Firs Hall Care Home Ltd

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Inspection report

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Date of inspection visit:
10 May 2017
11 May 2017

Date of publication:
22 December 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection was carried out on 10 and 11 May 2017. Our visit on 10 May 2017 was unannounced.

Firs Hall is a large detached residential care home located on the Oldham/Manchester border. The accommodation consists of 21 single rooms, 12 with en-suite toilets and five double rooms. The double rooms are only used to accommodate single persons, unless occupied by couples. None of these rooms were occupied by couples at the time of our inspection. Other facilities are a large communal lounge with adjacent small 'music room' and a dining room. At the time of our inspection there were 19 residents living at the home.

At the time of our inspection there was a registered manager in place. 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 our last inspection in January 2015 we rated the service as 'Requires Improvement' overall. At this inspection we have again rated the service as Requires Improvement. This is because we found a breach of Regulation 12 of the Health and Social Care 2008 (Regulated Activities) Regulation 2014. safe care and treatment. We identified concerns around infection control, cleanliness of equipment, managing medicines and monitoring people's nutritional needs. You can see what action we asked the provider to take at the back of the full version of this report.

We have made one recommendation in relation to quality assurance processes.

Staff understood safeguarding procedures and what action they should take in order to protect vulnerable people in their care. Recruitment checks had been carried out on all staff to ensure they were suitable to work in a care setting with vulnerable people.

Although the home was clean and attractively decorated, the outside environment was in need of maintenance and we found some equipment, such as wheelchairs were dirty. Positive efforts had been made to make parts of the home suitable for people with dementia. Checks and servicing of equipment, such as for the gas and electricity were up-to-date.

Medicines were stored correctly and staff who administered medicines had received the appropriate training. However, we found there were some omissions in the recording of medicines administration.

Risk assessments had been completed to show how people should be supported with everyday risks, such as risks to their mobility or nutrition. However, we found that where a risk had been identified and a plan put in place, this was not always followed fully. This was particularly in relation to risks to nutrition.

Staff had undertaken training to provide them with the skills and knowledge required for their roles and received regular supervision to talk about their training and support needs and to discuss any issues in relation to their work.

Staff encouraged people to make choices where they were able to and sought consent before undertaking care. The service was working within the legal framework of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards.

People were complimentary about the caring nature of the staff. Care plans were 'person-centred' and were reviewed regularly to ensure they reflected the current needs of individuals.

A range of activities were provided for people.

The service had a complaints policy although no recent complaints had been received. People spoke positively about the registered manager, the support they received from them and the management of the home.

There were a range of up-to-date policies available for staff to refer to for guidance on best practice. There were quality assurance processes in place to monitor the quality of the service and ensure it was maintained and improved. However, these had not identified all the concerns we found during our inspection.

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 medicines were stored safely we found some omissions in the recording of medicines administration.

The home was clean and attractively decorated. However, we identified a number of concerns around infection control and cleanliness of equipment.

Arrangements were in place to safeguard people from abuse and harm.

Recruitment processes were robust and protected people who used the service from the risk of unsuitable staff.

Is the service effective?

Good

The service was effective.

Staff had received training in a variety of subjects which enabled them to carry out their roles effectively.

Staff received regular supervision and an annual appraisal. This helped to ensure that the standard of care provided was monitored and any problems identified and managed appropriately.

Staff worked within the principles of the Mental Capacity Act (2005). Deprivation of Liberty Safeguards (DoLS) were, where appropriate, in place.

Is the service caring?

Good

The service was caring.

People we spoke with were complimentary about the staff and told us they were caring.

We observed kind and patient interactions between staff and people who used the service.

Is the service responsive?

Good

The service was responsive.

Care plans were detailed and 'person-centred' and were reviewed regularly to ensure they were kept up-to-date.

There were systems in place to enable people to make a complaint.

Activities were available for people to participate in.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Although there was a comprehensive range of audits in place to monitor the quality of care and service provision at the home, they had not picked up the problems we identified during our inspection.

People spoke positively about the registered manager and found her approachable. Staff worked well as a team.

There were a range of up-to-date policies available for staff to refer to for guidance on best practice.

Firs Hall Care Home Limited

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.

This was an unannounced inspection and took place on 10 and 11 May 2017. The inspection was carried out by one adult social care inspector.

