Aden House Limited

Aden View Care Home

Inspection report

Preseverance Street
Primrose Hill
Huddersfield
West Yorkshire
HD4 6AP

Tel: 01484530821
Website: www.newcenturycare.co.uk

Date of inspection visit:
01 February 2016
09 February 2016

Date of publication:
02 June 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 1 and 9 February 2016. The first day of inspection was unannounced and the second day was an announced inspection.

The service was last inspected 7 May 2013 and was compliant in the areas we inspected.

Aden View Care Home is registered to provide personal care and accommodation for up to 46 older people. The accommodation is on two floors, the first floor being accessed by a passenger lift. All bedrooms have en suite facilities. There are a number of communal areas and dining rooms. At the time of the inspection there were 38 people using the service. There was a unit called Primrose for people living with dementia and other memory problems.

The registered manager had applied to be de-registered as a manger in January 2016 and the current manager was in the process of applying for their registration. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People who used the service felt safe living there and felt staff had the skills and knowledge to carry out their role. Staff we spoke with had a good understanding of their role in relation to ensuring people were kept safe from harm. Risk assessments centred on the needs of the individual and were reviewed monthly.

Training for staff was up to date and they had a good understating of their role in relation to the Mental Capacity Act 2008 (MCA)and Deprivation of Liberty Safeguards (DoLS). The manager was aware of their role in protecting people's human rights and had made appropriate applications for a DoLS.

There was a choice of activities, both shared and individual available for people to take part in. Activities were organised by the activity coordinator.

Care records were person centred and focussed on the needs of the individual, however these were not always written by the staff who had provided people with their support.

People were offered a variety of food and drinks through the day but at lunchtime we observed there was not enough staff to support people eat their meal.

We observed interaction between staff and people who used the service was respectful and people felt the staff were very caring in their attitude toward them.

The manager had an auditing system in place. However, this had not been effective in identifying issues and concerns with the way information was recorded in people's daily records, on the medicine administration

records and on accident forms.

The manager was passionate about their role. Staff and people who used the service spoke highly of the manager.

We found one breach of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe

People who used the service felt safe living at the home.

Staff had the knowledge and skills to identify abuse and knew what to do if they had any concerns.

Risk assessments were aimed at the needs of the individual and were reviewed monthly.

Recruitment and selection processes were robust and safe

Is the service effective?

Requires Improvement

Is the service effective?

The service was not always effective.

The service was meeting its legal responsibilities under the MCA 2005 and DoLS.

Staff received a period of induction and on-going supervision, training and appraisal.

People had good access to other health professionals.

People were not always effectively supported at mealtimes.

Is the service caring?

Good

The service was caring.

Staff had a good understanding of people's support needs and they treated people with dignity and respect.

People felt staff were very caring and they enjoyed living at the home.

People felt involved in how the home was run

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care records had been created with the involvement of people and their relatives and were reflective of people's individual needs and preferences.

The activities coordinator had a programme of activities which gave people the opportunity to join in.

Is the service well-led?

Requires Improvement

The service was not sufficiently well led.

Accidents and incidents were not being analysed to identify patterns or trends.

Audits were not robust and there were concerns with the way information had been recorded.

Staff felt the manager was visible in the home and felt able to approach them. Staff felt supported by the manager.

Handover notes were not being completed correctly

Aden View Care 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.

This inspection took place on 1 and 9 February 2016 and was unannounced. The inspection took place in response to information of concern. The inspection team was made up of one adult social care inspector, a bank inspector and a specialist adviser who was a trained nurse with experience in medicine administration.

Prior to the inspection; we analysed the number and type of notifications we had received from the provider, we contacted the local Healthwatch office for feedback and the local authority safeguarding office. Healthwatch is the consumer champion for health and social care. They have the statutory power to ensure the voice of the consumer is heard by organisations such as the CQC who regulate health and care services.

We did not request a Provider Information Return (PIR) because the inspection was in response to concerns which had been raised. A PIR 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 spoke with six people who used the service, one relative, the cook, two senior members of staff, the activities coordinator, four care staff and the manager. We looked at nine care records, six staff files, the training and supervision matrix and the staff rota. We looked at records relating to the safety of the premises and equipment.

Good

Is the service safe?

Our findings

People who used the service told us they felt safe in the home. One person told us, "Yes I do feel safe, I have been here a long time and never felt unsafe." Another person told us, "I do feel safe, the way you're looked after is really very good."

