

Raj & Knoll Limited

Ami Court

Inspection report

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Deal
Kent
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17 October 2018

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This inspection took place on 16 and 17 October 2018 and was unannounced.

Ami Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Ami Court accommodates up to 38 older people in one adapted building, which included up to ten people who were receiving short term support and assessment as they had just come out of hospital. At the time of the inspection, 32 people were living at the service receiving nursing care.

There was a registered manager in post, who is also the provider. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We last inspected the service in March 2016 and the service was rated Good overall. During this inspection we found two breaches of Regulation and the service is no longer rated Good.

The registered manager was present at the service regularly, but relied on a team of staff to run the service on a day to day basis. The registered manager did not have oversight of the quality of the service. Checks and audits had been completed, however, the staff completing them did not have the knowledge to know when there were shortfalls and what action to take. The registered manager had not checked the audits staff had completed and had not been aware of the shortfalls present in the service.

Potential risks to people's health and welfare had been assessed but action had not been taken to mitigate the risks. Staff completed checks on the environment and these had been recorded, however, the registered manager and staff had not recognised when people were at risk and had not acted to rectify the shortfalls. Potential risks to people's health had been assessed but there was not always detailed guidance for staff to mitigate the risk.

Medicines were not managed safely. People were not always protected from the risk of infection. Incidents and accidents were recorded and analysed but there was enough detail about the action taken to reduce the risk of them happening again.

Staff had not received regular training updates, a new training system had recently been put in place, we observed staff moving people safely. Staff understood their responsibility to keep people safe. However, when incidents happened staff took appropriate action to keep people safe, but had not immediately reported them to the registered manager. When incidents were reported the registered manager took appropriate action and reported the incidents to the local safeguarding team.

Each person had a care plan, however, these varied in the level of detail about people's choices and preferences. People's care plans were reviewed but changes in people's needs were not always changed in the care plan. The care plans did not always reflect the care being given. Before people moved into the service, staff completed an assessment of the person's clinical needs, using referral documents and telephone assessments from health professionals.

People, staff and stakeholders were asked for their views about the service. Regular meetings were held and action had been taken when suggestions had been made. However, negative feedback from some people who had been at the service for rehabilitation had not been analysed.

Staff were recruited safely, people told us there were enough staff to meet their needs. Staff received supervision and appraisal to discuss their development. Nurses received training to keep their clinical skills up to date. Staff monitored people's health and referred them to health professionals when required. Staff followed the guidance from health professionals to keep people as healthy as possible and promote their independence. Staff supported people to live as healthy a life as possible. People were supported to eat a balanced healthy diet.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. People were supported to make decisions about their care and support. Staff supported people at the end of their lives and keep them comfortable.

People had access to a variety of activities which they told us they enjoyed. The provider had a complaints policy and any complaints received were investigated following the policy.

People were treated with kindness and respect. Staff supported people to be as independent as possible. Staff knew about people's choices and preferences including their sexuality and religious needs and supported them to live the lives they wanted. People's dignity was respected.

People were comfortable in the company of the registered manager and relatives told us the management team were approachable. The service was purpose built and met people's needs.

The registered manager attended local forums and groups to keep up to date. The service worked with other agencies to provide joined up care for people. The building was purpose built and met the needs of people.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. CQC check that appropriate action had been taken. The provider had submitted notifications to CQC in an appropriate and timely manner in line with guidance.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgements. We found the provider had conspicuously displayed their rating on a notice board in the entrance hall.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Checks had been completed on the environment but action had not been taken when required to keep people safe.

Potential risks to people's health and welfare had been assessed but there was not always guidance for staff to mitigate the risk.

Medicines were not managed safely.

People were not always protected from the risk of infection.

Accidents and incidents were recorded and analysed, however, there was not always detailed information about the action taken.

Staff knew how to report concerns about abuse but had not always realised when incidents should be reported. The registered manager took appropriate action when concerns were raised.

Staff were recruited safely. There were sufficient staff to meet people's needs.

Requires Improvement ●

Is the service effective?

The service was not always effective.

People did not meet with staff before moving to the service, people's clinical needs were assessed using referral documents from other health professionals.

Staff did not always receive training updates. Staff received supervision and appraisal to discuss their development.

Staff were working within the principles of the Mental Capacity Act 2005.

People were supported to eat a balanced diet. People were encouraged to lead as healthier life as possible.

