Shawlmist Limited

The Hollies

Inspection report

11 St Catherines Road
Broxbourne
Hertfordshire
EN10 7LG

Tel: 01992445044

Date of inspection visit:
28 April 2016
09 May 2016

Date of publication:
21 June 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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The Hollies is registered to provide accommodation and personal care for up 27 older people some of whom live with dementia. At the time of our inspection 26 people were living at The Hollies.

The inspection took place on 28 April and 09 Mat 2016 and was unannounced.

The home had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. However the details for the Provider's registration at the time of the inspection were incorrect.

At this inspection we found that there were not always sufficient numbers of staff deployed to meet people`s needs at all times. Risks to people's health and well-being were identified and responded to positively. People's medicines were not stored safely and information was not always available for staff on how to manage people`s medicines safely. However the registered manager was reviewing and developing this area.
People told us they felt safe living at The Hollies, and this was confirmed by their relatives and health professionals. People were supported by staff who had undergone robust recruitment processes which ensured they were of sufficiently good character to provide care to people.

Staff told us they felt supported by the manager. However training had not always been provided in a manner that supported staff's understanding of how to provide care. People's nutritional needs were met and monitored where required. People were able to choose what they ate and staff responded to people`s changing dietary needs. People we spoke with told us they had access to a range of health professionals, and records demonstrated they were referred quickly when their needs changed. This was also confirmed by visiting professionals.

Staff spoke to people in a kind, patient and friendly way, seeking their consent prior to delivering care. Staff did not always ensure people's social needs were met and people did not always receive care at a time when they needed it.

People did not always receive high quality care that was well led. The local authority visited the service and required actions were taken in relation to areas such as MCA 2005, training and records. These had not been improved upon, and a service improvement plan had not been developed. The provider's registration details were incorrect and people's personal records were not always accurate or kept up to date. People's views about the quality of service they received had been sought and people felt the registered manager was open to discussion about the running of the home.

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.

There were not enough staff deployed to meet people's needs. Staffing levels were not monitored to ensure there were enough staff to meet people's changing needs.

People's medicines were not managed safely.

People felt safe and staff were aware of how to identify and respond to any suspicion of abuse or harm to a person.

Where risks were identified to people's health and well-being staff were aware of these needs and responded accordingly.

Is the service effective?

Requires Improvement

The service was not effective.

Staff felt supported by the management team, however training had not always been provided where required. Where training was provided it did not sufficiently inform staff of how to provide safe care.

Staff were observed to seek people's consent for day to day tasks, however where people lacked capacity staff did not act in accordance with the Mental Capacity Act 2005.

People's nutritional needs were met. There were sufficient choices of appropriate foods and drinks for people.

People were supported by a range of healthcare professionals.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's personal preferences or choices were not always met due to insufficient staff.

People told us they were treated with kindness and compassion by staff.

People and their relatives were involved in reviewing their care and felt listened to.

Is the service responsive?

Requires Improvement

The service was not always responsive.

For the majority of people care was provided in a task led manner, managed on a day to day basis, and not based on people's preferences.

People we spoke with told us they felt staff listened to them and their views about their care mattered.

People we spoke with were aware of how to raise any concerns they had.

Is the service well-led?

Requires Improvement

The service was not well led.

The registered manager had not developed an improvement plan to improve areas of concern identified by either their own internal audits, or those of the local authority.

People's records were not always accurately maintained.

The views and opinions of people on how the service was operated had been sought.

People felt the registered manager was open to discussion and had a welcoming approach.

The Hollies

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 28 April and 09 May 2016 and was unannounced. The inspection was carried out by one inspector.

We reviewed information we held about the service including statutory notifications that had been submitted. Statutory notifications include information about important events which the provider is required to send us.

During the inspection we observed staff support people who used the service, we spoke with four people who used the service and relatives of two people. We spoke with four staff members, the Registered Manager and Deputy Manager, the Provider and two visiting health professionals.

We also reviewed the findings of a service monitoring audit carried out by the local authority. We sought feedback from the social care professional who carried out this visit from the commissioning team. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed care records relating to four people who used the service and other documents central to people's health and well-being. These included staff training records, medication records and quality audits.

Requires Improvement

Is the service safe?

Our findings

There were not enough suitably skilled or qualified staff deployed to provide safe care for people. We observed that care was provided to people in a task orientated manner. Staff were seen to attend to people's care needs, such as supporting them with bathing, eating and getting dressed, however had little time for any impromptu care needs. Staff, people and a visiting health professional all agreed that there were not enough staff available to support people. One visiting health professional said, "One thing that needs to improve is the number of staff on so that they are not always working in chaos." A staff member told us, "It's not nice when we don't have time to spend with people, like some of them will cry and say they want to go home, but because we are busy with other things we can't sit with them and help them."

