Country Court Care Homes 2 Limited

Lyle House

Inspection report

207 Arabella Drive
London
SW15 5LH

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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 22 March 2016 and was unannounced. This service was previously registered under a different name; this was the first inspection of this service under its new registration.

Lyle House provides residential care for up to 45 older people. The home is arranged over three floors and accommodates some people with a diagnosis of dementia. At the time of the inspection, there were 40 people using the service, although one person was in hospital.

There was a registered manager at the service. 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.

People using the service told us that staff were caring and ensured they had privacy and dignity when delivering personal care. We observed care workers interacting with people and they did so in a caring manner, taking time to speak with them and ensuring their needs were met. People told us they felt safe living at the home.

People had their support needs in relation to eating and drinking met by the provider. People were given choices in relation to food and we observed staff offering drinks to people during the day. Care records included nutrition assessments and care plans based around nutrition. Referrals were made to specialists such as speech and language therapists and dieticians in response to assessed difficulties.

People were supported to receive their medicines on time from trained staff. Their healthcare needs were managed by the provider, referrals were made to professionals such as their GP, district nurse, therapist and community teams.

Staff were aware of the need to ask people for consent before supporting them with personal care. The provider was not meeting the requirements of the Mental Capacity Act 2005 (MCA), we found that staff did not always know which people needed to be deprived of their liberty in order to keep them safe. Some of the care records related to assessing people's capacity to consent and whether any restrictions placed on them were lawful were not always completed appropriately.

Care records although comprehensive in scope where not always completed fully or up to date. For example, some risk assessments were not completed properly and some did not include an associated care plan. Some care plan reviews did not always reflect changes to people's support needs.

Staff underwent thorough recruitment checks before they started to work at the home. New staff completed an induction and thereafter, ongoing training which helped them to carry out their roles. At the time of our inspection, there was a high use of agency staff. The registered manager acknowledged this but confirmed

that a number of posts had been filled and they were waiting for checks to be completed for them to start.

The registered manager who had only been in post a short while had plans in place to drive improvement within the service. These were seen through feedback surveys and staff meetings that had been held and identified areas of improvement had been highlighted. However, checks and audits had not always identified or addressed issues that we found during our inspection.

We found three breaches of regulation in relation to consent, safe care and treatment and good governance. You can see what action we have 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 consistently safe.

Although risk assessments were in place for each person, they were not always completed appropriately and some did not have associated care plans.

People received their medicines safely however the storage of unused medicines was not safe.

Thorough recruitment procedures were in place and a number of vacancies had been filled, although there was reliance on agency staff at the time of our inspection.

People told us they felt safe living at the home.

Is the service effective?

Requires Improvement

The service was not always effective.

Record keeping in relation to the Mental Capacity Act 2005 (MCA) was not always completed appropriately and staff were not always fully aware of their responsibilities.

Staff told us they received a comprehensive induction and ongoing training.

People told us the food was nice and those who required specialist support with their nutrition were provided with it.

Is the service caring?

Good

The service was caring.

Care workers demonstrated a caring attitude towards people.

People's privacy and dignity was respected by staff.

Care records included people's preferences and how they liked to be supported and their life histories.

Is the service responsive?

Requires Improvement

The service was not responsive in all aspects.

Although care records were comprehensive in scope, they were not consistently completed by staff or updated as people's needs changed.

The provider had procedures in place for dealing with complaints and people were given information on how to raise concerns if they were not happy.

Is the service well-led?

Requires Improvement

Aspects of the service were not well-led. Staff gave mixed views about the leadership of the service.

Quality monitoring in the form of audits and feedback took place and we saw that the provider responded to some of the issues picked up. However, these checks had not identified or addressed all of the issues we found during our inspection.

The registered manager had only been in post a few months and had identified areas of improvements and areas that she needed to focus on.

Lyle House

Detailed findings

Background to this inspection

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

This inspection took place on 22 March 2016 and was unannounced.

This inspection was undertaken by two inspectors, an expert by experience and a specialist advisor. An expert by experience is a person who has personal experience of using or caring for someone who uses services like this. On this inspection the specialist advisor was a qualified mental health nurse.

Before we visited the service we checked the information that we held about it, including notifications sent to us informing us of significant events that occurred at the service.