Requires Improvement ●

Staff referred people to other health professionals when their needs changed.

The service was purpose built and met people's needs.

Is the service caring?

Good ●

The service was caring.

People were treated with kindness and respect.

People were encouraged and supported to be involved in their care and support.

People were supported to be as independent as possible.

Is the service responsive?

Requires Improvement ●

The service was not always responsive.

Each person had a care plan but these did not always contain details about people's choices and preferences. Care plans did not always reflect the care being given.

People had access to activities they enjoyed.

People were supported at the end of their lives.

Complaints were recorded and investigated.

Is the service well-led?

Requires Improvement ●

The service was not always well led.

Staff completed checks and audits, staff had not recognised when there were shortfalls and had not acted. The registered manager did not have oversight of the audits and these had not been effective.

People were comfortable in the company of the management team.

People, relatives, staff and stakeholders were asked their views on the quality of the service. However, they had not analysed negative feedback from people who had received rehabilitation services.

The registered manager attended local forums to keep up to date.

The service worked with other agencies to deliver joined up care.

Ami Court

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.

The inspection took place on 16 and 17 October 2018 and was unannounced. The inspection team consisted of two inspectors 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.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. Before the inspection we reviewed the PIR and notifications received by the Care Quality Commission. A notification is information about important events, which the provider is required to tell us about by law, like a death or serious injury.

We spoke with 12 people living at the service and five relatives who were visiting the service. We spoke with the registered manager, deputy manager, operations director, clinical lead, activities organiser, registered nurse and four care staff. Before the service we had feedback from two professionals that had contact with the service. We spoke with two professionals during the inspection.

We observed how staff spoke with and engaged with people. We looked at how people were supported throughout the inspection with their daily routines. We reviewed six care plans and risk assessments. We looked at a range of other records including medicines, staff files, checks and audits to assess and monitor the quality of the service. We 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 to us.

Is the service safe?

Our findings

People told us they felt safe and there were enough staff to meet their needs. One person told us, "I had a few falls at home on my own so they are really helping me here to help myself and keep safe." Another told us, "I am quite satisfied with the amount of staff on duty at any one time and never feel that I have to wait for attention." Despite these positive comments we found the service was not always safe.

Potential risks to people's health and welfare had been assessed but action had not always been taken to mitigate the risks. Staff completed checks on the environment and these had been recorded, however, the registered manager and staff had not recognised when people were at risk and had not acted to rectify the shortfalls.

Staff had been recording the hot water temperatures monthly. For three months, eleven bedrooms had water temperatures above the safe limit of 44c, six rooms were over 50c and one temperature reached 64.4c. Some people were mobile and had access to their hot water tap and water temperatures had not been recorded when people had a shower or a bath, to check the water was at a safe temperature. It had not been assessed if people were at risk of accidental scolding. Hot water regulation is needed to mitigate the risk of accidental scolding. Staff had not recognised that the temperatures were unsafe and had not reported them. We discussed this with the registered manager, who told us they had not been aware of the high temperatures. During the inspection, a plumber was contacted who adjusted the water temperatures.

A bedroom door was being kept open with a waste bin and the communal lounge door was also wedged open. The registered manager and staff had not recognised that this put people at risk if there was a fire. We discussed this with the registered manager, who removed the obstructions, they agreed that if the doors needed to be kept open an approved door opener would be fitted as soon as possible. Fire equipment checks had been completed, fire drills had been recorded but the staff attending had not been recorded, there was not record that a drill had been completed at night. The management team had not recorded if the drill had been successful or if there were any improvements needed.

In the communal lounge, we observed a pot of thickening powder on the side. Thickening powder is used to make fluids thicker so that people with swallowing difficulties can drink safely. If the thickening powder is swallowed without fluid, it can form an obstruction and people would be at risk of choking. Some people in the lounge were mobile and able to access the thickening powder. The thickening powder was removed from the lounge following discussion with the registered manager.

Potential risks to people's health had not always been assessed and there was not always detailed guidance for staff to mitigate the risk. Some people displayed behaviours that challenged including aggression and inappropriate sexual behaviour. There was no detailed risk assessment or behaviour care plan to give staff guidance about how to manage the behaviour and keep a person safe. Behaviours had been recorded in the care plan review but had not been added to the care plan. One care plan stated that there are no triggers to the person's behaviour, however, incidents of behaviour had not always been recorded and analysed, to identify patterns and trends.

