerns with regards to people's safety at the home.

We did receive a concern from a health and social care professional who contacted us during our inspection make us aware that the external gate was usually left open. As a result, one person had left the unit without staff knowledge, which could have put the person at risk. We discussed this with the registered manager as we wanted assurances staff were making sure the gate was kept locked to ensure people's safety. The registered manager did acknowledge that sometimes the gate was found to be left open, and this was not safe for some people on the units as they were at risk of absconding. The registered manager informed us that they had introduced two hourly checks of the gate as part of the walk around check. Additionally, the director informed us that a new gate was to be purchased.

We looked at how incidents and accidents were managed at the home. We saw that there was a process in place to analyse the number of incidents which occurred over the month. There was also consideration given to time of day of incidents and staff on duty. If the incident had resulted in a person sustaining an injury, a body map was also included within the body of the form. We saw that there were a significant number of incidents documented. Most of the incidents had been appropriately recorded; however, we saw a proportion of forms with missing information. Particularly the sections where the registered manager comments were required. Also there was no information recorded within the forms as to how the incident would be prevented in the future. For example, we saw that one person had an incident form in place because they had developed an unexplained bruise on their body. The body map section of the form was not completed to show were the mark was. Additionally, there was no follow up action recorded by the registered manager. Some of the other incident forms had missing or contained incomplete information. This meant that from looking at these records it was difficult for the service to evidence that incident and accidents had been appropriately analysed and scrutinised. Also, that reasonable steps had been taken to minimise future occurrences as these sections were often left blank.

We recommend the provider reviews their process for managing incidents and accidents and takes action accordingly.

Staff were able to describe the course of action they would take if they felt someone was being harmed or abused. This included reporting the suspected abuse to the registered manager, the local authority or contacting the police, depending on the nature of the concern. Staff had been trained in safeguarding adults and understood the different levels of abuse and who might be most at risk. There was also a whistleblowing policy in place. The staff knew what whistleblowing was and said they would report concerns without delay.

We discussed some recent safeguarding outcomes with the registered manager. This was because we wanted to be sure in cases where the safeguarding had been substantiated appropriate opportunities for lessons learned had been implemented within the home. We saw an example where the registered manager had clearly adapted further awareness into the home of the signs and symptoms of a particular illness. This was in response to a safeguarding outcome where appropriate medical invention was not sought in a timely way. This showed that the registered manager was appropriately making improvements to minimise the risk of future safeguarding occurrences within the home.

We checked the storage, administration and management of medications.
Medicines were held in locked trolleys on each floor of the home. Most medications were delivered to the home in an individual blister pack for each person. Medicines were administered individually from the trolleys to people living at the home. Medication requiring cold storage was kept in a dedicated medication fridge. The fridge temperatures were monitored and recorded daily to ensure the temperatures were within the correct range. Checking medications are stored within the correct temperature range is important because their ability to work correctly may be compromised.

Some people were prescribed medicines only to be taken as required (often referred to as PRN medicine) and had a plan in place to guide staff about when this medication should be given. PRN medicine was mostly prescribed for pain or if people became upset or anxious.

The medication administration records (MAR) included a picture that was sufficiently large enough to identify the person. We noted that the MAR charts had been completed correctly and in full. We spot checked the boxed medications (medications which were not blister packed) for two people and saw that the totals had been correctly documented. People who required topical medication (creams) to be applied had an accompanying body map which clearly showed where on the person's body the cream needed to be applied.

Arrangements were in place for the safe storage and management of controlled drugs. These are prescription medicines that have controls in place under the Misuse of Drugs Legislation.

One person had their medication administered covertly. This means that the medication was disguised in food or drink. When medication is administered covertly, the service must ensure additional measures are in place to support the person. We saw that the appropriate best interests meetings had been conducted, a Deprivation of Liberty Safeguard authorisation (DoLS) had been appropriately applied for and there was input from the GP and the Pharmacist. Additionally, the person had a list in their medication file which described which medications were to be taken covertly. This meant that the nurse was able to check this list before administering the medication to ensure all medication was given correctly.

