Seth Homes Limited

Stoneacre Lodge Residential Home

Inspection report

High Street
Dunsville
Doncaster
South Yorkshire
DN7 4BS

Tel: 01302882148
Website: www.stoneacrelodge.com

Date of inspection visit:
08 June 2016
09 June 2016

Date of publication:
15 July 2016

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

The inspection took place on 8 and 9 June 2016 and was unannounced on the first day, which meant no one related to the home knew we would be inspecting the service. The care home was previously inspected in July 2014, when no breaches of legal requirements were identified.

Stoneacre Lodge is a care home that provides care for up to 31 older people, some of whom are living with dementia;, the home does not provide nursing care. The home is a two storey building located in the village of Dunsville, near Doncaster. There is a stair lift to the first floor bedrooms.

The service had a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

At the time of the inspection 29 people were living at the home. We spoke with twelve people who used the service about their experiences, as well as three visitors. Everyone we spoke with told us they were happy with the service provided and the way care and support was delivered by staff.

People told us they felt the home was a safe place to live and work. We saw there were systems in place to protect people from the risk of harm. Staff we spoke with were knowledgeable about safeguarding people and were able to explain the procedures to follow should an allegation of abuse be made.

A structured recruitment process was in place to help make sure staff were suitable to work with vulnerable people. However, we found some elements of the process had not been consistently followed.

There were enough staff available to meet people's needs and many staff had worked at the home for a number of years. This helped to provide people with consistent care.

The service had a medication policy outlining the safe storage and handling of medicines, but we found this had not always been followed. We found shortfalls in relation to the recording and storing of medicines, which could mean people did not receive their medication correctly.

Relatives said they thought staff had the appropriate skills to meet people's needs. However, we found ancillary staff had not received an induction to the home and their job role and training records were incomplete. Therefore they did not demonstrate that all staff had received essential training.

The service was not fully meeting the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). Records showed that most staff had received basic training in this topic and the management team had, or were enhancing their knowledge and skills in these subjects. However, not all the people who used the service had been assessed to determine if a DoLS application was required, and care plans did not always clearly record decisions made in people's best interest. The deputy manager told us

they were liaising with the local authority to address this issue.

People were provided with a choice of healthy food and drink ensuring their nutritional needs were met. The people we spoke with said they were happy with the meals provided and we saw they were involved in choosing what they wanted to eat. On the day we visited the dining rooms were relaxed and people who used the service were given time to eat their meal at their own pace.

People were supported to maintain good health, have access to healthcare services and received ongoing healthcare support.

People's needs had been assessed before they moved into the home. Although people told us they had been involved in these initial assessments and planning their care, this was not always reflected in the care files we sampled.

We found most people had a clear care plan that outlined their needs, risks associated with their care and their preferences. However, on the first day of our inspection we found one person did not have a care plan in place. Although this had not had any adverse impact on the person, staff did not have clear written information about how to meet their needs and manage their care. When we returned on the second day a care plan had been formulated, but assessment tools had not been completed. The deputy manager told us any shortfalls would be assessed as soon as possible.

The home employed a part time activities person who provided two hours of activities a day Monday to Friday. However, there was no organised programme of activities to tell people what was planned and a few people said they often had nothing to do. People told us they had enjoyed the activities they had taken part in.

We saw the complaints policy was available to people who used and visited the service. The people we spoke with told us they would feel comfortable speaking to any of the staff if they had any concerns. Complaints received had been recorded and appropriately investigated.

The provider had a system in place to enable people to share their opinion of the service provided and the general facilities at the home.

There was a quality assurance system in place so the provider could monitor how the home was operating, as well as staffs' performance. However, the systems in place had not always identified the shortfalls we found during our visit.

Our inspection identified three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. 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.

Systems in place to safely manage medicines were not robust.

There was a recruitment process in place to ensure people were supported by appropriate staff. However, the correct procedures had not been followed consistently.

People felt the home was a safe place to live and work. Staff understood how to recognise signs of potential abuse and were aware of the reporting procedures.

Is the service effective?

Requires Improvement

The service was not always effective.

Training records did not demonstrate that all staff had received the essential training they needed to fulfil their job role and meet people's needs. We also found staff support sessions had not been provided on a regular basis.

