Masterpalm Properties Limited

Springfields

Inspection report

Springfield House
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Greater Manchester
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Tel: 01616204794

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14 November 2016

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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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 25 October and was unannounced. We made telephone calls to relatives on 14 November to seek their views and opinions on the service. This meant the provider did not know we were coming. Springfields was last inspected on 30 September 2014 and was found to be compliant with the regulation we inspected at that time.

Springfields is a care home with accommodation for 24 people who require personal care, some of who are living with dementia. At the time of the visit 14 people were using 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.'

At this inspection we found that there were breaches of three of the Fundamental Standards of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to the safe delivery of care and treatment, dignity and respect, person centred care, consent and the overall oversight of the home.

There were anomalies in the recording of the administration of medicines. Records for stock balances were not accurate. Medicines were not being stored securely. People's personal records were not stored securely.

Care plans did not set out how to support people with covert administration of medicines. There was a lack of mental capacity assessments and best interest documents to support such activity.

People's individual risk assessments did not contain specific detail on how to minimise risk.

The registered provider had ineffective systems for monitoring, assessing and reviewing the service; they failed to identify gaps in recording and lack of specific care plans and assessments. The system did not give an overall view of the service to aid improvement or development.

Staff failed to respect people's personal belongings. We made a recommendation that the service considers current guidance on dignity and respect when supporting people.

Infection control processes were not followed in respect of the transporting of laundry.

We found evidence in care records to suggest referrals were made to community services when necessary and of visits by health care professionals including dieticians and community psychiatric nurses.

Staff had a clear understanding of safeguarding and whistleblowing. They were confident any concerns would be listened to and investigated to make sure people were protected.

Systems were in place for recording and managing safeguarding concerns, complaints, accidents and incidents. Relatives we spoke to knew how to make a complaint.

Recruitment practices at the service were thorough, appropriate and safe so only suitable people were employed. Staff had received regular supervisions and appraisal. Staff received appropriate training to meet the needs of the service.

We viewed historical and current staffing rotas. Enough staff were employed to make sure people were supported.

Relatives made positive comments about the service. They described the service as being safe for their family members. One relative told us, "They are safe here, they do a tremendous job and are professional. We sleep easy now we know she is OK." One visiting health care professional told us, "I feel that people are safe here."

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People's medicines were not being managed safely.

Risk assessments did not contain specific guidance for staff to follow to minimise risk.

Recruitment processes were safe and robust.

Is the service effective?

Requires Improvement

The service was not always effective.

The provider did not always act in accordance with the Mental Capacity Act 2005 Deprivation of Liberty Safeguards.

Health care professionals were involved in people's care. For example, GP's and community nurses.

Staff received training to enable them to carry out their role.

Is the service caring?

Requires Improvement

The service was always caring.

Staff did not always treat people's personal belongings with respect.

The service had information relating to independent advocacy accessible to visitors, relatives and people.

People had personal effects in their rooms and close by whilst in communal areas.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People who received their medicines covertly did not have care plans in place to support this process.

The service made referrals to community services when necessary and of visits by health care professionals including dieticians and community psychiatric nurses.

The registered provider had a complaints procedure in place accessible to relatives, visitors and people.

Is the service well-led?

Requires Improvement

The service was not always well led.

Systems for monitoring, assessing and reviewing the service were ineffective and failed to identify shortfalls in medicine management and care planning.

The registered manager kept records of accidents, incident and safeguarding, these were analysed for patterns and themes.

Relatives and staff felt the registered manager was supportive and approachable.

Springfields

Detailed findings

Background to this inspection

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

The inspection took place on 25 October and was unannounced. This meant the provider did not know we were coming. We made telephone calls to relatives on 14 November to seek their views and opinions on the service.

The inspection was carried out by one adult social care inspector.

Before the inspection we reviewed other information we held about the service and the provider. This included previous inspection reports and statutory notifications we had received from the provider. Notifications are changes, event or incidents the provider is legally obliged to send to CQC within a timely manner. The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also contacted the local Healthwatch, the local authority commissioners for the service, the local authority safeguarding team and the clinical commissioning group (CCG). Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During our inspection we spoke with three people who lived at Springfields. We spoke with five members of staff including the registered manager, care staff and catering and ancillary staff, who were all on duty during the inspection. We spoke with one health care professional who visited the service. We also spoke with one relative who was visiting at the time and four relatives by telephone.