Before the inspection we reviewed information we held about the service. This included the previous inspection report from our last inspection in January 2015. We also reviewed the statutory notifications the CQC had received from the provider. Notifications are changes, events or incidents that the provider is legally obliged to send to us without delay. Prior to the inspection we contacted the local authority and Healthwatch Oldham to ask if they had any concerns about the service, which they did not. On this occasion we did not ask the provider to complete a provider information return (PIR) before our visit. A PIR is a document that asks the provider to give us some key information about the service, what the service does well and any improvements they are planning to make.

During our visit we spoke with the assistant director, registered manager, three carers, the cook, one person who lived at the home and one relative. Subsequent to our visit we spoke with a relative on the telephone to ask their opinion of the service. We looked around the building, including all of the communal areas, toilets, bathrooms, the kitchen, and the garden. We spent time observing a lunchtime meal and watched the administration of medicines to check that this was done safely.

As part of the inspection we reviewed the care records of three people living in the home. The records included their care plans and risk assessments. We reviewed other information about the service, including records of training and supervision, three staff personnel files, maintenance and servicing records and quality assurance documents.

Requires Improvement

Is the service safe?

Our findings

People who used the service and relatives told us they felt Firs Hall was a safe place in which to live. One person said ''I do feel safe here. They are very kind to me.'' The service had a 'Safeguarding Vulnerable Adults' policy, which had been reviewed in December 2016. Staff we spoke with had a good understanding of safeguarding issues and were able to tell us what action they would take if they thought that a person had been abused or if they were concerned that one of their colleagues was providing poor care to people living at the home. One member of staff told us ''They come first – it's their home.''

We looked round all areas of the home to check that the building and equipment were safe and that the environment was clean. Since our last inspection in 2015 there had been a programme of redecoration and a change to the use of some of the communal rooms in order to create a larger dining room and a 'music room'. These rooms were attractively decorated.

The home looked clean and we checked the cleaning schedules and found these were completed. One person we spoke with told us ''It's so fresh and clean.'' Pressure relieving mattresses and cushions were cleaned and checked every month. However, we found that several of the wheelchairs in use were dirty and stained, which was unpleasant for people sitting in them and was a potential infection control risk. The registered manager told us that they had recently noticed this themselves and the cleaning of all equipment, such as hoists and wheelchairs, was to be added to the cleaning schedule.

We looked at the arrangements for the prevention and control of infection. Staff had undertaken recent training in this area and we observed them using personal protective equipment (PPE), including disposable vinyl gloves and plastic aprons appropriately when carrying out care tasks. Alcohol hand gel was available at the front entrance to enable people to decontaminate their hands. We found that in several toilets, swing bins rather than foot operated bins were in use. This meant people risked contaminating their hands when disposing of soiled items. Toilets and bathrooms did not contain posters showing the correct handwashing procedure. In one toilet we found the soap dispenser was empty and no soap was available. In the laundry no plastic aprons were available and the sink for handwashing was dirty. We raised these concerns with the registered manager who took steps to address them.

There was a drive and a large lawned area to the front of the building, and on either side there were paved areas, one of which contained garden furniture. Both of the side areas looked neglected and did not provide a clean and pleasant environment for people to sit in. One of the paved areas contained several plastic bags strewn on the ground and there were a large number of cigarette ends on the ground outside the front door. The registered manager told us there were plans to improve the outside environment of the home.

We inspected the systems in place for the storage and management of medicines. Some prescription medicines are controlled under the Misuse of Drugs legislation e.g. morphine, which means that stricter controls need to be applied to prevent them from being misused, obtained illegally and causing harm. We saw controlled drugs were appropriately and securely stored and the stock balance checked weekly by two senior carers to ensure it was correct.

The medicine's fridge temperature was recorded daily to ensure medicines were stored at the correct temperature to maintain their efficacy. Records we checked showed the temperature was consistently within the appropriate range. The medicines trolley was stored securely in the corridor outside the office. Daily checks of the temperature around the trolley had been completed. We saw that on three occasions the temperature had been recorded as above the recommended maximum temperature of 25 degrees centigrade. The registered manager told us that on these occasions there had been problem with the corridor heater, which had since been rectified.