We spoke with 10 people using the service, two relatives and six care workers plus the registered manager, the activities coordinator and the chef. We looked at records including nine care records, four staff records, five medicine administration records, induction and training records, complaints and audits.

Requires Improvement

Is the service safe?

Our findings

People using the service and their relatives did not raise any concerns about their safety when we spoke with them during the inspection. We observed staff interactions with people and noted them to be warm, engaging and reassuring. However, we did find some incidences where the provider had not taken appropriate action to ensure that people were protected from avoidable harm.

There was evidence of risk assessments, including those relating to falls, moving and handling, pressure ulcers (Waterlow scoring methodology) and nutrition using Malnutrition Universal Screening Tool (MUST). There was evidence of the development of appropriate care plans to mitigate the risks. There was evidence of reviews, and scoring of risks. However, we did find some inconsistencies with some of the risk assessments we looked at during the inspection.

Risk assessments were specific to the person they were written for. For example, where a person was at risk of falling, staff were reminded to, 'make sure there are no obstacles in the way.' On another, where there were concerns about a person's poor appetite, we saw that this person was weighed on a regular basis, in line with the guidance on the risk assessment. There was evidence of responding to risk with referral to appropriate services, for example, district nursing services, speech and language therapy, dietitians, physiotherapy, chiropodists and the mental health team. There was evidence of seeking out personal preferences, routinely in the care planning.

However, in some records the risk assessment evaluations were completed intermittently. In one person's falls assessment it was recommended to partake in activities however this was not documented in a plan. A Waterlow assessment had documented a grade one discolouration on 27/08/15 and then on the 12/11/15 there was a documented grade three broken area. There were no dated pictures and the Waterlow record was not up-to date. In another person's record, the Waterlow risk assessment stated they were fully mobile but in the hygiene and personal care plan it stated this person had poor mobility.

Dependency profiles were completed and reviewed monthly. There was inconsistency with some of the dependency profiles/risk assessments. In some cases people were scored correctly in relation to mobility and memory and Waterlow but others were wrong. For example, one person's nutritional risk assessment was not completed, in their falls risk assessment they were identified at being of medium/high risk with a score of 12 and action points/guidelines were in place for staff to refer to.

In the clinic room the sharps disposal bin contained a brown envelope. The controlled drugs cupboard contained an excess of seven pain relief patches and this was not documented in the controlled drugs recording book. The medicines disposal bin was an old container that had been used to store confectionary and returns medicines were left on the side rather than in a locked cabinet which was not safe medicines practice. We pointed this out to the registered manager who took action. There were records documenting the return of medicines to the pharmacy.

The above identified issues were a breach of Regulation 12 of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

We examined five medicines administration record (MAR) charts. The home utilised a dosset system and these boxes were locked in a secure medicine trolley. We reviewed the MAR charts and found that they were appropriately completed. Staff recorded every medicines intervention and signed when they had been administered.

There were multiple medicines trolleys, related to different areas within the home, which were locked when not in use. The clinical areas, where medicine trolleys were retained when not in use, were noted to be locked when staff were not present.

There was evidence of routine double signatures for all controlled drug administrations and checks. We checked the records and stock remaining of three random controlled drugs and found them to be correct.

We reviewed the records for the temperature within the clinic area and noted that the temperatures of the room and medicines refrigerator were checked and recorded daily. The temperature readings for the refrigerator included maximum and minimum readings.

We observed a care worker preparing and administering medicines for people. The medicine was checked against the MAR chart. The medicine was individually prepared and administered before commencing the next person's medicine. The nurse engaged with people warmly and provided water, or their noted preferred drink, to assist the person to take their medicine. The MAR chart was not signed for until the medicines were actually taken by the person.

Staff were able to describe the process for identifying and reporting concerns and were able to give examples of types of abuse that may occur. One care worker said, "It is my job to make sure people are safe. If I notice anything out of the ordinary, such as mood swings or if they seclude themselves in their room, then I immediately report my concerns." Other comments included, "I always take note of any new marks on the body when I am assisting with personal care", "Safeguarding is about the care you give and looking after people", "You can contact social workers, CQC or the manager" and "I think people here are safe, we look after them."

Staff explained that if they saw something of concern they would report it to the duty manager, or the most senior person on shift. They were familiar with the term 'whistleblowing' and told us that they would report any staff or organisational concerns. One staff member said, "This would go up the line of management and ultimately, I would contact the Care Quality Commission."