Staff had undertaken training about the Mental Capacity Act and the procedures to follow should someone lack the capacity to give consent. The provider was working with the local authority to ensure decisions made in people's best interest were applicable and applications under the Deprivation of Liberties Safeguards were made as necessary.

People were provided with a choice of healthy food and drink to ensure their nutritional needs were met.

Is the service caring?

Good

The service was caring.

Staff were aware of people's needs and the best way to support them, whilst maintaining their independence, respecting their choices and maintaining their privacy and dignity.

People told us they were happy with how staff supported them and delivered their care. We saw staff interacting with people in a

positive way, respecting their preferences and decisions.

Is the service responsive?

Requires Improvement

The service was not always responsive

Care plans were not in place for everyone who used the service; therefore staff did not have access to detailed information about how to meet each person's needs and preferences.

People had access to social activities, but some people felt they did not meet their needs.

People were aware of how to make a complaint and knew how it would be managed. Where concerns had been raised action had been taken to address them.

Is the service well-led?

Requires Improvement

The service was not always well led

There were systems in place to assess and monitor the quality of services provided. However, shortfalls highlighted at this inspection had not been identified through the quality monitoring systems used.

We saw people using the service, their relatives and staff were consulted about the running of the home and the care provision, and were happy with how it operated.

Staff were clear about their roles and responsibilities.

Stoneacre Lodge 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 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.

An adult social care inspector carried out the inspection on 8 and 9 June 2016 and was unannounced on the first day.

Before our inspection, we reviewed all the information we held about the home. We spoke with the local authority and Healthwatch Doncaster, to gain further information about the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

At the time of our inspection there were 29 people using the service. Over the two days we spoke with twelve people who used the service and three visitors. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with the provider, the deputy manager, a senior care worker, two care workers, the kitchen staff and the activities co-ordinator, as well as a visiting healthcare professional.

We looked at the care records belonging to four people who used the service, as well as records relating to the management of the home. This included minutes of meetings, medication records, four staff recruitment and training files. We also reviewed quality and monitoring checks carried out by senior staff and the home's management team.

Requires Improvement

Is the service safe?

Our findings

People indicated they felt safe living at the home. On the whole we saw risk assessments had been undertaken to minimise any potential risks to people using the service. However, one care file only contained details of potential risks in the assessment document. No risk tools had been completed on admission to identify areas of risk and outline what, if any, action staff should take to minimise them. This had not had an adverse impact on the person as their risk level was low, but this was not evident in the care file.

Staff we spoke with demonstrated a good knowledge of people's needs and how to keep them safe. They described how they encouraged people to be as independent as they were able to be, while monitoring their safety.

Policies and procedures were available regarding keeping people safe from abuse and reporting any incidents appropriately. The deputy manager and the staff we spoke with understood their responsibilities in promptly reporting concerns and taking action to keep people safe. Where safeguarding concerns had been reported to the local authority we saw the provider had worked with them to investigate and resolve any issues.

We looked at the number of staff that were on duty on the days we visited and checked the staff rotas to confirm the number was correct. We found there was sufficient staff to meet the needs of the people living at the home at the time of the inspection. Staff told us that although there were occasions when they were 'extra busy' most of the time there was enough staff available to meet people's needs. We saw call bells were answered promptly and people received prompt care and support.

The staff recruitment system included pre-employment checks being undertaken prior to candidates commencing employment. For instance, obtaining written references and a satisfactory Disclosure and Barring Service (DBS) check. DBS checks help employers make safer recruitment decisions by preventing unsuitable people from working with vulnerable people. The aim of these checks are to help reduce the risk of the provider employing a person who may be a risk to vulnerable adults.

We checked four staff files and found checks had been undertaken, but the company recruitment procedure was not consistently robust. For instance, one file contained no photograph of the person employed. Another had a reference that the deputy manager told us could have been handed in by the employee, rather than applied for by the provider. This meant there were inconsistencies in how the procedure had been followed, including no system to check when and how references had been acquired. We discussed these shortfalls with the provider and deputy manager, who said they would improve the system in place to make it more robust.

