Orton Manor Ltd

Orton Manor Nursing Home.

Inspection report

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Date of inspection visit:
06 September 2016

Date of publication:
11 October 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 6 September 2016 and it was unannounced.

Orton Manor is one of three homes owned by a small provider and provides accommodation, personal and nursing care for up to 40 older people living with physical health conditions or dementia. The home has two floors, each with a communal lounge and dining area. At the time of the inspection 37 people lived at the home. Orton Manor was last inspected by us in June 2014 and we found the regulations were met.

The home is required to have a registered manager in post. 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 and associated Regulations about how the service is run. At the time of this inspection the home had a registered manager in post. Since our last inspection, there has been a change of manager, with the new manager registering with us in March 2016.

People felt safe living at the home because staff were there to support them when needed. Staff knew what abuse was and how to report any concerns to the registered manager. People were supported to take their prescribed medicines by trained staff. Risks associated with people's care were not always assessed and actions were not always put into place to reduce the risk of harm. Staff did not always have the information available to refer to, if needed, to know how to keep people safe from identified risks.

Staff worked within the principles of the Mental Capacity Act 2005 when supporting people with personal care. People had choices offered to them about what they wanted to eat and drink and overall, were supported to maintain their health and, when needed, were referred to health professionals. However, checks on people's health did not always take place as planned.

Staff had received some training and felt this gave them the skills and knowledge they needed to effectively meet people's needs and further training was planned.

The providers had installed Closed Circuit Television (CCTV) in all communal areas of the home, but had not given consideration as to how consent was sought from people when they were filmed. The information guide about the home, given to people, did not inform people about the use of CCTV or how recordings might be used.

People said staff were kind to them and involved them in making decisions about their day to day care and how they spent their time. There were planned group activities for people to take part in if they wished to, and people were supported to practice their religious beliefs if they wished to.

Staff promoted people's privacy and dignity and encouraged people to be independent whenever possible. People felt staff effectively responded to their care and support needs and listened to their views.

Systems were in place to assess the quality of the service provided but improvement had not always taken place as planned for. Feedback was sought from people who lived at the home and relatives and action taken to make improvement where needed.

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.

People felt safe living at the home because staff were there to support them. Staff knew what abuse was and how to report any concerns to the registered manager. People were supported to take their prescribed medicines by trained staff in a safe way. Some risks associated with people's care were assessed, however, actions were not always put into place to reduce the risk of harm. Some risks had not been assessed and actions were not in place to minimise those risks.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had undertaken some training to deliver care and support to people, and further training was planned. Staff worked within the principles of the Mental Capacity Act 2005 when supporting people with personal care and the requirements of the Deprivation of Liberty Safeguards were followed. The registered manager and provider had not given consideration as to how consent was sought from people when they were filmed by the home's closed circuit television. People were offered choices and given the support they needed to eat and drink. People's weight was not always monitored as planned. People were referred to health professionals when needed.

Is the service caring?

Good

The service was caring.

People and their relatives told us that staff were kind and caring towards them or their family member. People were respected and involved in decisions about their day to day care and felt their views were sought by staff. People's privacy and dignity was maintained.

Is the service responsive?

Good

The service was responsive.

People felt their care and support needs were met by staff, and requests for support were responded to quickly by staff. Staff knew people well and how to respond to their needs. There were planned group activities for people to take part in if they wished to. People's feedback was sought and acted on.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Systems were in place to monitor the quality of the service provided but actions in relation to identified areas for improvement had not always been implemented. Some audits had missed opportunities to identify where action was required to implement improvement. Staff told us they felt supported by the registered manager.

Orton Manor Nursing Home.

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 6 September 2016 and was unannounced. The inspection team consisted of two inspectors and an 'expert by experience.' An expert by experience is a person who has personal experiences of using or caring for someone who uses this type of care service.

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 reviewed the information we held about the service. This included information shared with us by the local authority commissioners. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority. We reviewed statutory notifications sent to us from the provider. A statutory notification is information about important events which the provider is required to send us by law.

We spoke with ten people who lived at the home and eight relatives who told us about their experiences of using the service. We spoke with staff on duty including eight care staff, one nurse, the cook, the activities staff member, two maintenance staff, one domestic housekeeper, the administrator and the registered provider. We spent time with and observed care staff offering care and support in communal areas of the home.