The training matrix showed staff had updated moving and handling training and the care staff we spoke with told us they felt confident using the equipment such as the hoist. We observed two care staff using the hoist to transfer people, this was done safely. We saw them explain exactly what was happening, for example, "We are going to lift you up, now moving you across to the chair, now going down."

Care staff we spoke with knew there was a whistleblowing policy in place but had never used it. They told us they would not hesitate to use the policy if they had any concerns. We looked at the policy and saw it was in the process of being reviewed.

We looked at the training matrix for the home and saw training in safeguarding was up to date. Care staff we spoke with gave us some examples of what they understood abuse to be. We asked them how they would recognise an abusive situation with someone who had difficulty with verbal communication. One member of staff told us, "I would look at their body language, are they smiling or frowning, do they pull away when you go to touch them." It was clear from the conversations with staff they understood their responsibilities in relation to reporting safeguarding issues and what they would do if no action had been taken as a result of their disclosing their concerns within the home. One care staff member told us, "I would contact Gateway to Care [local authority safeguarding team] or the Care Quality Commission (CQC) if my manager didn't act on what I had told them."

As part of their role, the manager had sent notifications to the CQC and had referred safeguarding cases to the local authority safeguarding team. This showed the manager was aware of their responsibilities in relation to safeguarding people.

In the care records we looked at we saw comprehensive risk assessments in place. The outcome of risk assessments at the point of admission to the service were used to create a care record covering; mobilisation, continence, nutrition, communications, mood, sleeping, personal hygiene and skin integrity. We saw details of moving and handling assessments including, what equipment was required and how many care staff were needed to move people safely. For example, one person had a history of falls. We saw a falls risk assessment was in place. The resulting risk plan detailed how staff should keep them safe and no falls had been recorded since they moved into the home. The risk assessments had been reviewed monthly and were updated to reflect any changes. This meant care and support was planned and delivered in a way that reduced risks to people's safety and welfare.

The manager told us people had Personal Evacuation Plans (PEEPs) in place. This was a document which

detailed the route to the nearest fire exits, equipment which may be required to support people and staff support for a named individual in the event the premises had to be evacuated. We looked at the PEEPs, they detailed people's medical condition and what support they required in the event of an evacuation.

As we toured the building, in one bedroom we noticed the carpet was uneven and could pose a risk of falls or trips. The manager told us they were aware of the need to remove the carpet and replace it. They told us there were plans in place to replace the carpets in this bedroom and a further five bedrooms.

The manager told us they felt the staffing levels were not an issue and they did not use a dependency tool to allocate staff. People who used the service told us they thought there were enough staff. One person we spoke with told us, "It's like a hotel; staff are always there if you need a bit of a hand to do something." We observed staff had a presence in each of the communal areas we visited. During one observation in the lounge on the Primrose unit, staff sat down with people, talked to them and supported them to have a drink. We noticed care staff sat in the communal areas to write up their daily records.

One of the people who used the service felt staff worked well together as a team and helped each other out. They felt this was why they did not have to wait long for their bell to be answered. During the inspection, we observed the call bells were answered within a timely manner.

We looked at the file of six staff members and saw safe recruitment practices were followed. We found recruitment checks, such as criminal record checks from the Disclosure and Barring Service (DBS) and references, were obtained before staff began work. The DBS enables organisations make safer recruitment decisions by identifying potential candidates who may be unsuitable for work with vulnerable adults. We saw the provider used the Home Office employer checking service to check an employee's or potential employee's immigration status. In these cases we saw a copy of the visa retained in the staff file.

The manager told us they would not hesitate to use the disciplinary procedure to address poor practice. There was evidence in staff files the manager had taken action in relation to staff who had not been performing up to standard.

The service used two medicine trollies and we saw the medicine trollies were locked and secured to the wall in a locked treatment room when they were not in use. We observed the senior care staff administer the medicines. They wore a red tabard which indicated they were not to be disturbed as they administered the medicines. The senior care staff asked people if they required pain relief and when they supported people to take their medicines we observed they gave people enough fluid and time to take their medicines. We looked at the medicine Administration Record (MAR) sheets and saw there were no gaps in staff signatures which showed people had received their medicines.

The senior care staff was able to tell us how medicines were received from and returned to the pharmacy. Medication waiting to be returned to the pharmacy was stored in a locked cupboard and there was a book in use to record all returned medicines. We saw evidence medicines were checked and signed as received by members of staff.