Detailed risk assessments were in place to support people with their clinical, emotional and psychological well-being. Each risk assessment had an accompanying care plan which provided further detail for staff with regards to how to keep the person safe and minimise the risk of harm occurring. For example, we saw that one person had a risk assessment in place which described them as being at medium risk of falls. There was also an accompanying care plan which stated that the person was to be supported by two staff and actively encouraged to move about the home themselves. The risk assessment had been reviewed recently and stated that the person was 'still unsteady', however they were making progress.

We saw that there was a risk assessment in place to support someone when they displayed behaviours which could put themselves and others at risk. The risk assessment explained various 'triggers' which staff were expected to notice. The triggers were accompanied by an explanation of how staff were expected to

intervene to help support this person and other people who lived in the home. One of the interventions was to give the person space. We saw there was a dedicated 'quiet room' in the home where this person could relax if they required space. This risk assessment was linked to the person's 'safe environment' care plan, as this gave more detail on how the staff could ensure a safe environment was maintained for the person and others.

Staffing rotas showed that there was some reliance on agency support staff and nurses to ensure shifts were covered. No one raised any concerns in relation to the use of agency staff and one of the agency staff we spoke with said they often came to home to work so knew people well. The registered manager discussed the service's current situation relating to staff and we saw they were trying all options to employ permanent staff.

Staff records we saw demonstrated the registered manager had robust systems in place to ensure staff recruited were suitable for working with vulnerable people. The registered manager retained comprehensive records relating to each staff member. Full pre-employment checks were carried out prior to a member of staff commencing work. This included keeping a record of the interview process for each person and ensuring each person had two references on file prior to an individual commencing work.

The registered manager also requested a Disclosure and Barring Service (DBS) check for each member of staff prior to them commencing work. This enables the manager to assess their suitability for working with vulnerable adults. For the nursing staff, checks and documentation relating to their PIN numbers were also kept to ensure they did not expire. All registered nurses and midwives in the UK are required to register with the NMC who is the regulator for nursing and midwifery professions in the UK. They make sure people have the right skills and competencies to practice in this profession.

We saw that all firefighting equipment had been checked and new equipment was in place in various parts of the home to help people evacuate safely. Personal emergency evacuation plans (PEEP's) explained each person's level of dependency and what support they would require to ensure they were evacuated safely. We spot checked some of the other certificates for PAT (portable appliance testing), electric, gas, and checks on the other equipment such as the hoists. These were all in date. We saw that fire doors were in working order, and there were key coded exits and entrances for the mental health unit and the dementia unit in order to ensure people who were at risk of absconding were kept safe.

We checked the process for preventing the spread of infection in the home. The home was odour free, clean and there were provisions for hand sanitizer on the walls. Sluice rooms were kept locked when not in use and staff wore personal protective clothing (PPE) when supporting people with personal care.

Good

Is the service effective?

Our findings

We asked if staff had the right skills and training to support people well. One person we spoke with said that they thought the staff were skilled. They said, "Yes the regular staff are quite good." Our observations indicated staff were skilled and used correct techniques when supporting people to transfer from chair to wheelchair.

We saw that people were assessed prior to them being admitted to the home. The initial assessment process viewed focused on people's needs and choices while taking into account the type of treatment and support they required. We saw one person had been admitted to the home after a stay in hospital and had high clinical needs due to developing a pressure sore. We saw that a 'Seventy two hour care plan' had been put in place to help support staff care for this person while additional documentation was being produced. This meant that the person was getting the care and support they needed from when they first came to the home. We saw that the outcome for this person was to eventually move back into their own home. We saw this information had been documented in the initial assessment. This had been transferred and incorporated into the person's care plan. For example, 'Encourage to do as much as possible, ready for when they return home.'