We observed a lunchtime medicines round and saw that this was carried out safely. We looked at the medicines files and saw that the Medication Administration Records (MARs) were clearly printed and contained information necessary for the safe administration of medicines, such as photographs of people living at the home and information about their allergies. Medicines were only administered by senior carers, all of whom had been trained to administer medicines. On six of the MARs we checked we found there were unexplained omissions in the signatures. This meant we could not be sure the person had received their prescribed medicine. If people do not receive their medicines as prescribed their health maybe put at risk. We discussed this matter with the registered manager who told us that auditing of the MARs had previously identified this to be a problem and those staff who had failed to sign the records correctly had received medicines supervision. Where staff continued to incorrectly complete MARs this would result in a disciplinary procedure.

We reviewed the use of medicines that were given 'as and when required' (PRN), such as painkillers and laxatives. We found there to be the correct protocols in place to ensure people were given these medicines safely and consistently.

We saw from people's care records that potential risks to their health, safety and well-being had been identified and reviewed monthly, or more frequently if needed. Risk assessments were in place in relation to a range of risk areas, including falls, malnutrition and pressure sores. Where risks had been identified we saw actions were identified in care plans which informed staff how they should reduce such risks.

However, we found that staff had not fully followed care plans regarding nutrition. We saw that on the advice of a dietician care plans for two people at risk of malnutrition instructed staff to record the level and amount of food and fluid consumed. When we checked, we found food charts were incomplete. For example, for one person, on two days nothing at all was written on the chart. On one day nothing was recorded for breakfast, and at teatime it was recorded the person was asleep. There was no record that food had been given at a different time. Where food had been recorded as given there was no indication of the amount of food eaten. This meant we could not be sure the person had received adequate nutrition. We brought this matter to the attention of the registered manager who told us she would speak to the staff about ensuring food charts were completed fully. In addition she devised a new food chart which specifically asked for the amounts of food eaten to be recorded. She also added the checking of food charts to her monthly audit schedule.

The concerns identified, in relation to infection prevention and control, cleanliness of equipment, administration of medicines and monitoring people's nutritional needs demonstrate a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

We received mixed responses from staff when we asked them if they thought there were enough of them to meet everyone's needs. In addition to carrying out caring duties, care staff were expected to assist with the laundry and heat-up meals at teatime, as the cook was no longer on duty at that time. One carer said, ''It's taking you away from residents. I think there should be someone to do those jobs so we can spend time with

residents''. One member of staff told us, ''We can be a bit pushed.'' However, another member of staff told us they felt there were enough staff. We saw that staff responded promptly to people's needs and were available to assist them when they needed help.

We were told by the registered manager that the service did not use agency staff, unless as a last resort. Any gaps in the staff rotas were filled by regular staff taking on extra shifts.

There was a 'business continuity plan' in place that provided guidance for staff in the event of an emergency, such as the failure of the lighting, heating or water systems. During the second day of our inspection we arrived to find the passenger lift was broken. The registered manager had taken appropriate steps to deal with the situation by bringing in an extra member of staff. This ensured that people who had to remain upstairs in their rooms received their care in a timely manner. The lift was mended by midday.

During our tour of the building we noticed that the upstairs bannister was quite low and there could potentially be a risk that someone might fall over it. We brought this to the attention of the registered manager who told us that a risk assessment had been done and that all people whose bedrooms were upstairs needed assistance with mobility and did not walk around unsupervised.

People who used the service had a personal evacuation escape plan (PEEP) in place which explained how they would be evacuated from the building in the event of an emergency, and contained information about their mobility and any communication problems. These were reviewed monthly to ensure this vital information was correct. PEEPs were stored in an 'emergency box' which was kept at the entrance to the building, where it was easily accessible to the emergency services. There were systems in place to protect staff and people who used the service from the risk of fire. Firefighting equipment, such as extinguishers and the alarm system, were regularly checked and the fire exits were all clear. The most recent fire drill had taken place in March 2017.

The kitchen had achieved the highest rating of five stars at the last environmental health inspection in July 2016, which meant food ordering, storage, preparation and serving were safe. We inspected the kitchen and found it to be clean and tidy.

All checks and servicing of equipment, such as for the gas and electricity were up-to-date.

To check on the recruitment process we reviewed three staff personnel files and found that all necessary pre-employment checks had been completed. These included two references checks and confirmation of identification. Staff had Disclosure and Barring (DBS) criminal record checks in place. These help the provider to make an informed decision about the person's suitability to work with vulnerable people, as they identify if a person has had any criminal convictions or cautions. A DBS has no official expiry date and any information included is only accurate at the time the check was carried out. Therefore the registered manager requested that each year all staff sign a disclaimer stating that the information on the DBS was still correct. This helped to ensure only staff suitable to care for vulnerable people were employed at the home.