We reviewed a range of records, these included ten care records, five medicine administration records and other key records kept to monitor people's health. We looked at quality assurance audits and feedback from people.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at the home. One person said, "I feel safe because staff are always about." Relatives told us they felt their family members were safe living at the home. Some staff told us they had received training on how to protect people from abuse and the registered manager told us other staff would complete online training during Autumn 2016 so that all staff had the information they needed to recognise signs of potential abuse." Staff told us they would report any concerns they had. One staff member told us, "I'd report any concerns of abuse to the manager." The registered manager understood their responsibilities in reporting any safeguarding concerns to the local authority and us.

The registered manager informed us that in May 2016, they had observed some poor moving and handling practices by staff and had addressed this. The registered manager told us, "We had a team meeting and I informed staff that moving and handling had to improve so that people were safely transferred. From my observations, I know things are better now." One relative told us, "I've seen staff using the hoist effectively." We observed safe moving and handling practices by staff. For example, staff explained to people what was happening when they used a hoist to transfer them from their armchair to a wheelchair and the hoist was used.

Some assessments were in place to identify where people were at risk of harm or injury but these did not always record actions to be taken, by staff, to minimise the identified risks. For example, some people were identified as being at high risk of falls but no information was available to tell staff how to minimise the risk of harm or injury.

We identified some potential risks to people had not been assessed, which meant people's safety could not always be assured. For example, we observed two people were smoking outside in a designated area. One of these people told us, "Staff assist me outside in my wheelchair, I sit under this gazebo to smoke. Staff don't stay with us. If we want to get staff attention we ring this bell, it's like an old ship bell. Most times they hear it and come, sometimes we have to ring it loud for a time." We found risk assessments had not been completed for those people that smoked at the home. No consideration had been given to the flammable gazebo material or how staff should support and check on people smoking outside. We discussed this with the registered manager and they told us, "The gazebo will be removed and the wooden shelter, which has a call bell system, will be repaired for people to use. Risk assessments will be completed for those people that smoke and staff made aware of what support should be given. It's been a bit informal, but I can see why things need to be tighter."

Staff told us that some people were at risk of pressure areas (skin damage). Overall, we found staff protected people against the risks of developing pressure areas and used pressure relieving equipment, such as special cushions and mattresses, to protect people's skin. However, when we looked at one person's care plan that we were told had a pressure area, we found their wound management plan was not detailed. For example, we found no information to say how often their dressings on their pressure area should be changed. The date of the last dressing change on this person's wound management plan did not correspond to the date staff told us. Following our inspection we discussed this with the nurse on shift and

they told us a detailed care plan would be written so that staff had guidance of what to do and what to record, so that a consistent approach was taken to the management of this person's pressure area. The nurse told us, "I have recently completed a pressure area course and also attended a road show on wound management. I'll bring these skills into the home and into people's care records. I have changed this person's dressing today and seen some improvement in the wound, this will be recorded, with an image so that effective wound management takes place."

Potential risks to people's health and wellbeing, posed from health conditions, had not always been assessed. For example, some people had respiratory illnesses but potential risks posed by aerosol products used in the home had not been considered. One domestic staff member told us, "I don't really like spraying this (air freshener aerosol) all about, it makes people cough, but it's all we are given to use." We discussed this with the registered manager and they agreed this had been an oversight and would ensure risks were assessed and told us alternative products would be purchased.

People, relatives and staff told us they felt there were enough staff on shift. One relative said, "I visit most days and there always seem to be enough staff on shift. My family member never has to wait long at all if they need staff to help them." This relative's family member confirmed this to us and said, "If I press my buzzer day or night, the staff are always around and I feel safe with them." During our inspection visit we observed there were sufficient skilled staff on shift to keep people safe.

We asked staff how they would deal with emergencies, such as a fire in the home. Staff told us they would phone 999 but were unsure of what action they should take to support people living at the home. One staff member told us, "I think all the staff evacuate and leave people in the home." Another staff member said, "It's a bit unclear really as to what we are meant to do." We saw fire evacuation mats were available but staff did not know when these should be used. People did not have a personal emergency evacuation plan (PEEPS) to inform staff or the emergency services how they should be moved in the event of an emergency. We discussed this with the registered manager and they agreed that the fire procedure needed to be clarified and all staff needed fire training. Following our inspection visit, the registered manager informed us that fire training had been arranged for staff and would take place, for all staff, before the end of October 2016. The registered manager told us PEEPS would be in place for people before the end of October 2016.

Care staff told us if a person sustained an injury, they would get help from the nurse. One care staff member told us, "Carers only complete first aid awareness by watching a DVD, so we would get the nurse." The nurse told us they were confident in dealing with any first aid emergencies that might arise and the registered manager informed us that all nurses would be updating their skills and completing a first aid taught course before the end of October 2016.