We spent time observing care delivery at various times throughout the day, including the lunchtime experience in the dining room. We carried out an observation using 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 looked around the home and viewed a range of records about people's care and how the home was managed. These included the care records of three people, the recruitment records of two staff, training records, medicine records and records in relation to the management of the service.

Requires Improvement

Is the service safe?

Our findings

On arrival to the home we were shown in to the registered manager's office by a care worker. The medicine trolley was in the office, the trolley was locked. People's individual medicine administration records (MARs) were left on the top of the trolley. We found the medicine trolley keys left unattended on the desk. The office door was not secured. Later in the day we found the medicine trolley in one of the communal lounges, although locked it was unattended by staff. People's individual medicine administration records (MARs) were left on the top of the trolley. This meant the service had failed to ensure people's confidential records were being stored securely.

We found anomalies in medicine management. Three people's MAR charts showed they had received their prescribed medicines. However, when we checked the blister pack which held the medicine the medicine was still in the pack. This meant that staff had recorded the medicine as being administered, but the amount suggested the medicine had not been given. This meant we could not be sure that people were receiving their medicines at prescribed times or frequencies.

We found three people were having their medicines administered covertly. Covert administration is the administration of any medical treatment in disguised form. This usually involves disguising medication by administering it in food and drink. Each person had a signed document on the medicine file from their GP regarding the option to administer in this way. One person's GP had written, 'I feel it appropriate to perhaps covertly administer medications.' Another had written on a fax cover sheet, 'As (person) is spitting her medications out this can be disguised and given to her.' We asked the registered manager if there was any mental capacity assessment and best interest meeting records to demonstrate these decisions had been discussed. The registered manager told us they did not carry out any assessments; this would be done by the social worker. The service had a policy and procedure in place for the storage, handling and administration of medicines which stated, 'when a service user is deemed to lack capacity to consent the manager must ensure there is evidence that the staff team, GP and where ever relevant a specialist consultant have made decisions that are it the service user's best interests.' This meant the registered manager had not followed the medicine policy and procedure. We checked the MAR charts for the people whose medicines could be given covertly. The MAR did not contain details for staff to follow regarding this type of administration. For example, a list of medicines, or whether they were to be crushed.

We checked the controlled drug book and found the stock balance for one person's liquid medicine was recorded as 200mls. When the registered manager retrieved the bottles from the controlled drug cupboard we found 300mls of the liquid medicine in stock. The registered manager acknowledged this was an error in recording. We found one person's record in the controlled drug book had only been signed by one member of staff, the policy and procedure for administration of medicines states two people must sign when checking out controlled medicines.

We found staff had received the appropriate training for administering medicines. We checked to see if the competency of staff responsible for administering medicines had been checked. We found two members of staff whose competency was last checked in 2013 and one in 2014. This meant we could not be sure that all

staff administering medicines were competent to do so.

Risk assessments were on file for people to cover needs such as skin integrity, falls and nutrition. We found the registered manager reviewed these on a regular basis. The assessments were not detailed and failed to give staff specific instructions on how to minimise risks for people. For example, where skin integrity was at risk, no timing of positional changes.

The service had a cat which roamed the downstairs areas. We found the cat's food and water bowl in the downstairs bathroom which was used for people's personal care needs. The manager advised that is where the cat ate. This posed an infection control risk as the cat had access to an area where people's personal and elimination needs were being met. The service did not have a risk assessments in place regarding the service having a cat. We also noted human faeces in the bath and on the side of the bath in the downstairs bathroom during our tour of the home at the start of the inspection. The bath was still dirty at 4.30pm; we made the registered manager aware who then ensured this was cleaned.

The manager showed us to laundry which was in the cellar of the building. On opening the cellar door we found people's clothes, soiled linen and towels strewn over the cellar stairs. The office furniture was in need of replacement or repair, the plastic side strip coming off the desk and the manager's chair split with foam exposed. The bath in the downstairs bathroom was damaged with the surface being cracked. We could not be sure these areas could be cleaned thoroughly. This meant that infection control processes in the home were not at safe and people were at risk of cross infection.

The stair carpet was worn and frayed on some of the edges of the steps. This meant staff and people were at risk of falls due to the worn carpet.

The above was a breach of Regulation 12 (Safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked relatives and health care professionals if they felt the service provided to people was safe. One relative told us, "They are safe here, they do a tremendous job and are professional. We sleep easy now we know she is OK." Another relative told us, "I am glad [family member] is here, it's definitely safe, they are great." One visiting health care professional told us, "Staff are friendly and approachable, I feel that people are safe here. This is one of the better ones."