Staff we spoke with told us they had received training in the safe administration of medicines. The training matrix we looked at evidenced staff had received training in the safe administration of medicines. In the care records we looked at there was a description of how people preferred to take their medicines and there was a record of their allergies to specific medicines. People we spoke with told us they received their medicines on time and had pain relief when they required it.

We checked the controlled drugs (CDs) record book and saw two staff members had signed for any CDs administered. A daily audit of the CDs had been carried out and there was evidence the number of CDs in the cupboard tallied with the number of CDs in the record book.

The manager told us three people who used the service required their medicines to be given to them without them knowing. Medicines given this way are known as covert medicines. The care records we looked at showed the provider had followed correct procedures which ensured the medicines were administered within National Institute for Health and Care Excellence (NICE) SC1 guidelines.

There was evidence meetings had taken place with a range of people including GPs, family members, community psychiatric nurses, care staff with personal knowledge of the individual and a pharmacist to assess whether people should have their medicines given covertly, including a capacity assessment and a best interest meeting. However there was no information stating whether the covert medicine should be given in food or a drink. We discussed this with the senior care staff and they contacted the pharmacy for advice. They assured us they would update people's care records and put a list in with the MAR sheets to say what food and/or drink the medicine could be put into.

Some people had been prescribed barrier creams and we saw a body map in place showing where the creams had to be applied. We observed the senior carer signed the MAR sheets confirming creams had been applied, however they did not apply the creams themselves and they did not witness the creams being applied by the care staff. Although there were forms for care staff to sign once the creams had been applied, these forms had been kept in people's bedrooms and the senior care staff had not checked the forms to establish the creams had been applied before signing the MAR sheets. We discussed this with the senior care staff and they told us they would discuss this with the manager to ensure the MAR charts were completed correctly.

Requires Improvement

Is the service effective?

Our findings

One of the people we spoke with told us, "The staff here are good; they know what they are doing." Another person told us, "They [care staff] are very good to me here. I love it here."

Relatives we spoke with felt the staff had the right training and skills to do their job. They told us, "Staff seem alright. When I've been here, they've been good. They know what they are doing with [relative]."

The staff we spoke with told us they felt the training was very good and enabled them to do their job effectively. We asked one care staff to describe their induction to us. They told us they shadowed a more experienced member of staff for a week and a half and they had training days. The training days included topics such as using a hoist, moving and handling, first aid and dementia awareness. The care staff told us they felt the shadowing opportunity and the training gave them the confidence to support people and use equipment safely.

The training matrix we looked at showed us training in topics such as health and safety, Mental Capacity Act (MCA) 2005, Deprivation of Liberty Safeguards (DoLS), nutrition and manual handling was mandatory and up to date. Other topics such as end of life care were discretionary and not all the staff had received end of life training. We also saw staff had received training in equality and diversity.

We asked staff about their experience of supervision and their response was varied. One member of staff told us they had not had supervision whilst another member of staff told us they sat down with the manager for their supervision and felt the supervisions were supportive. The manager told us they carried out supervisions with senior care staff and the senior care staff carried out supervisions with other staff including care staff. Records showed staff had received supervision in line with the policy of the service.

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 MCA requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this 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.

Although training in MCA and DoLS was up to date, not all the care staff we spoke with had a clear understanding of the MCA and how it could impact on the support they offered to people. However,

although staff had difficulty understanding the MCA, they understood the need to ask people for their consent before any personal care was carried out.

In the care records we looked at we saw consent to care had been obtained. When people had been assessed as not having the capacity to make a decision, their consent form had been signed by a relative with the legal right to do so. This is called Lasting Power of Attorney (LPA) which allows people to appoint another person to make certain decisions on their behalf when they are no longer capable of doing so.

The manager told us 18 people who used the service were subject to an authorised DoLS. We looked at five care records and saw the manager had made the appropriate applications. This showed the manager was aware of their responsibilities which ensured people's human rights had been respected.