The service had a medication policy which outlined how medicines should be safely managed, with senior care workers taking responsibility for administering medicines. The senior care worker on duty described a safe system to record all medicines going in and out of the home. This included a safe way of disposing of

medication no longer needed. However, we noted there was no system to dispose of medicines dispensed, but refused by people. The senior care worker told us they would put any such medicines in a clinical waste bag or in the sharps disposal bin. We discussed the need for an appropriate receptacle to be obtained and the medication policy to be amended with the management team.

We checked if a safe handling of medicines process had been followed correctly and found that overall it had. However, when we sampled medication administration records (MAR) we found handwritten entries had not been signed by the person completing them. This meant it was not possible to establish who had completed the entry. We discussed this with the provider and deputy manager who said they would address the shortfall. We also discussed the best practice of a second staff member countersigning handwritten entries to acknowledge they had been completed correctly as this would make the process more robust.

When we observed the senior care worker administering medicines on the second day of the inspection we saw there were no photographs of people in the medication file, this would have helped staff to identify the person they gave medication to. The deputy manager later told us they had intended to add photographs, but had not done so yet.

The senior care worker administered people's medication individually and recorded their administration only after the medicine had been taken. We saw some people were prescribed medicines to be taken only 'when required', for example painkillers. However, there were no protocols in place to tell staff specifically what these medicines were for or when they should be given, and the entry on the MAR was not specific. For instance one stated Paracetamol one to two tablets up to four times a day. There were no clear instructions to staff about what this medicine was for, when to give it or how to judge whether one or two tablets were necessary. We checked the care plan to see if this information was included and found only basic information was available, such as 'takes paracetamol for pain.' The local authority had identified this issue during their assessment of the home in 2015. We spoke with the deputy manager about this shortfall, which they said they would address.

This was a breach of Regulation 12 (1)(2)(g) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although staff were checking the temperature of medication stored in the refrigerator there was no guidance as to what the expected temperature range should be on the form they completed. The staff we spoke with could not tell us what this should be, although they said an alarm should sound if the temperature fell above or below recommended limits. We also found that although the medication policy stated that the overall room temperature should be checked twice a day this was not taking place.

The service had a controlled drug cabinet that met legal requirements. We saw that staff checked the balance of controlled drugs each time one was administered and this was recorded so that there was a clear audit trail of when the medication had been given. We checked two people's controlled medicines stock and found them to be accurate.

There was a system in place to make sure staff had followed the home's medication procedure. For example, we saw regular checks and audits had been carried out to make sure medicines were given and recorded correctly. However, the shortfalls we found had not been identified; therefore timely action had not been taken to address them.

Requires Improvement

Is the service effective?

Our findings

People we spoke with told us they were very happy with the care and support they received and relatives said they felt staff had received the training they needed to meet people's needs. A relative told us, "I have nothing but praise for the staff who care for my dad, they do very well."

People were supported to maintain good health and had access to healthcare services. A doctor visited the home on a weekly basis to provide medical support to people. Care records detailed any health care professionals involved in the person's care. A visiting healthcare professional told us, "They [staff] are a very caring bunch and have quite a good insight into caring for people with dementia."

We found care workers had completed an induction when they started to work at the home which included completing a booklet and shadowing an experienced member of staff. However, we found there was no formal induction process in place for ancillary staff, such as people working in the kitchen and the activities' coordinator. When we asked new ancillary staff about their induction one person told us, "I was shown round a bit and then thrown in the deep end." They went on to say they had been given a copy of the staff handbook. We discussed this shortfall with the deputy manager who acknowledged there was no induction for ancillary staff, but recognised one was needed.

This was a breach of Regulation 18 (2)(a) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The deputy manager told us they were considering enrolling new staff on the care certificate but this was not in place at the time of the inspection. The Care Certificate looks to improve the consistency and portability of the fundamental skills, knowledge, values and behaviours of staff, and to help raise the status and profile of staff working in care settings.

Staff told us they felt they had received satisfactory training to carry out their job roles. However, we found the training matrix initially provided to us had not been updated; therefore there was no clear record of training undertaken. Following our inspection the deputy manager provided us with an updated version of the training matrix, but we still found gaps regarding staff completing essential training updates. For instance, the matrix indicated that a senior care worker and four care workers had not completed a course in moving people safely. It also indicated that only one out of the 12 ancillary staff had completed this training. Other gaps in the matrix included food hygiene, infection control and dementia awareness. Therefore the tool being used to monitor training was not affective in ensuring training took place, or was updated, in a timely manner. The provider told us most training was accessed through the local council and they had or were booking staff onto available courses when they could. The local council told us they had also found gaps in training when they assessed the home.