We asked people if they felt they were being looked after. One person indicated 'yes' by nodding their head and smiling. Another told us, "Oh its lovely here."

The registered manager kept a log of all safeguarding alerts and statutory notifications. The service followed Oldham Safeguarding Adults Multi-agency Policy and Procedures. The registered manager informed us that she was attending the train the trainer event for safeguarding adults and would roll out the training to the care workers. We saw records to demonstrate the registered manager had submitted information to the local authority along with supporting evidence relating to any falls and/or pressure areas. The safeguarding team reviewed these and contacted the service with actions. We saw evidence of such plans being completed.

We spoke to staff to ascertain their knowledge and understanding about keeping people safe. They were confident any concerns would be listened to and investigated to make sure people were protected. Staff told us they received training on safeguarding and were able to give us examples of different types of abuse. For example, one care worker told us, "If you did not attend to someone's care or not having the correct

equipment that would be neglect." One care worker told us, "I would report anything to [registered manager]." We asked how staff would identify if a person was being abused. One care worker told us, "The way they react, they might feel insecure and not communicate." Another care worker told us, "They may be withdrawn and emotional."

The registered manager kept a record of all accidents and incidents, using these to look for trends or patterns. The service used a system called 'falls safety cross' this enabled staff to record plot falls, the information was reviewed by the falls team. Following the review action plans were submitted to the service. For example, people may be required to exercise, or have additional safety checks. Whilst at the service we were able to cross reference a recent fall had been recorded in the falls safety cross. This meant the provider had a system in place to ensure a referral to the falls team was carried out in a timely manner.

We looked at the most recent staff recruitment records. These showed checks had been made with the disclosure and barring service, (DBS) these were carried out before they were employed to confirm whether applicants had a criminal record and were barred from working with vulnerable people. Records contained completed application forms and references had been obtained.

Risk assessments were in place to cover work practices within the service, for example manual handling, along with building maintenance records. The registered manager ensured assessments were reviewed in a timely manner.

We noted checks were in place to ensure the safety and security of the home. For example, regular assessments for fire alarms, water temperatures and electrical installation checks. We found the gas certificate was due to expire. The provider advised the gas maintenance people were at a sister home carrying out checks and Springfield would be completed next. The registered manager forwarded a copy of the completed gas safety check to demonstrate the check was completed the day after our inspection.

We viewed historical and current staffing rotas. There were enough staff on duty to support people's needs. At the time of the inspection people were supported by the registered manager, one senior care worker, two care workers, the cook and one ancillary worker. This was replicated on the staffing rota. The registered manager did not use a dependency tool to ascertain staffing levels. They told us, "I go by people's needs, we have two people who need two carers, and people's mobility is assessed on a daily basis." Relatives told us they felt there were adequate numbers of staff on duty to meet their family member's needs. One relative told us, "They are always about to help, nothing is too much trouble." Another relative said, "There is plenty (staff) about, they always pop in to check [family member] is alright, nothings a problem here."

The provider had a business continuity plan in place which contained details of emergency contacts for staff to utilise. This was easily accessible to staff. People had personal emergency evacuation plans in place (PEEPs). The registered manager told us they also used a colour coded system on people's doors to enable swift identification for evacuation purposes. For example, green for independently mobile.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) providers a legal framework for making particular decisions on behalf of people who 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 procedure for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found people who had a DoLS in place had a copy of the authorisation in their care files. People's care plans did not contain details of the authorisation or conditions attached to them. People whose medicines were being administered covertly had not had the appropriate mental capacity assessment or best interest meeting held to make such decisions.

We found there were no capacity assessments even though evidence suggested some people might lack capacity. Care records did not describe the efforts that had been made to establish that the least restrictive option for people was followed and the ways in which staff had sought to communicate choices to people. This meant we could not be sure that the provider was acting within the principles of the MCA.

The registered manager tracked the DoLS applications and kept a log of each person who had a DoLS authorisation in place. The registered manager told us, "There has just been several mental capacity assessments carried out by social workers, I am waiting for the outcomes." We found a reliance on social workers to complete assessments for people. The registered provider failed to acknowledge their responsibility as the managing authority in completing their own mental capacity assessments to inform the decision to make a request for a DoLS authorisation.