People who required equipment to mobilise had risk assessments, but there was limited guidance for staff about how to use the equipment. Guidance included use hoist and sling, with the size of the sling, however, there was no information about the type of sling to be used and how to position the sling. Staff told us the different slings they used and when they used them to keep people safe.

Medicines were not always managed safely. Medicines should be stored consistently below 25c to ensure they remain effective. The temperature of the room where medicines were stored had been recorded daily. However, since May 2018, the temperature had been recorded as 25c or above on 128 days. The highest temperature was 30c, this was at 9am, there had been no other recording to check if the temperature increased or decreased. During the inspection, the room temperature increased during the day, the temperature was 25c at 9am, 26c at 2pm and 27c at 3pm. The registered manager told us they had not been informed of the high temperatures, they installed an air conditioner during the second day of the inspection. The use of the air conditioner had reduced the temperature in the room.

Some people were prescribed medicines on an 'as and when' basis, for example pain relief and to reduce anxiety. There was no guidance for staff about when to give the medicine, how often and what dosage to give. There was a risk that without guidance the person would not receive the medicine when they need it. Most medicines prescribed daily were ordered and received by the service on a 28 day cycle. When medicines are not prescribed regularly, a stock should be kept by the service. This stock should be counted and recorded to inform staff when further stock needs to be ordered and to be able to check that people are receiving the medicine as prescribed. The stock medicines had not been counted and recorded, there was a risk that further stock would not be ordered when needed or open to misappropriation.

Some medicine instructions had been hand written on the medicines administration record. These instructions should be signed by two people to confirm the instructions are correct, staff had not followed this practice, however, the instructions were correct. There were large amounts of stock of clinical equipment such as needles. Some of these belonged to people who no longer lived at the service and had left over a year previously, these should have been disposed of when the person had left the service. There was a large amount stock that was out of date including nutritional supplements and catheters, and there was a risk that these would be used.

People were not always protected from the risk of infection. There was a linen store on the first floor of the service, this was full and linen had been stored on the floor. During the inspection, clean linen was found in the sluice room on top of the bed pan washer. Staff did not have any means such as a trolley to store clean linen on the ground and second floor. In the kitchen area, there was a food trolley that was dirty. The clinical lead told us that the trolley was no longer used.

The registered person failed to assess the risks to the health and safety of people, doing all that is reasonably practicable to mitigate risks. The registered person had failed to manage medicines safely and assess the risk of infection. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people were living with health conditions such as diabetes, the potential risks to their health and welfare. There was information about the signs and symptoms staff should look for when people are unwell and what action to take. Nurses managed people's diabetes medicines and monitored their blood sugar. When people had a catheter (a tube that drains urine from the bladder) and were at risk of infection. There were clear instructions for staff on how to maintain the catheter and reduce the risk of infection.

Accidents and some incidents had been recorded and analysed to identify patterns, but there was little

detail about the actions taken. Action had been taken and recorded in people's care plans.

Staff understood their responsibilities to keep people safe and protect them from abuse. Staff described how they would recognise abuse and the action they would take. They told us they were confident that the registered manager would take appropriate action if they had concerns. However, staff had not always recognised immediately when incidents needed to be reported to the registered manager. For example, when medicine errors had happened staff had taken appropriate action to keep people safe, but had not reported it to the registered manager as soon as they had happened. Once the registered manager was aware they took appropriate action.

Staff were aware of the whistle blowing policy and had felt confident to whistle blow when needed. Safeguarding concerns had been raised with the local authority, however, the documentation was difficult to follow and not complete. There was no information about the investigation and what action had been taken following the safeguarding.

Staff were recruited safely. Checks had been completed to make sure people were honest, trustworthy and reliable. These checks included written references and an employment history, any employment gaps had been discussed. Disclosure and Barring Service (DBS) criminal records checks had been completed before staff began work at the service. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care services. Nurses personal identification number (PIN) had been checked to ensure they were registered to practice.

There were sufficient staff on duty to meet people's needs. The registered manager used a dependency tool to calculate how many staff were needed. People told us there were enough staff to meet their needs. During the inspection, people's call bells were answered promptly and we observed staff spending time with people. People were relaxed and were not rushed when staff were supporting them. Staff told us that there were enough staff to meet people's needs, sickness and annual leave were covered by permanent staff. People who required one to one support had the same staff to support them.

Is the service effective?