This was a breach of Regulation 18 (2)(a) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS), and to report on what we find. This legislation is used to protect people who might not be able to make informed decisions on their own and protect their rights. People can only be deprived of their liberty to receive care and treatment when this is in their best interest and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). DoLS is aimed at making sure people are looked after in a way that does not inappropriately restrict their freedom. Staff comments and training records demonstrated that most staff had received training in these subjects.

We saw the deputy manager had begun to complete capacity assessments and they told us that once they had received appropriate training they would be completing applications to the DoLS supervisory body, where applicable. They said they had been liaising with the local authority to discuss the delay in making the applications.

Records sampled demonstrated that in most cases where people could not speak for themselves, their capacity to make decisions had been considered. However, care records did not always fully incorporate information about decisions made in people's best interest.

We observed lunch being served on the second day of the inspection and spoke to people before and after the meal. The main dining room had a relaxed atmosphere and staff provided the support people as needed. The menu for the meal was displayed on a small board which was difficult for people to see. We asked if the service had considered using pictures of meals so people could make a more informed choice about which option they preferred. The deputy manager told us this had not been considered, but they would look into better ways to engage with people. Staff told us that sometimes they would plate up each option, so people could select the one they preferred. Several people had chosen a meal that was not on the main menu and we saw some people preferred to eat their meal in their room or in the lounge areas, and staff respected their decisions. We saw drinks and snacks were available between meals.

We spoke with both cooks and a kitchen assistant who all demonstrated a good knowledge of people's likes and dislikes in relation to food. They gave examples of different peoples preferences and what alternatives they preferred when certain foods they did not like were on the menu.

People said they had enjoyed their meal and commented positively about meals in general. One person said, "I really liked my meal today, it's always nice food here." Relatives told us they felt the meals provided met their family member's needs. One relative said, "The kitchen is always really clean and he [person using the service] gets a good breakfast. He gets what he chooses, small meals because that's what he wants."

Staff told us health professionals such as GPs, speech and language therapists and dieticians were involved if there were any concerns about meeting people's dietary needs. People who were at risk of poor nutrition or dehydration had a nutritional screening tool in place which indicated the level of risk. Care plans were in place to guide staff regarding supporting people to eat and drink enough. Where needed, monitoring charts had been used to record and assess people's food and fluid intake.

In some areas the home's exterior and interior décor, as well as some furnishings were in need of attention. The provider told us plans were in place to address these areas as soon as possible and we saw an ongoing action plan was in place. We saw gardens were suitably designed, with seating areas and flowerbeds.

However, as the service supported people living with dementia we did not find the environment to be very dementia friendly. Photos and large lettering had been used to tell people what room they were entering, for

example the dining room, but the menu board was small so made it difficult for people to read. We also saw corridors were decorated in the same neutral way, and handrails were the same colour as the walls, making it difficult for people to distinguish between them. In the new shower room the toilet had a different coloured seat so people could easily see it, but the room décor was neutral with no pictures or themes.

We discussed the need to develop a more dementia friendly environment that would help people find their way around the home and stimulate them with the provider and the deputy manager. The provider said he had been to a care conference where he had purchased books on the subject so they could consider good practice guidance.

Good

Is the service caring?

Our findings

Some people were unable to speak with us due to their complex needs, while other people shared their opinions. We spent time talking to relatives and observing the interactions between staff and people who used the service. We saw staff were kind, patient and respectful to people, and people seemed relaxed in their company. We saw staff communicated with, and treated people in a caring manner. If necessary they spoke with people by bending down to their level to communicate with them more effectively. We saw staff listened to people's requests, making eye contact with them and waiting patiently for answers.

Relative's comments indicated that staff respected people's decisions and they confirmed they had been involved in planning their family members care. However, this was not always clearly recorded in the care files we sampled. People we spoke with said they were happy with how staff cared for them. One person told us, "They [staff] do a great job, they look after us." A relative commented, "The staff are excellent." They went on to say, "I chose the home due to the staffs attitude [to people they were caring for] when I visited, compared with several other homes."