This was a breach of Regulation 11 (Need for consent), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that the staff had some understanding of the MCA and what actions they would need to take to ensure the home adhered to the code of practice. We spoke to staff about people's DoLS, and asked for their understanding about individual circumstances. Staff were able to explain who had a DoLS in place and what that meant in relation to their care and support. One staff member told us, "That's about [person] not having capacity to make decisions, to keep them safe so they cannot go out alone."

Relatives we spoke to felt the service was effective. We asked relatives if they felt staff had the skills and knowledge to provide support for their family member. One relative said, "They try things out and keep on

top of the latest methods, using new initiatives. They are well trained, I wouldn't like [family member] to be anywhere else." Another relative told us, "They give as much time as they can, I have no complaints at all about that."

Staff we spoke with felt confident and suitably trained to support people effectively, training was refreshed when necessary. Staff completed an induction into the service along with mandatory training which covered, moving and assisting, health and safety and fire training. We found the registered manager had a matrix in place so training could be monitored. Where some training had lapsed the registered manager confirmed additional training was booked for December 2016. One staff member told us, "I have just completed an NVQ (national vocational qualification) for cleaning, and I am going to start my level three. I am currently doing the care certificate as I do care hours as well." Another staff member told us, "I have completed moving and handling and training on dementia, we are now doing six steps training which covers end of life care."

Records confirmed staff received regular supervisions and appraisals. The service had a supervision and appraisal planner. Staff told us they felt their supervisions were important and were used to discuss development and to raise any issues or concerns. One staff member told us, "We discuss performance, how we are doing and any training we feel we need. Another said, "I have four or five a year, and an appraisal, it's about where you see yourself in your job."

Staff felt communication was good between management, senior staff and care staff, and that people's needs were discussed and updates or actions which needed to be addressed were shared. The staff also maintained daily notes about each person to ensure other staff knew what had occurred prior to them coming on duty.

We found records to demonstrate the provider worked collaboratively with other healthcare professionals. For example, dieticians, pharmacists, community psychiatric nurses and GPs to ensure people received effective care.

People were supported to maintain a varied and healthy diet. Nutritional assessments were completed regularly, along with care records to monitor people's food and fluid intake and weight. The cook showed us the information she held about people's nutritional needs. We found guidelines from the speech and language team regarding one person's special dietary needs. The cook told us, "Whenever the dietician rings I speak with them. They send out information to us about people's diets and thickener, (registered manager) also speaks to the dietician. The registered manager told us, "Everyone is weighed weekly, any weight loss we inform the dietician."
Relatives felt there family member had a varied diet. One relative told us, "The food is good, [family member] eats everything, always has a cup of soup before his meal." Another told us, "The food is very nice, plenty of it."

We observed the lunch time experience for people. There was background music playing. People either sat in the dining room or in the lounge with small tables. The lunch time meal was a lighter option with the main meal being served at teatime. People were supported with eating and drinking using prompts at a pace appropriate to them. We observed one member of staff supporting a person to eat their lunch, taking time to make sure the person's mouth was empty before reminding them there was a sandwich in their hand. One staff member said, "Are you going to eat a little more of your dinner, why don't you have another sandwich." Another staff member said, "Are you OK [person], try and eat a bit more." Staff clearly understood people's preferences and were knowledgeable about the care they required with eating and drinking. Staff were patient with people and no one was rushed with their meal. Staff explained to people what they were going

to do before they acted and gained consent either verbally or by gestures.

We observed one person who was not eating their soup particularly well, staff were patient in their support offering other choices. As the person was fond of sweet foods they tried the pudding which the person happily ate. One member of staff told us, "We will try again later, sometimes [person] eats later in the afternoon." We observed people having a snack in the afternoon along with hot and cold drinks.

Requires Improvement

Is the service caring?

Our findings

We found people's clothing along with bedding and towels had been thrown down the cellar stairs where the laundry was situated, these were strewn all over the stairs. Laundry bags had not been used for the transportation of soiled linen and clothes. One care worker opened the door and was about to throw a towel down the stairs but stopped when she saw us and the registered manager on the stairs. The registered manager pushed the clothes down the stairs with her foot so we could walk down safely. She then donned on personal protective equipment and placed the linen and clothes into to appropriate receptacles. This meant we could not be sure that staff were treating people's personal belongings with respect. We made a recommendation that the service seeks and considers current guidance on dignity and respect when supporting people.

We found a lack of information or explanation had given to people in relation to their care and support, decisions made regarding the methods used to administer medicines had not been discussed with people.