Good

Is the service effective?

Our findings

We reviewed the training schedule and saw that staff had received a variety of training, which included infection control, fire safety, health and safety, safe guarding vulnerable adults and moving and handling. Training was done predominantly through the viewing of DVDs, with staff completing competency booklets to test their knowledge. These were then marked by the registered manager. Medicine training was provided by a local pharmacy. The registered manager carried out medicine competency checks for all senior staff who administered medicines. All staff had received training in the use of the hoist to ensure they were competent to move people safely.

Staff received supervision every three months and an annual appraisal. Supervision and appraisal meetings provide staff with the opportunity to talk about their training and support needs and to discuss any issues in relation to their work. Where staff needed extra support, or a concern was raised around their practice, they received extra supervision. For example, we saw that a member of staff had received a supervision following concerns around them not completing care records accurately.

At the start of their employment all staff undertook an induction programme which included a period of 'shadowing', where they worked alongside other staff in order to gain experience of caring for people. The registered manager told us that the length of time spent 'shadowing' was dependent on how much experience of 'caring' each individual person had. People who were new to the caring profession were enrolled on the 'Care Certificate', a national qualification which demonstrates carers have achieved the standards and skills expected of them.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own 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 made in their best interests and as least restrictive as possible. During our inspection we saw that staff sought peoples' consent before undertaking any care or support task. For example, asking them if they would agree to having a clothes protector on while they ate their meal.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. At this inspection we found the correct number of DoLS were in place. The registered manager regularly checked the expiry date of all the DoLS authorisations to ensure they were renewed when required.

Records showed a range of health professionals had been involved in people's care, including GPs, district nurses and dieticians. During our inspection we spoke with a district nurse who regularly attended people living at Firs Hall. They were positive about the home and the response of staff to potential health concerns. They told us that staff were attentive to people's needs and when asked to carry out specific tasks, for

example, assisting a person at risk of developing pressure sores to change their position in bed, these were completed as requested.

At our last inspection in January 2015 we made a recommendation that the service explore relevant guidance on how to make the environment more 'dementia friendly'. At this inspection we saw that some adaptations had been made to the environment to help make it more suitable to people living with dementia. These included brightly coloured 'front door' style bedroom doors, and memory boxes outside bedrooms, which contained items and photographs that were significant to the occupants, and which they would recognise. In the lounge a calendar and clock displayed the date, time and weather in an easy to read format. Picture signage, for example showing the location of the dining room and toilets was in use. Such adaptations help to enable some people living with dementia retain their independence around the home.

The home had a large lounge which provided a communal living area. Here the chairs were arranged into small groups, rather than being placed around the sides of the room. This gave a homely feel to the room. A newly decorated 'music room' which displayed photographs of popular singers from the 40s and 50s, provided an area where people could sit and listen to music without being disturbed by sound from the television. There were also arm chairs in the entrance hall and we observed a person sitting there quietly reading a magazine. People were encouraged to decorate their bedrooms with personal effects, such as furniture, pictures and photographs to help them feel at home.

We checked to see if people were provided with a choice of suitable and nutritious food and drink to ensure their health care needs were met. One relative we spoke with told us, ''The food is excellent'' and another said, ''The food is magnificent.'' We spoke with the cook who was able to tell us how they catered for special diets, such as diabetic diets and how they fortified food with butter and full-fat milk in order to make it more calorific for those people with a low weight. Information detailing which people needed special diets and information about allergies was on display in the kitchen so that the cook had up-to-date information.

We were shown the menu plans which had been devised following consultation with people who used the service. Cereals and toast were offered for breakfast during the week, although cooked items were available on request. A full cooked breakfast was available on Sundays. A choice of two main meals and dessert were provided at lunchtime with a lighter meal offered at tea time. The cook finished work at 16.00, so where the teatime food was a cooked snack this was prepared in advance and then heated up by the care staff. Hot and cold drinks, biscuits and cakes were offered between meals. We observed staff prompting and encouraging people to eat and drink rather than leaving them when they had fallen asleep. One person who really enjoyed drinking a milky coffee was offered a second cup. We saw that where people did not like the meal that was on the menu staff offered another choice. For example a person who had not eaten any of their hot lunch was offered a sandwich with a choice of fillings as an alternative.