We spoke with the manager about the lawful use of restraint. They were able to describe what restraint meant and could distinguish between restraint for people who have the ability to consent and those who lacked capacity. We asked the manager about the use of bedrails. They told us bedrail assessments were used to minimise the risk of harm. There was evidence people who had capacity had asked for bedrails to be in place. Where people lacked the capacity to make a decision about the need for bed rails, we saw best interest meetings and risk assessments had taken place.
Care records showed people accessed other services in cases of emergency or when their needs had changed. This had included GP's, hospital consultants, speech and language therapy (SALT) team, community mental health nurses, opticians and dentists. When people required support for specific conditions, we saw the provider referred people to the appropriate service for an assessment. We saw the provider had put into action any outcomes of the assessment. This showed people who used the service received additional support when required to meet their care and treatment needs.
People who used the service felt they were looked after very well and felt the care staff got their GP out in a timely manner when they were not feeling very well. The records showed the home had frequent visits from other health professionals and the manager told us they had a good relationship with their local GP, pharmacist and other health professionals such as the district nurse. Care staff we spoke with felt the manager and senior care staff took action when people's health had deteriorated.

The care records showed people had a nutritional risk assessment using the malnutrition universal screening tool (MUST). The MUST is used to assess people who may be at risk of malnutrition or obesity. Where any concerns about people's weight had been identified referrals were made to the appropriate service, for example the dietician. We saw two people required the use of a drink thickener to minimise the risk of choking. The drink thickener was stored in the kitchen and we observed the thickener was used by care staff when people had a drink. Staff we spoke with understood the risks in relation to people's specific dietary needs. The training matrix we looked at showed staff had received training in MUST and food safety. This showed the service had taken steps to minimise the risk of malnutrition and choking.

We saw people's weight was monitored and recorded monthly. The care records we looked at showed people's weight was stable. One care staff told us people's weight would be monitored weekly if there were concerns about weight loss. In one care record we saw someone had been referred to the speech and language therapist (SALT) team because of a potential risk of choking. The advice was for staff to be with the person during meals giving assistance as needed. The food was to be pureed and assistance was to be unhurried. Our observations during lunch time showed the advice was being followed.

We spoke with the cook and they had a very good understanding of people's dietary needs and preferences. The cook confirmed they encouraged people to eat a varied and balanced diet. One of the people who used

the service told us, "The food is tasty and you can ask for more if you want."

We observed lunch being served on the residential unit and the Primrose unit. We saw the tables had been set nicely with covers, napkins, cutlery and condiments. People were given a choice of wearing an apron. There was a jovial atmosphere in the dining room, people were talking to one another and music was also playing. We observed staff wore protective clothing when serving food and drink.

In the residential unit we saw six people sat in wheelchairs at the dining tables. This meant people could not sit close enough to the table and affected their ability to eat their meal. For example one person held their plate in their left hand and used a fork with their right hand because they were too far away from the table.

People had to wait for staff to be supported to eat their meal. We observed one person experienced difficulty eating their food and they had to wait for 25 minutes for a member of staff to support them. Care staff told us this was not always the case and the person was usually able to eat their meal independently.

In the Primrose unit people sat and chatted to each other at the table. Some people required support to eat their meal and we observed that when staff were available to support them they did this discreetly. The meal was ready plated so people did not have a choice of portion size or whether they wanted gravy on their meal. People chose their meals from a menu on the day. There were no pictures of meals available to help people make their choice. People living with dementia can forget what a specific meal may look like so having a picture of the meal would help them decide which meal to choose. The meal of the day had been written on a white board and displayed in the communal area.

In both the residential unit and Primrose unit, people had been offered a choice of drinks: tea, coffee or juice during the meal and we saw drinks had been made available through the day.

Good

Is the service caring?

Our findings

One person we spoke with told us they felt the staff were, "Marvellous, they can't do enough for you. They are a good crowd of people." Another person told us, "The staff are good to me; I would not be alive today if it wasn't for the staff here."

Relatives we spoke with told us, "I always feel welcomed here, the staff are always lovely."

We observed staff responded to people when they were distressed. We saw one care staff sat down next to one person because they were upset. The care staff talked to them and held their hand until the person settled and became less distressed. Care staff were present in the communal area throughout a period of observation which lasted 20 minutes.

During our inspection we observed communication between staff and people who used the service was friendly and respectful. We saw people responded positively to staff with smiles when staff spoke with them. In the communal area on the residential unit, a member of staff started to sing and within a few seconds people sitting in the communal area had joined in the singing. One of the people we sat next to told us, "They are always doing this, just bursting into song; mind you they have a lovely voice so we don't mind."