One staff member told us, "Care staff can give out medicines if they are trained as a 'medicine assistant' and also the nurse's support people with their medication and any injections, such as insulin." One medicine assistant told us, "I completed a medicines training course, shadowed an experienced nurse here at the home and they assessed my competency skills before I gave out medicines to people." The medicine assistant added, "I can always ask the nurses anything I am unsure about, the nurses and the manager are very supportive. They don't make us feel silly, we can go to them with any question."

We observed staff administering people's medicines and saw these were available and given as prescribed. Staff were not interrupted or distracted from this task, and supported people with their medicines when needed. People's medicine administration records were completed by staff and checks were completed to identify any discrepancies and alert senior staff to a possible error.

We looked at five people's medicine administration records (MARs) and saw some people had medicines 'when required'. However, we found there was no guidance available to tell staff when these medicines should be given to ensure consistency.

Some medicines were stored in a secure medicine fridge. Staff told us they checked the fridge temperature and records confirmed this. However, we saw some readings that had been recorded were out of the desired range but no action had been taken. We found no guidance was available to staff to tell them what the minimum or maximum safe temperatures should be and what action to take when temperatures were not within this range. We discussed this with the registered manager and they told us, "I'll ensure guidance is put into place and staff know how to reset the fridge after reading the temperature."

People had been prescribed topical items such as creams and ointments and these were stored in people's bedrooms. One staff member told us, "Care staff apply these when they support someone with personal care, but we don't sign that we have applied them." This meant there was no record of prescribed topical items being applied as directed by the GP. We discussed this with the registered manager and they said, "I'll put a record in place in people's bedrooms so that care staff can sign after they have applied creams as directed."

Requires Improvement

Is the service effective?

Our findings

People felt staff had the skills they needed to support them effectively. One person told us, "The staff know what they are doing, I love living here and get on with everyone." Relatives also told us staff had the skills they needed to support their family member effectively. One relative said, "My family member can, at times, be challenging toward staff but the staff remain calm and supportive and are really good with them. I can't fault the staff at all."

Staff told us they received an induction when they started work at the home. One staff member told us, "I had an induction and also did some shifts with an experienced staff member whilst I got to know people." Staff spoken with told us they felt they had completed most of the training they needed. One staff member said, "I feel I've had most of the training I need and have the skills to care for people, it's only the fire safety that I need to do." Training records showed gaps in staff training such as in safe moving and handling, managing challenging behaviours, food hygiene and fire safety. We discussed this with the registered manager and they told us, "The way training is delivered is changing. From Autumn 2016, most training will be completed using on line teaching sessions that staff will do. I hope all staff will have completed what they need to do by October 2016 and will be monitoring this is done."

Some people had a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) form in their care records. These showed discussions had taken place with the person, their relatives and GP and were signed and dated. However, we identified some people's care records stated there was 'No DNACPR' in place when in fact we found there was. We were concerned that this may delay the correct course of action being taken for individuals in an emergency situation. We discussed this with the registered manager and they told us, "During the daily shift handover, staff should be aware as to who has a DNACPR, but I agree the care records should also be clear. The front sheets are not always accurate. I'll get that sorted out so the information is correct."

Staff understood the importance of gaining people's consent before undertaking personal care tasks. One staff member told us, "We always explain to people what is happening. We don't force people to do things, such as have a shower or bath. We'd try again later if someone said 'no' or tell the manager if someone always refused support with personal care.'" Some staff told us they had completed training on the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act 2005 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.

We identified that senior staff completed a generic mental capacity assessment for people. However, the tool being used was not in line with the most recent guidance. We pointed this out to the registered manager and they told us, "I'll make sure we update ourselves and use the most recent." The registered manager understood their responsibilities under the Act and told us when they would make a referral for a 'best interests' meeting.

The registered manager informed us that seven people were deprived of their liberty and they had submitted referrals for a further eight people whose mental capacity was to be assessed for a DOLs. 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. Most staff could not recall which people had a DOLs in place, but told us they would check with the registered manager.