We looked at the response times for when people pressed their call bells. These showed that people waited for their calls to be answered from one to 18 minutes at times. Staffing levels were not monitored, assessed or reviewed to ensure there were enough staff available to meet people`s needs. The registered manager told us that the staffing levels had not changed for a number of years without being reviewed, increased or altered. They also told us that they had seen an increase over the years in the needs of people either living at The Hollies already, or those who were newly admitted. We asked them to show us how many care hours were required during the morning to deliver personal care to people. They were unable to tell us this, and were surprised when they began to look at the varying needs of people, and the number of hour's support each requires.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities)

People's medicines were not managed safely. Staff had not been provided with sufficient training to administer and manage medicines safely. The training provided to staff only covered the theory. Staff had no practical training before they were assessed as competent in administering people's` medicines. The competency assessment were carried out by the Deputy Manager, however we found that they were not trained to review and assess staff. We found numerous areas were medicines were not managed safely. For example, one senior staff member we spoke with told us they had no training for medicines administration but they shadowed another senior, they told us, "[The senior] showed me how to do the medicines the way they did it."

Both senior and care staff told us that even though they wore a tabard when administering people's medicines, instructing staff to not disturb them, they were frequently distracted and interrupted. Staff told us that this led to mistakes, such as not completing the medicines administration record (MAR). One staff member said, "Medicines are really frustrating, staff distract me and I am not surprised there are mistakes." We looked at the MAR records for six people which confirmed that mistakes had occurred. For example, one person had started a course of medicine, staff had administered the medicines but this was not recorded on the MAR records and staff had not signed to confirm it was administered. One person was given two medicines to manage their medical condition instead of the prescribed one tablet. Another person's night time sleeping tablet had been given by staff but MAR records were not signed to indicate they had their medicines. This meant that the person was at risk of harm because staff could have administered their

medicines again and unknowingly overdosing the person. Staff had documented and identified where there were gaps in the MAR records; however, little had been done to identify whether it had been given, why the record was not complete, or whether staff needed additional training.

We observed staff commenced administering people`s medicine for the morning after nine o'clock in the morning. Senior staff told us they were busy assisting the care staff on the floor providing personal care to people. At 09:45 in the morning 13 people out of the 21 were still waiting for their medicines. Breakfast had been served to people at this time, which meant medicines required to be given with or before food, such as antibiotics, were not given at the correct time. This meant that people had not received their medicines as intended by the prescriber.

When people refused their medicines for a variety of reasons staff had not recorded this, or the reason for refusal on the rear of the MAR chart. When medicines were tainted, for example one person spat there medicine out, and left it on the table before staff spotted this and gave it back to them, they were not destroyed, recorded as such and a new medicine given in its place. Handwritten entries onto MAR charts were not countersigned to minimise the risk of errors. For example one person's medicine had written on the box to take two tablets daily, however the handwritten entry noted one tablet. Boxes were not signed and dated when opened which meant it was difficult to reconcile medicines where there were anomalies in recording and remaining stocks. For example, of the six MAR records we checked two had errors in the stocks remaining where tablets were less than what was expected, suggesting that people did not receive their tablet when needed.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People, their relatives and health professionals told us that people were safe living at The Hollies. One person said, "I have lots of my friends here, and the staff are lovely and kind, I am very happy." One person's relative said, "I think the care people receive is what keeps them safe."

Staff we spoke with demonstrated to us their knowledge of keeping people safe and identifying signs of potential abuse. Staff were able to describe to us the actions they would take if they suspected someone was at risk of harm. One staff member said, "Marks, bruises, anything that isn't quite right I would report to the senior." One staff member was able to describe to us a time they had reported a bruise they found on a person when providing personal care, they were clear about the actions they took, and that the matter was reviewed. Incidents when they occurred were investigated and reported. We found that people sustained very few numbers of falls within the home. There were no serious injuries reported since the last inspection, which was further confirmed by the visiting health professionals.

Where staff identified risks to people`s health and well - being they ensured the concerns were reviewed and measures were put in place to mitigate the risks. For example, two people were observed during the inspection to be wearing pressure relieving boots to protect their skin from developing pressure ulcers. They had been provided with the appropriate profiling beds, and pressure mattresses, and staff were aware of the need to monitor, and report any changes in peoples` skin condition. Staff we spoke with were aware of each person's care needs and how to support these individually. For example, one person had their legs up on a stool; a second had their legs down rested on the floor. When we asked why this was, staff told us it was because the second person had arthritic knees and found it painful to raise them up. Where care records did not always accurately reflected the identified risks to people and how to manage these, we found that staff knowledge about the risks was sufficient to ensure risks were mitigated and people were safe.

Requires Improvement

Is the service effective?

Our findings

People told us they thought the staff were sufficiently trained to provide care that met their needs. One person told us, "They are wonderful and very confident in how they go about their jobs." A relative said, "I have worked in care so am hot on that and the carers are very good at what they do." A visiting health professional said, "They work as a team and are very effective at supporting people well."

New staff were required to complete an induction programme during which time they shadowed an experienced staff member until they had demonstrated they had the necessary skills and confidence to work unsupervised.