People's weight was monitored either weekly or monthly, depending on the level of need. Where people were losing weight we saw that they had been referred to a dietician. Care plans following the dietician's advice were then implemented. We have commented in the 'safe' section of this report about staff not always following a nutritional care plan fully.

Good

Is the service caring?

Our findings

People we spoke with were complimentary about the staff. One relative told us,''They give 110%. I can't praise them enough'' and another relative said ''The staff are lovely – so kind.''

Some of the staff had worked at the home for a number of years. This provided a stable care team who knew the people living there well and who had developed caring relationships with them over a number of years.

We observed staff interactions with people and which showed that staff were patient. For example, we saw how staff assisted people to move using a mobile hoist, which they did unhurriedly and carefully, offering reassurance to the person they were moving. Staff were attentive and took time to ensure care was given correctly. For example, we saw that where people were moved using a wheelchair, staff always ensured their feet were put on the footplates to prevent damage to their legs and feet. During a lunchtime meal one person who was sitting at the table in their wheelchair was distracted from eating because they were sitting uncomfortably. We saw that staff took time to move her to another chair to make her more comfortable.

Through our observations we saw that staff were kind and considerate and always offered people choices. For example, at lunchtime people were asked which table they would like to sit at to eat their meal. We saw that staff used touch appropriately, taking people by the arm as they led them to take a seat and after they had sat down helped adjust their clothing appropriately so that they looked comfortable.

Staff we spoke with understood the importance of treating people with dignity and respect and could describe ways in which they would do this while assisting with personal care, such as using a towel to cover a person. The registered manager told us that she carried out regular 'dignity observations' to check that staff behaved in a respectful way to people. During one recent check she had observed a staff member entering a person's room without first knocking. This had resulted in a reminder to all staff to be courteous and polite.

During our tour of the building we noticed that in two bedrooms there were several packs of continence pads which had not been put out of sight and were visible to people passing the rooms or to visitors. This did not respect the dignity or privacy of the two people concerned. We asked the registered manager for the pads to be put away, which they were.

The home had completed the 'Six steps to success – Northwest end of life care programme for care homes', a number of years ago. This is a course which helps to guide staff in supporting people nearing the end of their lives. In addition, the majority of staff had undertaken some training in end of life care.

Visiting was open and unrestricted. One person we spoke with, who had been a regular visitor over a couple of years, told us that they were always made to feel very welcome.

Good

Is the service responsive?

Our findings

A member of staff we spoke with told us, ''I feel like I've got a good relationship with them (people living at Firs Hall). I know their ups and downs.''

Prior to moving into the home a pre-admission assessment was carried out by the registered manager to ensure the service could meet the person's needs. The person and/or their representatives were involved in the pre-admission assessment and provided information about the person's abilities, likes and dislikes, daily living needs and behaviour. This assessment process helped to ensure that people's individual needs could be met safely at the home.

We reviewed three care files and saw that they contained a range of information, including risk assessments, care plans, personal details and mental capacity assessments. Risk assessments and care plans were reviewed monthly to ensure that they reflected the current needs of people who used the service. The care plans showed what level of care people needed and how staff should support them on a daily basis. Each section, for example personal care, emotional wellbeing, diet and nutrition, mobility and tissue viability was written in the first person. This helped promote the individual nature of each care plan. The care plans we saw were detailed and personal. There was a daily record of what care and support people had received from staff, which helped to keep people informed. The quality of care plans was regularly audited by the registered manager and assistant director to ensure all the required information was present and up-to-date.

A notice board in the entrance hall displayed a list of the week's activities. These included board games, movie and popcorn afternoons, arts and crafts and musical sessions. The home normally employed an activities coordinator who worked 15 hours per week. However, at the time of our inspection they had recently taken sick leave. A replacement activities coordinator had been found, however, they had not yet started to work in this role. In the meantime, activities were provided by the care staff. During the two days of our inspection we saw limited activities and stimulation and long periods where people were unengaged or sat watching the television. However, we did observe several people sitting and listening to music in the 'music room' and during both afternoons we observed staff encouraging people to participate in a short musical session involving singing and using percussion instruments. One carer told us that there was a collection of 'memorabilia', such as old photographs which carers used to prompt and encourage conversations with people. However, we did not see this being used during our inspection.