Notices were displayed to inform people and visitors that Closed Circuit Television (CCTV) was used throughout all communal areas of the home. However, we found no information to inform people of the reason for the CCTV being used in the home. For example, we looked at a copy of the provider's 'Service user Guide' displayed in the home and saw this did not inform people about the use of CCTV in the home and how recorded images were used. We discussed this with the registered manager and they confirmed the service user guide we had looked at was the current one being used. The registered manager told us, "The CCTV was in use before I started here, it's something the provider wants. The images are displayed live in the office but also recorded and kept for seven days. I understand it is for safety and security. I can certainly mention this to the provider and make sure it is put into the service user guide for people and we remind people of it being used at 'resident and relative' meetings. I can also ask people or their relatives to sign a form giving consent for the CCTV recording." The decision whether to use surveillance, such as CCTV, is for care providers to make in consultation with people who use their services, their families and staff. Staff had been consulted, however, we found no evidence that the provider had, whenever possible, consulted with people, or their relatives, about using the surveillance in communal areas of the home.

We observed the support people received during their mealtime and saw staff gave this when required. Mealtimes we unrushed and staff gave choices to people about what they wanted to eat and drink. People told us they enjoyed their meals. One person said, "I always have enough to eat and drink."

The cook told us, "People prefer to have a snack lunch and their main meal late afternoon and we then offer a light supper if people want anything. We have ready prepared cook chill meals delivered weekly and most people enjoy these. If people don't like them, we offer alternatives. For example, one person did not enjoy the Asian cook chill meals, so we offer them alternatives that we make." This person confirmed to us that they enjoyed the alternatives they were offered and said, "The staff get what the Asian foods that I like." Another person told us, "I find meat hard to digest and prefer a vegetarian diet, I don't eat many foods but staff always make me an omelette which is what I prefer most days."

Some people had Malnutrition Universal Screening Tool (MUST) assessments. (MUST) is a management plan for people who are malnourished or at risk of malnutrition. We spoke with the cook and they told us they added extra calories to people having a softer food diet, such as butter and cream to mashed potato, and high calorie snacks, such as full fat yogurts, were made available to people.

Staff recorded details about people's food and fluid intake when needed, however, we found there was no information to tell staff about what a person's target intake was and people's fluid intake was not totalled at the end of the day. We found there was no effective monitoring or checks of these records taking place where risks of malnutrition and dehydration had been identified.

Staff informed us that people's weight was checked on a monthly or weekly basis. One staff member told us, "If a person has lost weight, then we support them to get weighed weekly so that we can monitor their weight and take action if needed, such as refer them to the dietician." We found staff did not monitor people's weights as planned for. For example, we identified one person had no record of their weight since October 2014. We discussed this with the registered manager and they told us, "This person is too poorly to

use the weight machine." Another person had declined to be weighed in January 2014. We found no consideration had been given to alternative ways of monitoring people's weights that were either unable to use the weight machine, due to their health, or did not want to use it.
We identified people's weights were not always checked as planned for on a monthly basis or a weekly basis where concerns had been identified about weight loss. Records showed us that some people had gained weight and others had lost weight. One person's record was unclear because two weight records were kept and these were contradictory, which meant it was unclear which record was correct. We discussed these issues with the registered manager and they said, "I have previously identified some failings by staff in monitoring people's weights. This was discussed at the last team meeting and I told staff improvement was needed. This has clearly not happened with all staff yet, but I am aware of it and monitoring the improvement. I agree we had not implemented alternative ways of monitoring weight for people cared for in bed or who decline to be weighed, but this will now be done."

People told us they had been visited by healthcare professionals and that if they told staff they felt poorly, staff would ask for the GP to visit them. One relative said, "Staff have told me my family member has been visited by the doctor." Other relatives commented to us that family members had been visited by healthcare professionals such as chiropodists, opticians and GPs. Staff told us they would inform the registered manager or person in charge of the shift if someone was unwell and a GP visit was needed. People's care records confirmed visits were made to them when needed.

Good

Is the service caring?

Our findings

People told us they felt staff were kind and caring toward them and had a caring approach. One person said, "Staff are very caring." Another person said, "I think the staff are generally kind and caring."

Relatives told us they felt their family member was well cared for and that staff were friendly and kind. One relative told us, "If I needed care myself in the future, this is the type of home I'd want to live in." Another relative said, "The care is exceptional here, staff always keep in touch and are supportive to us as well."

During our inspection visit, we observed that staff were cheerful, friendly and had a caring approach toward people. Staff spoke with people in a polite way and listened to them. One person told us, "Staff are kind, they listen to me, I know staff and who the manager is. They come and see me now and then. I find the staff approachable."

People told us staff involved them in making day to day decisions about their care. One person told us, "I prefer to spend my time in my bedroom, staff ask me if I'd like to go to the lounge but I tell them 'not today.' I feel I'm involved in what I can be involved in." Another person told us, "I made the decision to come and live here, because I was satisfied that I couldn't cope at home. I feel glad I made the right decision. I'm happy with my bedroom, staff are happy and caring."