Our findings

People and relatives told us that they enjoyed their meals and were supported to see health professionals when they needed to. One person told us, "I have no complaints about the menu, I like the food very much."

An assessment was completed before people moved into the service. Staff completed an assessment using written information from other health care professionals and a telephone assessment with staff providing care to the person. Staff only met with the person before they moved into the service, if they had needs such as behaviours that challenge. We discussed this with the registered manager who explained that the service had a good working relationship with the hospital and other professionals. They were happy with the information they received and felt that they could decide if they could meet people's needs.

We reviewed the provider's pre-admission policy. The policy stated that 'A meeting with the prospective resident, preferably in the form of a visit will be arranged.' Also, 'We will discuss this issue with prospective resident and relatives or care manager as appropriate.' The registered manager was not working within the policy, as they were not speaking or meeting with the person. The assessment did cover people's physical, emotional and social needs, but this was from the perspective of the professionals. By not meeting the person, the service did not know about their own personal goals, preferences and needs, that may not be apparent to health professionals. We discussed this with the clinical lead, who agreed the provider's policy needed to be changed to represent how the service completed their assessments.

Following admission to the service, people's needs were assessed using recognised tools and following current guidelines.

Staff told us they received training appropriate to their role. During the inspection, we observed a practical training session in moving and handling. However, the training matrix supplied by the registered manager showed that not all staff had received training in many topics including infection control and fire safety. The registered manager told us that they were introducing a new training system and would be updating all the staff training. We will check this on our next inspection.

When new staff started work at the service they received an induction. Staff completed a training booklet and online training to meet the requirements of the Care Certificate. The Care Certificate is a set of standards that care workers are expected to adhere too. Staff confirmed that they had received instruction on observation, reporting and supporting people with all elements of their personal care. Staff also worked with more experienced staff to learn about people's choices and preferences. Staff told us that they only supported people by themselves when they had been assessed as competent.

Staff received regular supervision and appraisal to discuss their practice and development. Staff told us they felt supported by the management team and could discuss any concerns they had at any time. Nurses completed training to update their clinical skills including verification of death and the use of syringe drivers. They received clinical supervision from the clinical lead.

People were supported to eat a balanced diet, people were given a choice of meals. We observed the lunchtime meal and the food looked appetising. The catering staff were aware of people's dietary needs including puree diet. People had the choice of where they ate their meals, some chose to eat in their rooms while others had their meals in the lounge.

On the first day of the inspection, people in the lounge did not receive their meals at the same time. Some people were eating while people sitting next to them were still waiting for their meal, people who required assistance were left till last. We discussed the serving of meals in the communal area with the registered manager, on the second day, changes had been made and people received their meals at the same time and staff were present in the lounge. The meal was more sociable, people were chatting with each other and staff, discussing the meal. People told us they had enjoyed the meal.

Staff monitored people's health and referred them to healthcare professionals when their needs changed. People's weight was monitored and when people lost weight they were referred to the dietician. People who had difficulty swallowing were referred to the Speech and Language Therapist to be assessed. Staff followed the guidance from the health professionals, people had started to gain weight and people were eating and drinking safely.

Some people were receiving support following an admission to hospital, staff worked with health professionals such as occupational therapists, to assess people's long-term needs. Staff followed guidance to support people to, where possible, to become as independent as possible and return home.

People were encouraged to be as active as possible. People who were able walked around the building to keep active, and people could take part in chair exercises.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack 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 so that they can receive care and treatment when this is in the best interests and legally authorised under MCA. The application procedures for this in care homes and hospitals are called Deprivation of Liberty Safeguards (DoLS). We checked the service was working within the principles of the MCA.

The registered manager had applied for DoLS authorisations when appropriate and these had been authorised, no conditions had been put in place. There was a system in place to identify when the authorisations were coming to an end, and had made timely manner. People were supported to make decisions, people were given choices such as what to wear and how to spend their time. Staff told us that if people were unable to make simple decisions, they would use what they knew about their likes and dislikes to decide. When decisions had been made in people's best interests these were recorded and involved staff, relatives and professionals that know the person well.

The building had been built to meet people's needs. People had access to the garden and were able to move around the building. People's rooms had en-suite facilities including a walk-in shower, which could be used while sitting in a chair. There were also communal bathrooms if people preferred a bath.

Is the service caring?

Our findings

People and relatives told us that staff were kind and caring. One person told us, "They can't do enough for us it makes me feel really happy." A relative told us, "It is humbling to witness how caring and gentle the staff are."