We could not be sure the provider was maintaining people's confidentiality. We found people's personal care and daily records left unattended in the lounge area.

We asked people and relatives if they felt the service was caring. One person gestured by nodding their head. One relative told us, "Oh yes they are, nothing is a problem to them. They are like friends and often say 'do you want a brew' when I visit." Another relative told us, "They are very thoughtful, and are very good with [family member]."

Staff were open and relaxed, speaking and listening to people in a caring manner. Throughout our inspection we observed positive interactions between people and staff. We noted where people were receiving support, either moving throughout the home or with a drink or food, staff spoke to them clearly, offered them choices and if needed, described to them either what they were doing or what their options were.

Staff spoke about people with genuine affection. They knew what individual people liked to do and had interests in and could explain people's daily routines. There was lots of laughter in the home, staff were having a joke with people in an appropriate manner. We found staff had positive relationships with people who used the service.

Staff used moving and assisting equipment in a dignified manner supporting people but also encouraged independence by supporting them to mobilise independently at a pace appropriate to their needs. We observed staff support one person both verbally and with gentle interactions to continue to mobilise to the dining room.

Staff treated people with dignity and respect. We observed staff speaking to people in a respectful and polite manner, and referred to them by their preferred name. People's dignity was valued, staff supported people with choice of clothes, and made sure they had their hair done and glasses on and walking frames were

close at hand.

The service supported people with their well-being, we observed staff gave people the opportunity to take part in activities, which helped to maintain or improve their health and mental wellbeing. For example, being in a group to make arts and crafts for Halloween. One small group enjoyed sitting together in one of the communal areas to watch the television. Staff popped in and out to check they were alright, asking if they were warm enough or if they wanted a cup of tea.

Staff had commenced training to improve skills and knowledge to support people at end of life. The registered manager told us, "Staff have started on the 'Six Steps' training as part of their development. "The training aims to enhance end of life care through facilitating organisational change and supporting staff to develop their roles around end of life care. End of life care champions within the service will be supported to develop their knowledge, skills and confidence and encouraged to empower staff within the service to deliver quality end of life care. This meant the provider was proactive in their responsibilities to provide a caring service.

The communal areas were homely, with pictures and ornaments on display. Pieces of art and crafts made by people using the service were on display. Lounge areas had a range of seating, with small tables for people to have personal effects close by.

The service had information relating to independent advocacy accessible to visitors, relatives and people. The registered manager advised social workers would be contacted if it was felt someone required an advocate.

Requires Improvement

Is the service responsive?

Our findings

We found care plans lacked detail around medication needs in relation to how covert medicines were administered. One person had a catheter in place, the moving and handling assessments had not been updated with this additional information to enable staff to carry out safe moving and handling techniques. We found no care plan around the specific care of the catheter. The service's clinical procedure – catheter care document appeared dated and gave instructions to use a jug to empty catheter bags which were kept on the individual's hook in the sluice room and that certain catheters should be changed fortnightly. This document needed to be updated to meet the current infection control measures for catheters. NICE (National Institute of Clinical Excellence) Healthcare Associated Infections: Prevention and Control in Primary and Community Care.

This is a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were able to discuss people's care needs and had an understanding of personalised care. One staff member told us, "We get to know people and always give choices. Some people can get washed themselves, others we ask if they want a bath." Another staff member told us about a particular food the speech and language team had suggested one person could eat safely. We found this information was reflected in the care plan.

Relatives and people felt the service was responsive. One relative told us, "If they get the Doctor they keep me informed." We asked people if they felt they were being looked after. One person indicated 'yes' by nodding their head, another told us, "I am all right here."

Relatives told us they were involved in planning their family member's care and were regularly kept up to date. One relative said, "Communication from staff is very good with family. They keep you informed. I visit once or sometimes twice a week." Another relative told us, "They get the Doctor if [family member] is unwell, all the time they get in touch to let me know." A third relative told us, "[registered manager] will sit me down and tell me what has happened, she is good like that."

We found evidence in care records to suggest referrals were made to community services when necessary and of visits by health care professionals including dieticians and community psychiatric nurses. One health care professional felt staff were responsive. They told us, "I said to the staff that I did not know the lady I was visiting, they said, 'oh, come on we'll introduce you."

During our inspection we observed the morning handover, where written notes were verbally shared by night staff to day staff, this contained a good level of detail.