Some people were able to recall being involved in their care plan and telling staff about the support they needed. Some people were not able to recall this, however family members felt they had been involved in planning their relation's care and support. One relative said, "I am happy with the staff in how they care for my family member and have been totally involved in planning their care."

During our inspection visit, we observed staff practices that promoted people's privacy and dignity. For example, bedroom doors were closed when staff supported people with personal care. Staff gave us examples of how they would promote people's dignity such as covering a person's body with a towel when they supported them with a body wash. We saw staff knock before entering people's bedrooms showing people were respected.

Staff told us they tried to encourage people to be independent whenever possible because they knew this was important for people's wellbeing and sense of value. One staff member said, "If someone can wash their face on their own, or pick out their own clothes for the day, that's the kind of thing where we can encourage people's independence."

Relatives told us they were able to visit people at any time and there were no restrictions placed on them. One relative said, "We can visit whenever we wish to, there are no set visiting times here." Another relative told us, "I have been given a key because I visit most days, though this is not for use during the night time, I'd advise staff if I was visiting at night. When I arrive, I always sign in the visitor's book." The registered manager told us that some relatives had been visiting the home for several years and had been issued with a key that enabled them access to the home. The registered manager said, "Security issues are assessed before we

issue keys, but it enables relatives who visit frequently to come whenever they wish to." One person told us, "I know my daughter has a key and I think it's a good idea. She had a key to my house when I lived at home." Other relatives that did not have keys said they did not experience any problems with visiting their family member at the home.

Good

Is the service responsive?

Our findings

People felt staff responded to their needs and care was personalised to them. People told us they were happy living at the home and gave us some positive feedback about staff. One person said, "The staff ask my opinion about things, they are good about giving me choices and I have no concerns." One relative said, "I am more than happy with my family member's care here and how staff respond to my relation's needs."

Throughout our inspection visit, we saw people's needs were responded to by staff who knew them well. When people pressed their call bell for staff support, these were responded to in a timely way. A few people told us they'd had to wait for staff on a few occasions. One person said, "There have been just a few times that I've pressed my buzzer and staff have come and said, 'could I wait a moment,' they (staff) have always come back though and I've never just been left to wait and wait." Another person told us, "Staff always come to me when I press my buzzer, whatever the time of day or night. If I want a drink, even in the middle of the night, they will go and make me a hot chocolate."

People's care needs were assessed and their relatives had been involved in initial assessments to plan care. One relative told us, "I came to visit the home on behalf of my family member and was very pleased with what I saw. I feel fully involved in my family member's care and the staff have asked us about preferences such as what food they like and dislike."

Care plans did not always include information on people's history, hobbies or interests which meant some lacked personalised information. Staff told us that some relatives had taken up the offer to complete 'This is My Life' information, which gave personalised information about people and some care records looked at contained these. The registered manager and staff team were able tell us detailed information and preferences of people living at the home. For example, one staff member said, "[Person's Name] does not want any male carers, so we make sure this does not happen as it would upset them." Another staff member told us, "[Person's Name] is cared for in bed, we go and check this person every two hours and reposition them. This person loves ice cream, it is their favourite."

We looked at how people spent their time in the home and saw some people independently pursued interests and hobbies. One person told us, "I have enough different things to do in my bedroom, like watching the television. Staff offer me other activities as well." Another person said, "There are two girls (staff) who do activities. They help with breakfasts in the mornings, but then do other things as well. I'm happy enough with what is offered." During our inspection visit, we saw a 'movie afternoon with ice creams' took place. The registered manager informed us that a group of local volunteers visited twice a month to offer 'Bright Hour' events. These included themed activities such as 'Elvis Sing-alongs' which people enjoyed.

A few people told us they enjoyed it when the 'Church' visited the home. One person told us, "I like it if we can have a church service here." The registered manager explained that they had links with a local Church of England that offered monthly 'Sacred Space' events that people could attend if they wished to. One person told us, "Staff are respectful of my religion and I know they would take me to the local Mosque if I wanted to

go." This meant that staff recognised the importance of supporting people with their religious beliefs in a way they wanted.

People living at the home told us they felt listened to and staff always asked how they were. Most people could not recall any 'resident meetings,' but the registered manager showed us details of the next date in October 2016 when they had planned for a 'resident and relative' meeting. The registered manager said, "These meetings will take place once a quarter and I'll remind everyone of them."