The training matrix and examination of staff training certificates showed that all mandatory training was in date, and had been completed by staff. Training was a mixture of classroom based courses and e - learning. We saw, however, the overall percentage of staff to have completed all training, which included mandatory and non- mandatory was poor. We saw that the training matrix included every course staff were expected to complete however, some of this training was not mandatory to their role. For example, most staff had not completed person centred planning training which meant they were not using this training in their day to day roles. We discussed this at length with the registered manager, who acknowledged that the current training matrix required adjusting to only include mandatory training subjects. This would ensure a true reflection in the percentage of trained staff. The service provided additional training courses for staff. However, most of these were optional or 'when requested'. The registered manager informed us that the service had just registered with the nation minimum data set for social care (NMDS-SC) so would use this database as a more accurate training matrix once it was up and running. NMDS-SC is an online database which holds data on the adult social care workforce.

Staff we spoke with confirmed they received regular supervision and an annual appraisal. The induction process for staff who had no previous experience of working in health and social care settings was aligned to the principles of the Care Certificate. The Care Certificate is a twelve week programme designed to help newly appointed staff working within the health and social care sector develop their skills within the role. This can then be signed off by a senior colleague when completed. In addition, the provider had their own induction which all staff were required to complete. This included discussions around polices such as whistleblowing, safeguarding and equality and diversity. All staff who had been working at the home for more than six months had been enrolled onto the relevant NVQ qualification.

People were supported to access medical care when they required it. Each person had a health record in

their care plan detailing their appointments with GP's, Tissue Viability Nurses, Opticians and Chiropodists. We spoke to a visiting healthcare professional during our inspection who confirmed that staff worked well with them to ensure people were supported with their needs. The healthcare professional told us that staff followed guidance and instruction in order to help people improve their health.

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 decision's and are helped to do so when needed. When they lack mental capacity to make 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).

The service was working within the principles of the MCA. Additionally, we checked to see whether the conditions identified in the authorisations to deprive a person of their liberty were being met. The registered manager was knowledgeable about the MCA and DoLS and knew the CQC (Care Quality Commission) needed to be notified when the outcome of any applications were known. We saw that some people had conditions stipulated on their DoLS authorisations and these conditions were subject to continuous checking.

We saw that 'best interest processes' were being followed for people who had limited capacity and understanding of complex decision making. The need for 'best interest' processes were clearly identified in people's support plans. The service had documentation in place which was a simple question and answer session to check people's ability to make day to day decisions. Also the support they may need to make these decisions. Their answers were recorded which evidenced whether the person needed more support to understand and make day to day decisions or complex decisions depending on the answers they gave. This showed the service was checking and recording people's ability to make choices for themselves and encouraging this where possible.

The building was adequately adapted to meet people's needs. There was directional signage in place to support those living with dementia, and various parts of the home had been redecorated. The director informed us that plans were on going to further improve the building and environment for people.

We ate lunch with the people who lived at the home and found the food was plentiful and flavoursome. We saw that the menu was produced using a four week rolling method. People told us they had choices when it came to the food they ate. Our discussion with the chef evidenced that they had a good knowledge of people's likes and preferences. This included people who required specialised diets such as diabetics.

Good

Is the service caring?

Our findings

People we spoke with raised no concerns regarding the caring nature of the staff. Some people did not want to speak with us. One person told us they felt the staff were, "Very nice and caring." We spent time observing the interaction between staff and people who lived in the home across all of the units and found that staff were kind and considerate in their approach.

We observed one member of staff discreetly whispering to someone if they would like a shower. Another member of staff was supporting someone to make themselves a drink in the kitchen area and spoke to them with respect and dignity.

We observed during our inspection that one person became upset. The registered manager engaged with this person and gave them emotional support and reassurance.