There was evidence that the provider took action when concerns were raised and liaised with appropriate agencies when investigating safeguarding concerns.

Care workers we spoke with confirmed they went through a robust recruitment check and had to complete an application form, attended an interview and supplied two references and had a Disclosure and Barring Service (DBS) check. The DBS provides criminal record checks and barring functions to help employers make safer recruitment decisions.

There were adequate numbers of staff on duty on the day of our inspection, including some agency staff. One care worker told us, "At the moment, we have more agency staff than full time workers. This can be difficult as it takes time to show a new agency worker around." They told us this had an impact on people at

times, "I know there have been new full time staff recruited. It will be good when they start, as the persons need consistency of staff." Some care workers told us they were sometimes short staffed and the high use of agency staff meant that they were rushed. One staff member said, "We don't always get enough time to do our jobs and speak to people." An agency care worker said, "For me its ok, the day is planned and I know what is expected of me. Whenever I am given an option I choose to work here."

On the day of the inspection there were three care workers on each floor with a senior floating across all three floors. There were four care workers during the night, one on each floor and a senior floating across all three. The registered manager was on call.

On the ground floor, there were three care workers on duty. Two were agency staff and one permanent staff member who had been in post for six months. There were six agency staff in total on the day of inspection. On the week of the inspection, there were between two and six agency staff on duty on the majority of shifts. This meant that people were not always provided with continuity of care by staff who were familiar with their needs.

The registered manager acknowledged that there had been issues with staffing levels but was confident that these would soon be resolved. She told us there had been 11 vacancies but nine of these had been recruited for. They were waiting for DBS checks to clear for some of them. She had also recruited a new head of housekeeping. The registered manager told us about some of the staff changes she wanted to implement. Currently three care workers were assigned to each floor and a senior floated across all three floors. Moving forward, the plan was to have a senior care worker on each floor.

Requires Improvement

Is the service effective?

Our findings

We found that the provider was not always protecting people's rights as they were not meeting the requirements of The Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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

A form called 'Informal mental health and capacity assessments' were completed every month and staff were prompted to answer a number of questions based around the key principles of the MCA and were therefore supported to come to a conclusion about a person's capacity. However, we found there was some confusion around how these assessments were being followed up. For example, where one person was deemed to have capacity, consent forms were signed by a family member, rather than the person. We also saw on the same person's record, where a GP had signed a Do Not Resuscitate [DNR] form a note was made 'discussed with sister' rather than the individual concerned. We also found that consent forms were completed by family members with no description of the person's involvement. □

There was another form called 'Restrictive Practice Assessment' which documented whether there were any restrictions in place and whether people were able to consent to these or not. We found that they were not always completed consistently for all the records we saw. Some forms were not signed or dated by the manager. In another record the informal mental health and capacity assessments alluded that the person had fluctuating capacity. In another record, there was no informal mental capacity or restrictive practice assessment, however there were pressure sensor pads in place for this person monitoring their movement.

The provider had submitted DoLS applications for those people who were being deprived of their liberty in some way and a record was kept of those that were currently on a DoLS authorisation. However, when we asked staff to tell us which people were on a DoLS, we found that they were unclear about which people had a DoLS. This meant staff may be unclear about whether they were depriving a person of their liberty lawfully or not.

The above identified issues were a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with were familiar with the Mental Capacity Act 2005, and the need to obtain consent from those who used the service. One person told us, "We must give people time to give their consent. I find if I sit with them and give them time, then they come back to their old self and understand what I am trying to do." Another told us, "Even if a person cannot verbalise their consent, I watch out for small signs and gestures

which a person makes when expressing their preference." We heard care workers offering choices to people during the day relating to preferred activities, food or where they would like to sit. We saw there were consent forms on people's records relating to access to information, photographs, administration of medicines and continuing health and social care assessments.

Staff told us they were supported to gain the knowledge and skills to enable them to support people effectively. They said they had undertaken induction training and other in-house training. A care worker told us, "My induction was so good. The manager supported me with this, which was so helpful."

We were shown the training planner for the service which gave details of the training that staff had been provided with, which included medicines competency, safeguarding, dementia, fire safety and Mental Capacity Act 2005 (MCA) amongst others.