Staff knew people, who had lived at the service for a long time, very well. They could describe the care and support they gave people. They knew about people's choices and preferences including their sexuality and religious needs and supported them to live the lives they wanted. We observed staff providing support to people in the way they preferred. In the lounge, staff arranged a person's chair and table in the way they like it, as the person walked to the lounge.

We observed examples of person centred care during the day, for example one person who was usually in bed all day wanted to attend the singing in the afternoon, two carers took great care getting them ready to leave their room and take them into the lounge in their adapted chair and settle them. Staff found a person, confused and walking in a corner of the garden so they quietly coaxed them back into the lounge and sat with them, while a cup of tea was brought to them, until they settled.

People were encouraged to be as independent as possible. People were supported to walk using aids to keep them safe. Staff gave people specialist cutlery and plate guards to enable them to eat their meals independently. People sat in the garden and could call for assistance if needed, people told us they liked the independence of sitting by themselves.

Staff spoke to people with kindness and compassion. People were addressed in the way they preferred, we observed staff knocking on people's doors before entering. There was evidence that strong relationships have been formed between staff and people. One person told us, "The staff are all kind, soft and gentle but still manage to have a laugh with us."

When people required support from a member of staff constantly, the same staff worked with them. Relatives told us that they had observed the person's mood and behaviour improve, "I feel I have my (relative) back." Relatives told us they could visit at any time and staff made them feel welcome.

People had brought in their own photos and ornaments that were important to them. People told us that their rooms were comfortable and felt like home. Staff told us and we observed staff knocking on people's doors and waiting to be asked in. Staff closed the door and curtains when providing care and support.

People were supported to be involved in decisions about their care. When people could make complex decisions the care plan was agreed with them. Staff were guided by their choices and respected their decisions. Some people signed their care plans to confirm they agreed with them. People who could not express their views, staff involved their relatives and their previous choices and preferences to make decisions about their care.

The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. The provider had looked at ways to make sure people had access to the information they needed in a way they could understand it, to comply with the Accessible Information Standard. They provided information in picture form such as menus and meetings.

Is the service responsive?

Our findings

People who had lived at the service for a long time, were known well by staff and staff understood their choices and preferences. People and relatives told us staff supported them as they wanted. One person told us, "They know what I like and make sure that I am looked after in that way." Another person told us, "They look after me just as I like."

However, the needs of some people varied, they received one to one support or lived at the service for a short period of time and their needs changed as their health improved or declined. To enable staff to deliver consistent, effective and responsive care they need to have access to accurate, up to date information.

Each person had a care plan that covered all aspects of their care and support. However, not all care plans included details about people's choices and preferences and did not always reflect the care that was being given. Care plans were reviewed regularly, but any changes in people's needs had not always been put into the care plan. One person had stopped having a catheter, to drain urine from their bladder, this had not been changed in their care plan, however, staff knew about this change and were meeting the person's needs. Other care plans had some details about people's choices and preferences such as when they liked to get up and go to bed, while others did not.

Staff completed food and fluid charts for each person whether or not they were at risk of eating or drinking enough. The use of the charts had not been decided on a person's needs, staff only recorded the diet and fluids they had given people. However, some people could pour their own drinks and these were not recorded so the charts were not accurate. Some people's care plans gave the amount they should be drinking, this was not written on the fluid charts for staff. The fluid charts were added up each night but action had not been taken when people had not drunk as much as they had been assessed as needing. Following discussion with the registered manager, they advised us they would review the use of food and fluid charts and only use them when clinically relevant.

Some people had wounds which were managed by the nurses. The record of the treatment used and the progress of the wound were not always clear or accurate. Local Clinical Commissioning Group (CCG) guidelines state that when photographs are taken a tape measure should be used to show the size of the wound, although photographs had been taken a tape measure had not been used. Between dressing changes, the only information available to assess the wound are written records. The management of the wound may affect the needs of the person and the information available to health professionals should be accurate to enable an accurate assessment of people's needs.

The registered person had failed to maintain accurate, complete and contemporaneous record in respect of each person. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported at the end of their lives. People were asked about their end of life wishes and these were recorded, some people had declined to discuss their wishes and this was respected. Staff received

training in palliative care and nurses could support people with the administration of medicines to keep them comfortable. Staff made sure that medicines were available when people needed it. Staff liaised with the GP and other health professionals to ensure people's needs were met.