We observed staff included people in conversations about what they wanted to do and explained any activity prior to it taking place. For example we heard a care worker asking a person if they wanted to walk to the dining room or use a wheelchair. This showed the person had been given a choice and had the opportunity to maintain their independence.

People were dressed with thought for their individual needs and were smart in appearance. This indicated that staff had taken the time to support people with their personal care in a way which would promote their dignity. Care staff told us they would always let people choose what they wanted to wear when they got ready in the morning.

Care records showed people accessed other services in cases of emergency, or when their needs had changed. This had included GPs, hospital consultants, speech and language therapy (SALT) team, community mental health nurses, opticians and dentists. When people required support for specific conditions we saw the provider referred people to the appropriate service for an assessment. We saw the provider had put into action any outcomes of the assessment. This showed people who used the service received additional support when required to meet their care and treatment needs.

One of the people who used the service told us they attended a committee meeting in the home, they thought it was once a month and they told us they felt able to contribute. However, this was not supported by the meeting minutes we looked at which showed meetings had not taken place monthly. We saw a meeting had been held for relatives and residents on 24 June 2015 and the activities coordinator told us they had arranged a meeting in August 2015 but not many people attended. The activities coordinator told

us the meetings had been arranged to establish what people wanted to do in relation to activities. The manager told us relatives' meetings were not well attended and no relatives had turned up at the last meeting. However, the manager told us people had been consulted about the refurbishment of their bedrooms and colour of carpets. We were not shown any evidence of the consultation.

We asked the manager about advocacy which ensured decision making was effective in safeguarding and promoting the interests of people who did not have the capacity to make a decision. They told us advocacy was not in place to support people who had no lasting power of attorney (LPA) or next of kin. The manager contacted an advocacy service for advice and they told us they would update people's care records with this information.

We asked the care staff how they preserved people's dignity. One care staff told us, "I always make sure they are covered up during personal care and when I use the hoist." Another care staff told us, "I make sure the curtains and the bedroom doors are closed so people can't just walk in." We saw care staff knocked on people's bedroom doors before they entered.

One of the people we spoke with told us," They [staff] talk to me normally, they don't shout to get impatient with me." Another person told us, "They make sure I am covered and they know to cover me up when I am on the hoist." This showed staff took steps which ensured people's privacy, dignity and independence were respected.

As we walked around the home we looked into the bedrooms of four people who used the service. We saw bedrooms had been personalised with people's own furniture and photographs of their family. There were ornaments on the windowsills and on top of chests of drawers. Personalising bedrooms helps staff to get to know a person and helps to create a sense of familiarity and make a person feel more comfortable.

Requires Improvement

Is the service responsive?

Our findings

We asked people if they were aware of their care records. Only one person we spoke with was able to talk to us about their care record. Other people we spoke with were not able to tell us about their care record. When we asked one person about their care record, they simply told us, "They [the staff] know what they are doing."

Care staff we spoke with told us they found the care records easy to read and understand. They felt each care record gave them an understanding of people's support needs. A senior care worker told us, "I am aware of one resident's past life history and that at one time [they] liked their hair doing…now they don't like having their hair washed." This showed people were supported and cared for by staff who knew them well.

We saw people had signed their consent to the care record and where people did not have the capacity to sign there was evidence a LPA had acted on their behalf. This showed that as far as possible, people had been involved in the creation of care records.

One senior carer we spoke with told us, "Relatives are involved in the assessment when a resident first moves into the home but are not consulted when care plans are reviewed. If a relative asked I would involve them but no one has ever asked me." There was no evidence in the care records people who used the service or their relatives had been involved in the reviews of the care records and risk assessments.

We looked at the care records for four people. The care records were organised in different sections which made it easy to find information. The care records were centred on the support needs of the individual and covered areas such as communication, mobility, social preferences and mental health and wellbeing. There was a short personal history which included a record of a person's background, what they enjoyed doing in their leisure time and what type of work they had been employed in. We saw the care records had been reviewed monthly by staff. The reviews helped monitor care records and ensured they were updated to reflect people's current needs so that any necessary actions could be identified at an early stage.

People we spoke with told us they had no complaints about the service but knew who they should complain to. One person said, "Why ever would anyone want to make a complaint, this place is first class." Another person said, "If I need to make a complaint I would speak to [name] and they would get it sorted." One of the relatives we spoke with told us they would talk to the manager if they were not happy with any aspect of the service. In people's bedrooms we saw a sign on the door explaining how people could complain if they were not happy with the way the service was provided.