Care workers we spoke with confirmed that they had been provided with induction training, ongoing training support and ongoing supervision. Staff supervisions took place every two months and included feedback on individual performance, understanding of key policies, concerns, team working, the views of the supervisor and training. Tasks for follow up were also recorded. One care worker told us, "We get face to face training, which is so good, it gives a chance to reflect on our learning with others" and "We get taken off the rota to attend training." However, one care worker told us they had not been able to go to recent training, despite it being booked. They told us this was due to staff shortages.

People using the service told us, "The meals are lovely. Someone always comes round the day before to ask what you want" and "The food is not too bad."

The menu was on a four week cycle and included a wide range of dishes. If a person did not want any of the choices, there were alternatives which included an omelette, a baked potato and toasted sandwiches. There was a separate snack menu available for people who may wish to eat after supper and throughout the night.

We observed lunch on the ground floor. Food was brought in on a heated trolley, with top and bottom insulating covers. There were large portions and people were given a choice of meals to eat. Everyone ate independently and communication from the care workers was task based. We observed staff offering choices of drinks to people during the day. It was noted that there were drinks freely available, that there was a coffee bar for people to use as they wished, and we noted that people asking for additional drinks during the inspection were provided with them promptly.

We saw that food was appropriately stored in fridges and was wrapped and dated. We also looked at records of all checks carried out on a daily basis, including temperatures of fridges and freezers and temperatures of food served and found these were up to date. We saw there was a plentiful supply of fresh and frozen food, including fruit, vegetables and dry stores.

The registered manager said the chef had been on a course on special soft food preparation techniques, so that soft foods could be presented in an appetising way for people. We discussed people's dietary needs with the chef. She told us that relevant information was passed onto her by care staff. We saw this information was added to the sheet which care workers used to obtain people's food choices. We were told that there was nobody with specific cultural needs at the time of our inspection, however, the chef commented, "But if this arose then I would make sure I provided this." We saw pictures of special cakes made for people's birthdays and the chef said, "We like to make a big fuss of people's birthdays."

All care files included nutrition assessments and associated dining, nutrition and eating habits plans. There

was evidence of the use of dietary supplements. There was evidence of assessment of choking and dietary risks, with referrals to speech and language therapists (SALT) and dietitians in response to assessed difficulties. Weights were recorded and incorporated into the Malnutrition Universal Screening Tool (MUST).

Dietary instructions were on display and these that had been reviewed recently by the dietitian. They included the type of food that was recommended for people. There was evidence that these recommendations were being adhered to.

All people were registered with a GP and had the choice to remain with their own GP if they so wished. One person told us they were seen by a chiropodist at the home and their own GP who visited them. They told us they had a cataract operation performed on one eye whilst living at the home and were now awaiting an operation on the other one.

We saw evidence on care records of multi-disciplinary work with other professionals. There were guidelines from a Behavioural and Communication Support Service (BACSS), a health team which specialises in assessing people whose behaviours challenge. We also saw that people had been seen by a dentist, optician and chiropodist. There was evidence of regular involvement of other healthcare professionals, for example, GPs, dietitians, district nurses, speech and language therapists and opticians.

Care plans were reviewed monthly which included recording people's baseline observations such as their weight, pulse and blood pressure.

People that had underlying health conditions had care plans in place. For example, one person had a health and wellbeing care plan in place in relation to his diabetes. The care plan had an identified need, an expected outcome and how their care needs were to be met. There was a monthly care plan evaluation to see if the care plan was still relevant.

Good

Is the service caring?

Our findings

We saw how staff interacted with those who used the service in a kind and respectful way. One care worker told us, "It is important to have a gentle approach, to be patient and calm, when offering any assistance."

Staff interactions with people were caring and warm. On one occasion a person requested to go for a walk by themselves, the staff member was not completely sure if this was part of the person's plan so they suggested going with them to ensure their safety. On another occasion, we noticed a staff member cleaning a person's spectacle's while engaging in meaningful conversation.

We viewed a few rooms and noted them to contain personal memorabilia that was important to people. People told us they were given the freedom to bring in their own items if they wanted. One person said, "They encourage you to bring familiar items so that it feels like home."

A care worker said, "As a key worker I am responsible for making sure people have their toiletries, their room is clean and keeping families up to date." Another said, "My role is to make sure the care plan is up to date." There was evidence of people's likes and dislikes in some of the files. People's life history was comprehensive and completed with input from relatives and these provided information about people's early life, jobs, and interests. These also included life aspirations and future wishes.