Care plans reviewed were written in way which took the person's choices and diversity into consideration. For example, how people liked to be dressed each morning, when they liked to get up, and how they wanted their personal care needs to be met. One care plan stated, '[person] must be offered a bath every day, and it is important that staff only use their toiletries.'

Staff we spoke with described how they protected people's privacy during personal care. This included closing doors and windows and covering people up with towels and blankets. One staff member discussed the importance of not discussing people's personal information in communal areas, as it would be breaking their confidentiality.

All of the staff we spoke with told us they enjoyed working at Fleetwood Hall and liked spending time with the people who lived there.

Care plans were signed by people who were able to do this. For people who were not able to sign their own care plans we saw this had been done via a best interest processes. People who were able to had also signed consent forms within their plan of care to say they agreed with the plan, and have given permission for their records to be shared with appropriate professionals.

There was information provided for people with regards to the local advocacy agency. At the time of our inspection there was no one making use of this service.

Good

Is the service responsive?

Our findings

Two people we spoke with told us that staff were responsive to their needs and knew them very well. One person said, "The ones that have been here a while know about me and how I like things."

Care plans contained an 'All about me' document which provided details about people's backgrounds, hobbies, likes and dislikes. This meant that staff could get to know people and what they liked to be able to form positive professional relationships with them.

We saw that people were getting the care and support which was right for them and specific to their assessed needs. For example, people who were at risk of developing pressure sores had an appropriate turning regime in place which had been completed accurately. Additionally, people at risk of weight loss or malnutrition were weighed regularly and where there had been a recorded weight loss the appropriate referrals had been made to dieticians. We saw that for people who were diabetic, they had appropriate care plans in place to incorporate regular foot care checks. This is because people who have diabetes are more at risk of having problems with their feet.

Additional to people's specific clinical needs we saw that there was specific information around people's mental health requirements. For example, one person was in receipt of a very specific strategy to help them manage their behaviour. This was subject to continuous monitoring by external organisations as well as the service. We saw as far as possible the person was supported to understand their strategy and we also saw that their rights to challenge this had been clearly explained to them. Staff had undergone specific training to help them understand this person and how to support them correctly. This meant that the service was working with people in a person centred way to ensure they understood their support and they received the correct support.

We looked at how complaints were documented and responded to in the home. The home had received seven complaints since our last inspection. We looked at one of the complaints in detail to see if it had been responded to in line with the organisation's policy in relation to complaint handling. We saw that the complaint had been investigated and a response had been sent to the complainant. The complaints process was clearly displayed in the communal areas of the home which meant that if people or visitors wanted to raise a complaint they would know who to contact.

There were various activities which took place in Fleetwood Hall. On the day of our inspection we observed a quiz taking place and all people from across the five units had come together to partake in the quiz. In addition, we saw that day trips had been planned and recent trips had taken place which included a barge trip. Visits from external companies such as 'the insect man' had also taken place. The 'Sky Cafe' which we saw at our last inspection, had been well utilised. Themed nights had taken place in the Sky Café, such as Chinese food, Havana nights, and Burns night was being planned. One staff member told us how they had taken one person fishing as this was something they had been interested in. Following the fishing trip, the staff and the person had cooked the fish and ate them. There was also a vegetable patch where people grew their own vegetables, and this was also often cooked and eaten. The service was signed up to 'OOMPH!'

which specialised in activities for people with dementia. This showed that the service was providing meaningful activities for people based on their needs.

Staff were trained in end of life care and if it was they choice, people were supported to remain in the home. People had information in their care plans regarding what arrangements would be needed to be made in the event of their death. The service had recorded and responded to people's deaths appropriately and sensitively.

Requires Improvement

Is the service well-led?