We spoke with the manager about the recording of complaints. They told us they had not received any complaints over the past 12 months. We asked them whether they recorded any negative comments made to them informally and they told us they did not routinely record conversations they had with relatives who had expressed their unhappiness with any aspect of the service. The manager told us, "This door [to their

office] is always open and people come and talk to me. They don't like doing anything more formal." We asked the manager how they audited these types of conversations to establish any consistent pattern. They told us because they did not record the conversations, they could not audit them. We looked at the policy of the service regarding complaints and the manager told us they were aware of the policy and how they should respond to complaints.

We spoke with the activities coordinator. They told us over the past twelve months they had introduced a new range of activities from art and craft to gardening and cultivating their own vegetable patch. They told us the vegetable patch had proved very popular with people and there were plans in place to repeat the activity in the summer. We saw people's art work had been displayed throughout the home. The activity coordinator routinely encouraged people from the residential unit and the Primrose unit to take part in the activities. They did not separate the activities between the units. This meant people living with dementia had access to the same activities as people living on the residential unit. Enabling people with dementia to take part in meaningful and enjoyable activities is a key part of 'living well with dementia'.

The activities coordinator told us they arranged for external entertainers to come and sing at the home. They told us people really enjoyed the entertainment and care staff often joined in the singing.

People we spoke with told us there was plenty to do and had a choice as to whether they took part. One person told us, "There's lots of art and craft and bingo and people coming in to sing." There were photographs on view from the various outings people had been on. The activities coordinator told us they were aware some people found it difficult to join in group activities, especially people living with dementia. They told us they found people enjoyed one to one activities more, "I wash people's hair and talk to them, they seem to enjoy the contact." This showed the service was meeting the social needs of people who used the service.

Requires Improvement

Is the service well-led?

Our findings

People who used the service told us they felt the home was well managed. One person told us, "This home is first class and well led [manager] is a good leader." Other people we spoke with told us they knew who the manager was. One person told us," I know [manager] I see them walking about."

The previous registered manager applied to de Register with the CQC in September 2015. The current manager started the registration process in September 2015. Prior to their current role as manager, they had been the care manager at the home. This meant they were familiar with the home and had knowledge of people who used the service and the staff.

Staff we spoke with told us they felt the staff team worked well together. One member of staff we spoke with told us they thought the vision of the home was, "Everyone is well looked after, no neglect." All the staff we spoke with felt the home was well managed. They felt the manager was approachable and they felt able to take any concerns to them. One staff member told us, "I see [manager] out on the floor a lot during the day."

Some staff we spoke with told us they had received an appraisal and had regular supervision with the manager. They told us, "The manager does listen and if they think anyone comes up with a good idea they are willing to try it out". Another staff member told us "I can approach the manager and senior carer at any time for advice and support."

We spoke with the manager and asked them about their responsibilities. They told us, "I do a daily walk around the home and carry out room checks to see staff have done what they've said they've done." They felt this helped them keep an overall view of how the home was functioning. We saw the manager spent a lot of the day walking on the two units and talking to staff and people who used the service.

We looked at the audits of the home. We found some of the audit systems in place were ineffective and staff had not been diligent when audits had been carried out. For example the guidance produced by the home stated hand written MAR sheets should be written in capital letters for clarity and signed by two people. When we looked at the audit of the MAR sheets we saw the person who had carried out the audit had recorded 'yes' when asked whether the guidance of the home had been followed. However, when we looked at the MAR sheets over the same period, we saw the guidance had not been followed.

The manager told us information about people was shared at each handover using an information sheet. The sheet contained a short summary of how people's support needs had been met through each shift, a short description of people's dietary and fluid intake and detailed any concerns. On the handover sheet instead of recording people's fluid intake, care staff had stated 'poor diet' or 'asleep'. This showed the form was not being used correctly and important information was not being recorded. We discussed this with the manager. They were not aware care staff had not been using the handover sheet incorrectly. They told us they would discuss this with staff at the next staff meeting. Although the handover sheet had not been completed correctly, one staff member told us, "Handovers are useful, they state people's condition, their mobility and their food intake."