People's preferences were documented with respect to hygiene, shaving, hair, oral care, clothing, mobility, and communication and sleep. Staff told us they used this information when supporting people but also asked them how they liked to be supported. One person said, "If I can't manage a shower I arrange with the carers to have a bath, in the long bath they call it, with bubbles all around me."

We observed staff knocking on doors and asking for people's permission to enter their room. Staff gave us examples of how they respected people's dignity by making sure they were covered during personal care activities and "There is a minimal amount of their body exposed at any one time." Another told us, "I make sure I have prepared the bathroom before I assist the person to get undressed. I have the towel and flannels laid out and the water already run in the sink or shower."
We noted people being provided with personal care had their doors closed whilst this was undertaken.

People told us, "I find [living here] quite good. The staff are nice and everything; the food is good, my bedroom is nice…. I've been here 10 years", "Here's a nice place; we're looked after very well", "The staff are not too bad."

One person said they felt involved, "In actual fact people do consult us as to what we feel about things. It's quite pleasant, there's no quarrelling….There have been a lot of changes; it's a more inclusive system than it used to be. [Previously] those that had a voice were OK but those that didn't just had to accept everything and take note."

Relatives also praised the environment and the attitude of staff, "I like it [here]. It has a nice feel about it.

Everyone is very welcome. It feels homely….You can come in anytime." Another relative said that their family member was recommended by an occupational therapist to be allowed and encouraged to walk with his frame and the home were accommodating this. We observed this in practice during our inspection.

Requires Improvement

Is the service responsive?

Our findings

People were at risk of not receiving care and support that met their individual needs as their care records were not always fully completed or up to date.

In some care records we looked at, there was evidence of individualised assessment and care planning. For example, one person at risk of pressure ulcers had records related to skin risk assessments, pressure relieving equipment was put into use and appropriate body mapping was completed. In others we found that records were incomplete, for example not all personal preference forms were complete, life aspirations forms were incomplete and external Multi-Disciplinary Team (MDT) advice was not used to develop and/or update care-plans.

We noted on each record that these assessments were reviewed on a monthly basis. However, it was not always apparent how these reviews were carried out or who took part in them. There were no specific comments made about these reviews other than, 'previous assessment remains the same' despite the fact that in some cases, the assessment referred to could be several months old. For example, for one person, four monthly reviews of their food and nutrition assessment made no reference to their weight loss during the preceding period, or to the recommendations made in response to this weight loss by a dietitian. We asked a care worker how this information is shared, where the care plan was not updated .They told us, "Because the alterations are on the MARs chart."

The above identified issues were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A pre-admission assessment was completed which included details about people's current situation. These included a number of areas related to their personal care and other support needs, for example health and wellbeing, communication, hygiene and personal care needs, food, sleep and rest and family contact. Areas of potential risk were also identified, for example, mobility and falls, skin assessment and risk. Other information such as discharge records from the hospital were included and baseline observations on admission were recorded. These included people's pulse, temperature, weight and Body Mass Index (BMI).

The care files showed documentation of daily notes took place. Documentation was completed the majority of the time. Keyworker input sheets were completed monthly which was a tick sheet according to tasks done such as clothing checked, care plan updated, toiletries, any complaints and activities record.

Dependency profiles were carried out for a number of areas including mobility, continence, pressure sores, dressing, orientation and pain amongst others. Scores were allocated to each area based on people's level of independence in each area and these were calculated every month. Any areas that were identified as being highly dependent were documented in a care pan.

People's care records were divided into different sections, for example, health and well-being, communication and respect, skin, hygiene and personal and food and nutrition. A care worker told us, "Care

plans are person centred and should include everything the person wants for themselves." Another said, "Care plans are very important, they include people's wishes and how best to support them."

We spoke with the activities co-ordinator who had been recruited recently. She worked full time and alternate weekends with the part time activities co-ordinator. She spoke about her plans for the service which included the possibility of converting one of the activities rooms into a restaurant room for people and their relatives. She also told us that she was attempting to complete a care plan for life histories for people so that bespoke activities could be arranged in future. We saw some examples of where she had tried to complete these for people.