Our findings

There were systems in place to monitor the quality of service provision. Audits for the environment and health and safety of the building regularly took place and actions were completed. We saw however, that some of the governance framework was not always effective and did not identify when further action was needed. For example, numerous incident forms were missing pieces of information and remedial action to be taken by the registered manager. The audits of incidents and accidents had not identified that this information was missing and forms were incomplete. In addition, we saw that some audits of care plans had required further action to be taken. For example, an audit of a person's care plan had identified that a wound care plan was needed. We saw there had been no action set or assigned to anyone to complete. We did see a tick on the form which meant the nurse in charge had completed the activity. We raised the fact that a more formal action plan might be more appropriate, as this would be easier to check and it would be assigned to a nurse so they had ownership of the action.

When we checked medication audits we saw that some audits had identified that there was some missing signatures on the MAR charts. We did not see any accompanying action taken by the registered manager or nurse in charge which explored the reason for the missing signatures. This was important, because it have meant that people may not have received their medication. Additional action would have been required to address the issue. When we discussed this further a full audit of medication stock had identified that this was not missed medication, it was a records error. This mistake had happened more than once, and we could not be sure by looking at the actions from the audit that this had been dealt with. A full medication audit had taken place from an external company in August 2017. We saw that the service had been sent some actions in relation to the storage of keys. The action plan for this audit had not been completed, so we could not tell if the registered manager had completed the actions required.

We discussed our concerns with the registered manager and one of the directors at the time of our inspection. The service had recently implemented new auditing paperwork and had employed two people in charge of quality. We looked at an example of the new audit, which was mapped to the Care Quality Commissions own domains of Safe, Effective, Caring, Responsive and Well-led. Despite this new audit being in place we could not test its effectiveness at this inspection. The directors of the service spent time every week at the home performing 'walk rounds' and checks. These were not documented, so were unable to check if any concerns had been highlighted or addressed.

This is a breach of Regulation 17 of the Health and social care act 2008 (Regulated Activities) Regulations 2014.

There was a registered manager at the home who had been in post for 18 months.

We received positive feedback from staff about the registered manager and the director. Comments included, "Yes they are approachable" and "Very fair".

All of the staff we spoke with said they enjoyed working and the home and liked working for the

organisation.

We found during our observations around the service and our conversations with people, that the service was relaxed and friendly. The outcomes for people were well documented and the service tried and succeeded to provide a personalised approach to care.

The service worked well with outside agencies such as the local authority, community practice nurses (CPN)'s, psychiatrists and local hospitals. This was recorded in the form of minutes from Multi-Disciplinary Team meetings (MDT)s.

We saw during this inspection that the approach to recording people's information within their care plans had improved, as well as the services understanding of the MCA. This demonstrated that the service had acted on requirements to improve and had managed to sustain this improvement in these two areas over the last twelve months.

Team meetings took place every few weeks and we saw some of the minutes for these. Agenda items included safeguarding, training, and recruitment.

People who lived at the home and their relatives had the opportunity to have their say about the care and support in the form of 'Resident meetings'. Additionally, questionnaires had been sent to people and their relatives to gather feedback about the home. There were no responses for us to view as yet.

The service had policies and guidance for staff regarding safeguarding, whistle blowing, involvement, compassion, dignity, equality and safety. There was also a grievance and disciplinary procedure and sickness policy. Staff were aware of these policies and their roles within them. This ensured there were clear processes for staff to account for their decisions, actions, behaviours and performance.

We saw that two incidents had not been reported to CQC in line with our regulatory requirements. We discussed this with the registered manager at the time of our inspection and found this had been an oversight by them. We have since received all notifications as required by law.

From April 2015 it is a legal requirement for providers to display their CQC (Care Quality Commission) rating. 'The ratings are designed to improve transparency by providing people who use services, and the public, with a clear statement about the quality and safety of care provided'. The ratings tell the public whether a service is outstanding, good, requires improvement or inadequate. The rating from the previous inspection for Fleetwood Hall was displayed in the main part of the building, and the provider's webpage.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance systems were not robust enough and there was no process in place for formulating action plans and checking actions had been completed.