People had access to activities. There was an activities organiser, who was enthusiastic about people being able to enjoy their themselves. People and relatives told us they were kept informed of planned activities, asked what kind of activities they would like and they enjoyed them. During the inspection, people joined in singing with an outside entertainer, with obvious enjoyment, but clapping and singing. One person told us, "It's never just boring old bingo on offer here we have all sorts going on."

The provider had a complaints policy and this was displayed within the service. People and relatives told us they knew how to complain. One relative told us, "No complaints at all. He would speak to the manager himself if he was unhappy."

Complaints had been recorded and investigated in line with the provider's policy. Verbal complaints were recorded and dealt with immediately, to the person satisfaction.

Is the service well-led?

Our findings

People and relatives told us they thought the service was well led and the registered manager and the management team were approachable. One person told us, "The office are really understanding and I find that they really do want to help." Another told us, "The manager is really approachable and will have a chat too." Despite these positive comments, the service was not always well led.

Checks and audits had been completed on the quality of the service, however, these had not been effective in improving the service. Staff completed and recorded checks on the environment, such as water temperatures, but had not recognised when some temperatures had been unsafe. Audit tools used by staff had consisted of questions that needed to be answered yes or no, for example, the medicines audit asked, has the room temperature been recorded. The answer was yes, however, staff had not recognised that the room temperature had been too high to maintain the effectiveness of the medicines.

The audits had not identified the shortfalls found during this inspection. The audits had not identified the shortfalls in care planning and risk assessments. Shortfalls concerning fire safety and infection control had not been identified by staff. Staff had not always recognised immediately when incidents should be reported for investigation to keep people safe.

Quality assurance surveys had been completed by people and staff. Analysis had been completed and the results of the people's survey was displayed in the main reception. However, the results of the surveys completed by people who received short term support and assessment had not been analysed. The surveys were not dated but the feedback for most of the surveys were not positive. We discussed this with the registered manager who had not been aware of the surveys and confirmed that no action had been taken about the surveys.

The registered manager is also the provider, they were present at the service often. They were also the registered manager and provider of three other local services. The registered manager had a team of staff who were responsible for the day to day running of the service. The registered manager lacked oversight of the checks and audits that were being completed. They had not assessed if the staff completing the audits had the skills and knowledge to recognise shortfalls and act to rectify them. The registered manager did not have oversight of the audits and had not identified and acted on shortfalls. The registered manager had not recognised issues around fire safety and infection control within the service.

The registered person had failed to assess, monitor and improve the quality of the service and risks relating to the health, safety and welfare of people. The registered person had failed to evaluate and improve their practice in respect to improving the quality and safety of the service. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and staff told us that there was an open culture within the service and they could speak to the management team at any time. During the inspection, we observed that people and relatives were comfortable in the company of the management team. People recognised and chatted to the registered

manager when they saw them in the communal areas.

Staff understood their role and responsibilities. The service supported people who moved to the service to receive short term care and assessment by health professionals. Staff told us their aim was to encourage people to improve and develop. Staff worked with health professionals to achieve the best possible outcomes for these people, including them returning home.

People, relatives, stakeholders and staff were asked their opinion on the quality of the service. There were regular resident meetings where people were reminded how to report concerns and if they wanted to raise any at the meeting. People had raised issues around the menu's and how to call for assistance in the garden. Action had been taken and there was now a bell in the garden for people to use to call for assistance. People told us they now had more fish dishes and prunes on the menu. Regular staff meetings were held for staff across all the provider's services, they were reminded about good practice and any concerns that people had raised.

The registered manager attended local forums and groups to keep up to date with changes. The service worked with other agencies and healthcare professionals, to provide joined up care, including the clinical commissioning group.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. CQC check that appropriate action had been taken. The provider had submitted notifications to CQC in an appropriate and timely manner in line with guidance.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgements. We found the provider had conspicuously displayed their rating on a notice board in the entrance hall.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The registered person failed to assess the risks to the health and safety of people, doing all that is reasonably practicable to mitigate risks. The registered person had failed to manage medicines safely and assess the risk of infection.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The registered person had failed to maintain accurate, complete and contemporaneous record in respect of each person. The registered person had failed to assess, monitor and improve the quality of the service and risks relating to the health, safety and welfare of people. The registered person had failed to evaluate and improve their practice in respect to improving the quality and safety of the service.