One person told us, "It's very good here. I can't find nothing wrong with it." They said they liked to go out into the garden and enjoyed the visits from the 'Pets as Therapy' (PAT) dog. Another person was sitting in the hallway with his walking stick and his coat on. They told us they went for a walk "nearly every day". They said they took the bus to their family home and returned home by lunchtime. Another person said, "A friend comes once a week to take me out. Everyone's birthday and anniversaries [are celebrated]."

We saw a leaflet 'How to raise and escalate a concern' on display which included contact details for who to contact about any concerns and also a flowchart for complaint handling. We also reviewed the complaints policy for the home which was based on the Ombudsman's principles of good complaint handling. It also had details of the Local Government Ombudsman (LGO) to contact if people were not satisfied with the handling of their complaint. There were separate verbal complaints and formal complaints and we saw that where complaints were raised, a complaint investigation report was completed to document any findings or conclusions.

Requires Improvement

Is the service well-led?

Our findings

We received mixed feedback from staff about the management of the home. Some of the comments were, "The manager is very nice. She is hard working and committed, always on the floor", "The manager has changed the environment; it looks more like people's own home now",
"The manager is very approachable, and operates an open door policy." Others said, "There is no communication between management and us" and "She sometimes makes changes without telling us."

The registered manager had only been in post for two months and told us it had been a busy period in terms of implementing some of the issues she had picked up. She acknowledged the issues around high use of agency staff but was confident that they would be rectified soon as some of the vacancies were being filled. One staff member said, "I am hopeful that the new manager will be able to make better changes." The registered manager told us another area that she wanted to emphasise was to get staff to interact informally with people by chatting about themselves and their interests. She told us it was important to include everyone in the life of the home no matter what their abilities. She had introduced rewards in the form of high street vouchers for staff who had been particularly commended by people.

We looked at records of staff meeting minutes, the last one which had taken place in February 2016 which was attended by nine staff. Some of the topics discussed included rotas, redecoration and staff issues. This indicated that the registered manager was aware of some of the concerns that staff had raised and was trying to address them.

Residents meetings were also held every few months. These focussed on people's views about the menus and activities on offer and any other concerns. Between nine and 12 people attended these.

We reviewed some of the audits that took place. These included medicines audits, infection control and a general home audit. These were all up-to-date and reviewed routinely. A self-planner for the year was in place which documented which audits needed to be carried out every month. For example, care practice, surveys, medicines, health and safety, food safety and infection control. The medicines audit was done weekly and looked at medicines management, stock balance check and a review of the MAR charts for two people. However, these monitoring checks had not identified or addressed all of the issues we found during our inspection.

There was evidence that the provider was involving staff and professionals and looking at ways in which it could improve the service. We reviewed a survey that had been sent to staff and professionals. Areas identified for improvement included staff rotas which included an action of holding a staff meeting to discuss this further which we saw had taken place from the staff meeting minutes. Other surveys sent out included activities and family involvement as possible areas of improvement. Each identified action was assigned to a person with a completion date.

There was regional oversight of the home. Head office carried out an audit of staff file compliance and achieved a rating of 92.3%. Some of the identified issues included unsigned contracts and missing National

Insurance (NI) numbers on file. These were assigned to staff for follow up.

The registered manager completed a quality indicator monthly report, documenting the number of people at risk of malnutrition, infections, full health reviews, medicine reviews, safeguarding referrals, compliments and complaints, trips/falls and CQC notifications. We saw that the provider took appropriate action where trends were picked up, for example one person who had repeated falls was referred to the falls clinic.

A self-assessment audit for the environment was carried out. Current safety certificates were seen for the emergency lighting, fire alarm certificate, gas safety, and sling test certificate current. A maintenance person carried out regular call bell system checks, wheelchair visual checks, shower chairs, slings and hoists and water quality checks, including temperatures and flushing records.

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 11 HSCA RA Regulations 2014 Need for consent Where people using the service were unable to give such consent because they lacked capacity to do so, the registered person did not act in accordance with the 2005 Act. Regulation 11 (3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not always assess or effectively mitigate the risks to the health and safety of service users in relation to care or treatment. Medicines were not managed safely. Regulation 12 (1) (2) (a) (b) (g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Accurate, complete and contemporaneous records in respect of each service user, including a record of the care and treatment provided to the service user were not maintained in the carrying on of the regulated activity. Regulation 17 (1) (2) (c).