Staff told us they would support people to make complaints. One staff member said, "If a person was not comfortable discussing any concern or complaint with me, then I would tell the team leader." People said they had no complaints about their care and support at the home. Relatives told us they had no current complaints about the overall care their family member received. One relative said, "I am happy with everything." The registered manager informed us that complaints were recorded an investigated and we saw the few complaints that had been received had been resolved to people's satisfaction.

Requires Improvement

Is the service well-led?

Our findings

Since our last inspection, there has been a change of manager, with the new manager registering with us in March 2016. The registered manager told us, "I was the deputy manager here before becoming the manager. This meant I knew people really well and also knew the staff team, which overall is quite stable." The registered manager informed us that the vacant deputy manager post had not yet been filled because they and the provider were assessing whether this position was needed. The providers informed us they visited the home on a monthly basis and the registered manager said the providers were contactable by email or telephone if needed and a regional manager was also available for support if required.

One staff member told us, "I know the manager would like to have a deputy for support. As far as I know, this has now been agreed by the provider and the manager is going to recruit. The manager has so much pressure on them, I think they need support." The registered manager told us, "The team are good, we all support one another. But, it is a very busy and demanding role and I think a deputy would be beneficial. I've fed back to the provider on this and they have agreed that this can be advertised internally and the closing date for applications is the end of September 2016."

Staff told us they felt very supported and that the registered manager was approachable. Staff informed us they attended team meetings and had one to one supervision meetings with the registered manager. One staff member said, "The manager always supports us and will always make changes to improve if they can do." The nurse said, "I feel supported by the manager, they support us clinically and are always available if I need to ask something."

The registered manager told us feedback had been sought from people during May 2016. We identified there was a very low response rate with only eight questionnaires being returned from people or their relatives. However, this had been analysed and actions taken to make improvement, which included more activities being offered to people. The registered manager told us they were planning a further questionnaire during October 2016 and would look at ways to enable more people to complete these, for example a 'smiley face' format which some people may find more accessible.

Systems were in place to audit the quality of the service, however these were not always effective in implementing the planned improvement. The registered manager informed us they completed informal checks on staff and the environment as a part of their walk around the home whenever they were on shift. One staff member said, "The manager is never just stuck in the office, they are always checking the shift is going okay and people are alright."

The registered manager informed us of areas where they had identified improvement was needed and said, "If I observe any poor practice, I always address it with the staff member and staff are also reminded in team meetings of best practice. I complete audits and if these show things need to improve I will inform staff by a notice, at handover and also in team meetings." Team meeting minutes and staff notices confirmed issues had been addressed and some improvements had been made such as moving and handling practices. However, we found some issues that had been identified as requiring improvement had not yet improved.

For example, in May 2016 the registered manager had reminded staff of the need for improvement in completing and recording people's weight checks. However, we found not all staff had responded to the registered manager identifying that improvement was required.

The August 2016 medicine audit had identified some areas where improvement was required such as missed signatures and missing information on medicine administration records. We found actions to improve had effectively been implemented. Minor actions for improvement had been identified by the registered manager in the August 2016 infection control audit and these were due to be completed by the end of October 2016.

Accidents and incidents were recorded and analysis took place. We saw action was taken, such as a medication review for one person, so the risk of reoccurrence of them falling was minimised.

Care plan audits were not always effective because they had not identified the issues we found. For example, where people had a specific health care condition, this was stated on their care record. However, information about the person's health care condition was not always available for staff to refer to when needed so that a consistent approach was taken.

The registered manager informed us that an electronic recording system had been implemented in the home during the summer of 2016. The registered manager said, "The provider would like us to go 'paperless' and we had this new system of electronic records." We found that the electronic records system was not detailed enough to enable staff to accurately record how people's identified daily needs were met. For example, a 'night supervision' was recorded but gave no detail on what was checked. 'Repositioning' was recorded but gave no detail on which position the person was placed in which meant staff did not have the information needed to rotate people's positions. A further example was the use of two hour 'time bands' on the electronic system which meant specific times of support were not recorded. We discussed these issues with the registered manager and they told us. "I can see there are some gaps because the system does not allow staff to add detail. I have a meeting planned later this month, with the system providers and will inform them of where we need more detail. However, I can see there is also a need for some paper based care records as well. "

Following our feedback to the registered manager, they sent us details of actions taken to make improvements. These included assessments of risks to ensure people's safety such as when smoking and how they intended to improve checks on planned tasks being undertaken by staff.