The registered manager told us she was interested in finding ways to improve the well-being of people living with dementia and had recently acquired a 'dementia doll' which several people had responded well to. Doll therapy can be an effective way to alleviate distress and anxiety in some people with dementia.

A monthly communion service was held for those people who had a Christian faith. At the time of our inspection there was no one living at the home from non-Christian faiths or cultures.

'Handover' meetings between the registered manager and senior carers helped to ensure that information

about changes to the health or care needs of people living at the home were discussed and that any alterations in their care were communicated promptly. Information discussed at the handover was then passed to the care team and recorded on a form which could be referred to at a later time if required.

The service had a complaints procedure which was on display in the entrance hall which told people how to complain, who to complain to and the timescale in which they could expect a response to their concerns. The registered manager told us that they had not received any recent complaints, which she felt was a result of having an 'open door' and also spending time working with people who used the service, where she was visible to visitors and relatives and available should they need to raise any concerns with her.

Requires Improvement

Is the service well-led?

Our findings

The service had a registered manager who had been in post since July 2016. 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.

The registered manager and the assistant director of the parent company were present on both days of our inspection and were helpful and cooperative with the inspection process. The registered manager told us they were in regular contact with the assistant director on a day to day basis to discuss the management of the home and seek advice where needed. This ensured there was managerial oversight. They commented, ''I do get good support.''

Staff we spoke with were complimentary about the registered manager. One member of staff said '' (name) is a really good manager'' and told us that they had seen improvements in the home, particularly in the environment, since the registered manager had been in post. They said ''The home has come on so much since (name) took over.'' Staff talked about working well together as a team: a carer told us, ''We do help each other'' and from our observations during the inspection we saw that staff shared their duties and supported each other while caring for the people living at Firs Hall.

We saw evidence that staff meetings were held four times a year. These provided an opportunity for both the registered manager and staff to discuss issues that affected the running of the home and the care provided. For example, we were told that at a recent meeting there had been a discussion around the best way to record the application of topical medicines, such as creams, as it had been identified that charts used to record these were not always completed accurately. Following the discussion a decision had been made to introduce a different method for recording creams. The registered manager told us this had been an improvement, and cream charts we viewed were completed correctly.

The registered manager reviewed incidents and accidents to make sure risks to people were minimised. We checked the incident and accident log and found that full details, including name of person involved, what and where the incident happened and action taken had been recorded. Any falls were recorded on a 'falls cross'. This is a tool used to log and record the frequency of falls and is used to aid analysis and look for patterns or trends. Notifications of incidents occurring at the home had been made to the CQC in line with their registration requirements.

We looked at some of the policies, which included safeguarding vulnerable adults, whistle blowing, health and safety, complaints and infection control. All the policies had been reviewed in December 2016 and were available in the office for staff to refer to for guidance on best practice.

The provider had sent out quality assurance questionnaires in October 2016 to people who used the

service/family members and health professionals. Although only three questionnaires had been returned these had all been positive about the care provided at the home.

From 1 April 2015 it has been a legal requirement of all services that have been inspected by the CQC and awarded a rating to display the rating at the premises and on the service's website, if they have one. Ratings must be displayed legibly and conspicuously to enable the public and people who use the service to see them. During this inspection we saw that the rating and a summary of the report from our last inspection were displayed in the entrance hall.

The registered manager carried out a range of weekly and monthly audits to monitor the quality of the service. These included checks on care plans, the environment, infection control and medicines management. In addition to these audits, the assistant director carried out their own comprehensive quarterly audit covering a wide range of areas, including maintenance and cleanliness of the building, care documentation and training. We saw from our review of the audits that where issues had been identified an action plan had been formulated and completed. For example, one audit had identified that photographs on the front of the MARs were out-of-date and were not a recent likeness of the person. This had resulted in new photographs being taken. Another audit had identified that the 'prn' medicines protocols needed to be reviewed and this was subsequently completed.

Although the provider carried out a range of audits, the issues we identified during our inspection, which were in relation to infection control, medicines management, and monitoring nutritional needs had not been identified. We recommend the provider review their quality assurance processes to ensure they are robust.

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 The provider had not ensured medicines management was always carried out safely. The provider had not ensured nutritional monitoring was always carried out correctly. The provider had not ensured equipment was always clean and infection control practices adequate.