Our observations, as well as staff comments, indicated that they had a good knowledge of people's needs and preferences as well as the best way to support them, whilst maintaining their independence as much as possible. We saw staff supporting people in a responsive way while assisting them to go about their daily lives. They treated each person as an individual and involved them in making decisions.

People's needs and preferences were recorded in the majority of care records we sampled, so staff had clear guidance about what was important to them and how to support them. The staff we spoke with demonstrated a good knowledge of the people living at the home, their care needs and their wishes.

People living at the home looked well-presented and cared for. We saw staff treated them with dignity and the relatives we spoke with confirmed their family member's dignity and privacy was respected. Staff described to us how they preserved people's privacy and dignity by knocking on bedroom doors before entering and closing doors and curtains while providing personal care. This was confirmed by the relatives we spoke with and we saw staff supporting people appropriately. One person we spoke with commented, "We can always go into a private room if we want to be on our own."

We saw people chose where they spent their time, with some people choosing to stay in their rooms while others sat in communal areas, and staff respected these decisions. Staff said they offered people choice in areas such as the food they ate and the clothes they wanted to wear.

People said visitors could visit the home without restriction, although we saw a notice as we entered the home asking people to respect mealtimes so people could eat undisturbed. We saw visitors freely coming and going as they wanted during our inspection.

In the reception area there was information about how to contact a local independent advocacy agency should anyone need additional support. Advocates can represent the views of people who are unable to

express their wish.

The provider showed us a copy of the home's newsletter, which they said was produced twice a year to keep people informed about what was happening. It included information about new staff, planned events and changes to the environment, such as the purchase of new dining chairs.

Requires Improvement

Is the service responsive?

Our findings

The people we spoke with indicated they were happy with the care and support provided. We saw they looked happy and interacted with staff in a positive way. One person said, "I'm quite happy thank you." A visitor told us they thought communication at the home was good and spoke about the good care staff provided.

An assessment of people's needs had been carried out prior to them moving into the home. We were told that where possible people had been involved in these assessments. Relatives we spoke with confirmed they had been involved in planning and reviewing the care provision for their family member.

On the first day of the inspection we checked four people's care files, two for people who had lived at the home for quite a while and two for people who had recently moved into the home. Three of the care files we looked at contained detailed information about the areas the person needed support with and risks associated with their care. However, we noted there were several blank or partially completed forms in each file. For instance, in one file there was a form for pain management which was blank except for the person's name. The deputy manager told us some forms were not required, whereas others just needed signing and dating.

The fourth file we looked at, for someone who had moved into the home a few weeks before, had no care plan or risk assessments in place. Although this had not had any adverse impact on the person, staff did not have clear written information about how to meet their needs and manage their care. The deputy manager said staff were working from the assessment carried out prior to their admission to the home. This highlighted areas of need and potential risks, but did not provide any detailed guidance for staff about how to meet the person's identified needs and preferences. We saw staff had completed detailed daily notes which provided information about the care delivered and any medical appointments attended. On the second day of our inspection the deputy manager had put care plans in place, but assessment tools were still to be completed. They said all missing information would be fully completed as soon as possible.

This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the whole, care plans and risk assessments had been reviewed and updated on a regular basis. Family members we spoke with told us they felt the home was responsive to their relatives changing needs. They gave examples of how staff contacted them in a timely manner when changes occurred and said they seemed to act promptly to address any concerns.

We saw a 'Hello Senior' file was used to pass information on to senior care staff. This contained information about GP and district nurse visits, body maps and results from blood tests. The deputy manager said this helped to make sure important information was passed on between shifts.

A visiting healthcare professional told us, "The staff are always clued up on the residents. They follow up on

requests and recommendations and will always phone and ask if they are not sure about something." They said people were well cared for and discussed how the GPs weekly visits to the home were beneficial.

The home had a social activities co-ordinator who worked two hours a day Monday to Friday providing social activities and stimulation. However, there was no formal activities programme to tell people what activities were taking place and when. Care workers told us they tried to carry out activities at other times but time for this was limited. The activities person told us, "I ask people what they want to do, and then l try to do it." They said this had included arts and crafts, bingo, games, and nail care and one to one sessions. However, when we asked people what they spent their day doing one person told us, "I just sit here and watch the traffic go by." Another person said there was "Not much to do." When we spoke with relatives about this subject one person said they did not think there was an activities organiser. Another relative said there had been three activities people over the last 18 months, adding that their family member was not interested in group activities so they were not too worried about the lack of social activities.