The service employed an activity coordinator. We found a plan of activities which contained entertainers and crafts. Another person enjoyed caring for the china cups and ornaments and spent time washing and cleaning them. Staff supported them in this, chatting and engaging them in conversation. Pictures of

previous activities were on the walls, people had made decorations ready for Halloween these were on display. One relative told us, "They had a Christmas party, and suggested that [person] used doll therapy, it brings a smile to [family member's] face, if it works for her then it works for us." We observed the doll therapy being used, the person was clearly enjoying the activity.

We found relatives had submitted some written feedback about the service giving comments on any improvements they felt would benefit the service. One read, 'All the staff have been extremely understanding of [family member's] condition. A wet room or a shower suitable for wheelchair user.' Another commented, 'I feel the treatment my [family member] has received does not need to be improved.' The registered manager acknowledged that a shower had been discussed with the registered provider, however no decision had been made. The registered manager told us they had put out compliments and complaints slips in the reception area to gain more feedback on the service. However, relatives or visitors had not completed any. The registered manager told us, "I have put up dates for family meetings but no one came. I am now scheduling one to one meetings every three to four months." One relative told us, "I have met with [registered manager] to see how things are going."

The complaint's policy and procedure was accessible to relatives, people and staff. There had not been any formal complaints made to the service. The manager told us that any minor comments or concerns could be dealt with immediately to prevent them from developing into complaints. One relative told us, "I know how to complain, but I feel I can speak to any of them if there was a problem, the door is always open." Another relative told us, "I would call in and see [registered manager], although I don't have any complaints, they are very good with [family member]."

Requires Improvement

Is the service well-led?

Our findings

The registered manager had developed a quality assurance process which covered areas such as care plan audits, medication audits and health and safety audits. We found the care plan audit had not identified the lack of medication care plans for covert medicines, or the lack of detail in risk assessments documents. The medicine audit had not identified that the policy and procedure for the administration of covert medicines had not been adhered to. Care plan audits had not identified people with DoLS in place did not have a specific plan for staff to follow to ensure conditions of the authorisation were being met.

The quality assurance process did not feed into any plan to improve the quality and safety of the service. Audits were carried out independently with no link to improvement. A report was forwarded to the registered provider following the audits process but this was for the purpose of information sharing only. We found the medicine trolley was not being stored safely with people's personal medicine administration records left unsecured. The policy and procedure for the safe handling of medicines had not been followed in respect of the safe storage of medicines.

This was a breach of Regulations 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a registered manager in place. The CQC registration was on display along with a copy of the most recent inspection report. We saw that the registered provider ensured statutory notifications had been completed and sent to CQC in accordance with legal requirements. The registered manager kept a copy of all notifications sent to CQC.

The registered manager operated an open door policy in the home. Staff told us they felt the service was well managed. They said the registered manager was supportive and approachable and they could raise any questions, queries or concerns at any time. One staff member said, "I would speak to [registered manager] about absolutely anything, she's great." Another staff member told us if they had any issues or problems the registered manager would sort it saying, "She's fair". They also told us, "We are like a big family." During the inspection we observed staff enter the office to speak with the manager for various reasons and to obtain particular files. One relative told us, "It's a nice place, with really nice people, [registered manager] is fine, I can speak with her. "Another relative told us, "The manager is very approachable, and I am told about everything." A third relative said, "She is not like a manager, if I want to sit and talk that's fine. They are great, just brilliant."

We found evidence of accidents, incidents and allegations of abuse being reported. The manager audited these to identify if there were any trends or patterns. The registered manager told us, "We now have crash (sensor) mats in place for people to reduce risk." Sensor mats alert staff is someone gets out of bed.

The staff followed a job file which set out specific tasks. The registered manager monitored this to ensure actions were being completed and signed off. The registered manager had records from their daily walk around. Any maintenance issues were recorded in the maintenance book for the handy person. Remedial

works were signed off when completed.

Staff attended regular meetings to discuss issues and concerns. Minutes of meetings were available.

The registered provider ensured statutory notifications had been completed and sent to CQC in accordance with legal requirements. The registered manager kept a record of all notifications sent to CQC.

The registered manager attended monthly meetings with other registered managers in the group to share best practice and to address concerns. The registered manager told us they felt these were important for the development of the service and made her feel supported. The registered provider visited the service on the day of the inspection. We found an open and honest relationship between both parties.

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 11 HSCA RA Regulations 2014 Need for consent Policies and procedures for gaining consent were not being followed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not being managed safely. Infection control procedures were not being followed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have a robust quality assurance process in place.