We saw record keeping within the home was not consistent and in some cases records had been filled in falsely. For example, one member of the care staff who had worked the morning shift had asked a care staff member who had come on duty at two o'clock to write up the daily reports for the morning shift. We asked the care staff how they knew what had happened during the morning. They told us, "They [people who used the service] have a routine and the senior has just told me what has happened." We asked the senior care staff who had worked the morning shift why they had asked the care staff on the afternoon shift to write up the daily reports for the morning. They told us, "I asked them to do it because we have got behind today." We pointed out our concerns that they had asked a member of the care staff who had not been at work to write up and sign notes. We asked them if they had done this before and they told us they had done so on three other occasions.

We discussed our concerns with the manager. They immediately spoke with the care staff involved and informed us they had started the disciplinary process to take action against the senior care staff involved.

We looked at the accident and incident records of the home. After each accident the policy of the home was to carry out 12 hourly checks to monitor the person's wellbeing. Care staff carrying out the checks had to sign they had completed the checks and comment on the persons condition. In one record we saw care staff had recorded and signed they had carried out a check on one person who had fallen. However, the person was in hospital at the time the care staff had signed to say they had checked on the person. This meant the records were not accurate.

In the daily records we saw staff had been recording people's wellbeing, their food and fluid intake but they did not record the time; they wrote 'cont'd' this made it difficult to establish what had happened at what time.

In another example, we saw one person was at risk of losing weight and staff had to complete a food diary. When we looked at their food diary at 1.30 pm, we saw nothing had been recorded since nine am. We brought this to the attention of the manager and they addressed the issue with the care staff and the food diary was completed.

Prior to this inspection we had received a concern about the care and treatment of one person who used the service. As we looked at their notes, it was difficult for us to establish times and dates of care and treatment because of the way these had been written. In one multi-disciplinary team record, we saw no entries had been made. However, on a separate loose piece of paper we saw staff had recorded visits from the district nurse which had not been recorded on the person's notes.

The manager was not aware of these examples and showed people had not been protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records had not been maintained.

These examples demonstrate a breach of Regulation 17 (1) (2) (b) (c) (d) (i) (ii) of the Health and Social Care Act 2008 (regulated activities) Regulations.

The manager told us they had tried on many occasions to address the issue of poor recording in relation to fluid and food charts but felt staff did not understand the impact the lack of recording can have on people's health and wellbeing. Staff meeting minutes from 6 October 2015 showed the manager had shared with the staff the importance of completing the fluid and food charts.

We saw audits had been carried out on the safe attachment of bed rails to prevent entrapment, and another

on the quality of mattresses. Both audits showed where discrepancies had been found the manager had taken action to rectify them. We saw the outcome of audits regarding health and safety. For example one outcome had resulted in a review of the home's risk assessments under the Control of Substances Hazardous to Health regulations 2002 (COSHH). We saw the risk assessment had produced a list of all current chemicals and cleaning products used in the home along with safety measures to be used with each product.
The manager told us they had not reviewed the accident and incident records, they had plans in place to do this. This meant that they had not carried out audits of the records to ascertain whether there were any patterns in the number, type or time of day accidents occurred.

The provider had up to date policies in place covering topics such as safeguarding, medicines, nutrition and privacy and dignity. We saw the policies had been reviewed and updated. Reviewing policies enables registered providers to determine if a policy is still effective and relevant or if changes are required to ensure the policy is reflective of current legislation and good practice.

We saw evidence various staff meetings took place, for example, there were meetings for care staff, managers, domestic staff and night staff, this ensured information was shared amongst all the staff at the home. Not all staff who attended the meetings found them useful. One staff member told us, "We have team meetings every two months but hardly anybody says anything in these meetings, I prefer to do it one to one, I do not like speaking in front of a lot of other staff." However, other staff we spoke with felt the staff meetings were a useful way to share information.

The manager told us the reason they had not picked up on some of the issues we highlighted in the recording of information within care records was because they relied on senior care staff to audit the care records. They acknowledged they had not carried out audits on incidents and accidents. They told us they wanted to understand why things had been happening and what could be done to improve the service. The manager understood one way to do this was to carry out audits themselves and ensure staff who assisted with the audits were able to do so effectively and accurately.

The care records were kept in an office which was locked when it was not occupied. This prevented unauthorised access to people's records.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The manager did not have in place a system to monitor and assess the quality of the service. The manager did not ensure records contained correct and accurate information in relation to the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. These are examples of a breach of Regulation 17 (1) (2) (b) (c) (d) (i) (ii) of the Health and Social Care Act 2008 (regulated activities) Regulations. Good Governance