Staff told us a hairdresser visited the home on a regular basis and described how a priest visited the home each month to give Holy Communion.

The provider had a complaints procedure which was available to people who lived and visited the home. We saw two concerns had been logged. The system in place provided the detail of each complaint, what action was taken and the outcome. This demonstrated that the provider listened to people's concerns and took action to address any shortfalls.

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection the service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider. The manager was not available when we inspected the service, so the deputy manager was in charge.

People we spoke with said they were happy with the support they or their relative received and the general facilities at the home. However, one relative said the only issue they had was regarding the fabric of the building. They said, "The general condition of the outside of the building gives people a false impression of the care provided, which was excellent." We discussed their comments with the provider who showed us their action plan for the home. They said they had already replaced windows at the front of the building and there were plans to shortly widen and replace some doors to provide better access and replace the reception and stair carpets. We saw improvements already made included the refurbishment of the upstairs shower room.

In 2015 the provider had used questionnaires to gain people's views on how the home was operating. The summary of the returned questionnaires showed 15 of the 29 questionnaires distributed had been completed. The questionnaire we sampled showed that overall people were happy with the care provided, as well as the general facilities available. Additional comments to the set questions were positive with one relative writing, "Could not be happier with this home. X [name of person living at the home] is flourishing."

We saw minutes from periodic meetings demonstrated that people using the service, and their relatives, had been involved in how the home operated. Staff told us the registered manager and deputy manager were also available to speak to people informally on a one to one basis.

We asked people who used the service if there was anything they thought could be improved, most people said there was nothing they wanted to change. However, two people felt social activities and the general environment could be better. When we asked staff the same question, they were complimentary about the home and the management and staff team. Two people could not think of anything that could improve, but one person said more day trips would be beneficial to people living at the home.

Staff told us they enjoyed working at the home. They confirmed they attended meetings where they could voice their opinions and said they felt they were listened to. One member of staff said, "People get really good care. It's like one big happy family. The provider is doing things as he can [meaning improvements at the home]." Another staff member commented, "I have a good relationship with them [the management team]. I have never felt I can't approach them."

A visiting professional told us they could not think of anything major they thought the provider needed to improve. They praised the staff for the care provided and said they were always happy to visit the home. They added it may be beneficial for the home to be more dementia friendly, especially regarding the carpets and access to the garden.

There were policies and procedures to inform and guide staff and people using the service, these had been updated in 2015, but staff had not always followed them.

Various audits had been used to make sure policies and procedures were being followed and essential checks were carried out. We saw daily, weekly and monthly checks had taken place which covered topics such as infection control, health and safety, care plans and medication practices. However, the shortfalls we found during this inspection had not been highlighted and actioned in a timely manner. For instance, one person did not have a plan of care and medication practices were not robust.

This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems were in place to make sure staff learned from events such as accidents and incidents. This reduced the risks to people using the service and helped the home to continually improve. Records showed that action had been taken following the previous months analysis, for example one person had been referred to the local falls team.

We saw the environmental health officer had awarded a five star rating for the systems and equipment in place in the kitchen. This is the highest rating achievable.

Doncaster council told us they had undertaken an assessment of the home in 2015 and an action plan had been drawn up to address shortfalls found. The provider told us all actions had been addressed and the action plan completed by February this year. However, the council told us when they visited in May 2016 the following areas were highlighted as needing further improvement. Care plan evaluation, introduction of a handover document so information was passed on between shifts, monitoring charts were completed more comprehensively and better completion of records, such as daily notes and body maps. The deputy manager told us most issues had been addressed, but some were still in progress.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not fully protected against the risks associated with medicines because adequate information was not available regarding medicines to be administered.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The system to assess and monitor the quality of the service provided was not robust, so did not always identify and address shortfalls in a timely manner. Care records did not always provide staff with sufficient information and guidance to meet people's needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Records did not evidence that all staff had received an induction to their job role or essential training to meet people's needs, which could put people at risk.