Staff we spoke with told us they felt supported by the management team and were able to discuss their performance or any issues relating to their work with them. One staff member said, "[Manager] is open and supports me whenever I need help or anything. I have my supervisions with my senior which is a good thing."

However, some staff felt that the training they were provided with was not robust or thorough enough to give them the knowledge and skills to deliver a high standard of care to people. They told us that for areas such as moving and handling or first aid the training was provided by an external trainer with practical assessments which they found very informative. We saw from training records that these areas were provided to those staff who required this training.

However staff said they completed work books at home on areas such as safeguarding adults, nutrition, dementia, falls management and medication administration. When we checked staff knowledge in areas such as safeguarding we found that although they although understood the basic procedures for reporting, they were not all confident in identifying abuse. Training for staff was either not completed in some key areas or had elapsed. For example, of the 36 staff employed only two had completed challenging behaviour training. This was the registered and deputy manager. Only one staff member had completed training in continence management. There were numerous gaps in the training record for staff in other areas. Staff said that they worked as a team and relied on each other's experience when delivering care to people. One staff member said, "I learn more from my colleagues that I do from the book training." This meant that staff were not provided with comprehensive, up to date training based upon safe and best practise, which increased the risk for people of not receiving appropriate care.

We spoke with the registered manager about the training. They told us, "I know training is an area I have fallen down on, but I am pleased that they [Staff] have said what they have about the training so I can look at other training providers."

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed throughout our inspection that staff were courteous and polite when seeking to assist people.

Staff took their time to explain to people how they wished to support them and waited on each occasion for people to agree. When going into people's rooms to provide care, staff knocked and waited for the person to respond. People were seen to ask staff to return later to assist them as they were not ready and staff willingly obliged.

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 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).

Decision for people who lacked capacity were not made in line with the MCA 2005. For example, where people used bed rails to keep them safe, staff had not followed the required process in assessing capacity and considering what was both in people`s best interest and least restrictive option. We asked the manager about the use of bed rails for one person who lacked capacity. They told us it was the staff's decision and that if they asked the person they, "Would have just told us to [Go away] so we used them without discussing it with [Person]." There were at the time of the inspection six people using bed rails, four of whom were considered to lack capacity to decide for themselves whether they needed bedrails. The registered manager told us that assessments had not been carried out for those that required them. A risk assessment and care plan was put in place to manage the bed rails safely, and staff were aware of the need to frequently check the person when in bed to keep them safe. This meant that although we found initially that the registered manager had not worked in line with the MCA 2005, they took action during the inspection to consider the least restrictive options and act in the person's best interests.

Where relatives had informed the home that they held Power of Attorney to make decisions in relation to financial or health matters for people, the registered manager had not verified this by ensuring they had seen a copy of the relevant documents. Where people lacked capacity, staff had taken the wishes of the families on board in relation to people's needs, however, had not considered if this was also in the person`s best interest. We saw that during the inspection the registered manager wrote to people's families asking them to provide copies of their power of attorney and also sought additional training in relation to MCA and DoLS.

However, as these areas were pointed out to the registered manager during the inspection, they had not ensured consent arrangements were in place for people who lacked capacity.

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

DoLS applications had been made in some circumstances, for example, where people were felt to be at risk of coming to harm when they left the home, the manager had sought authorisation to deprive them of their liberty. However, people then rarely left the confines of The Hollies unless accompanied by staff. We were told by one person that, "It's no good asking to go out, it's the rules, once you're here you only go out with family, that's all good for them but I don't see my family." This person was rarely supported to leave the home to visit shops, cafes or walk along the river. People were unable to freely access the communal garden area in the home as the door was kept locked and people had to request staff accompany them. A person repeatedly tried to open the back door setting the door alarm off. When we asked the registered manager why this was, and why they didn't have the door open they told us it was because the person had a DoLS in

place, and could not access the garden unsupervised in case they fell and hurt themselves. Staff had wrongly assumed that the DoLS authorisations gave them the rights to keep people indoors, and did not allow them into the garden alone for fear people would fall.

DoLS assessments were not in place for other areas such as the use of bed rails. Staff had not considered the least restrictive methods to use and had not applied for the authority to use these. We saw during the inspection that staff had reassessed people, particularly in relation to bed rails. We spoke with one staff member who told us how they had tried different options, such as lowering a person's bed and using a crash mat, prior to using the rails. They had completed the appropriate assessments and the registered manager was now in the process of submitting a DoLS application.

DoLS that were in place for people to ensure they did not leave the home alone, contained conditions such as ensuring people are able to leave the home periodically, or follow interests. However, where DoLS were in place for people, staff did not support them to leave the home for short periods, or freely access areas such as the garden. The authorisation of a DoLS, meant for some people without family, that they were not able to leave the home should they wish to, even if this meant a supported trip to the shops, or into the garden. People were controlled in a manner that was not proportionate to mitigate the risk of harm posed to them.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People we spoke with were positive about the food they were provided with. We observed staff offered people a choice of meals at lunchtime, and people were provided with ample drinks and a range of fresh fruit and snacks throughout the day. When meals were served to people that may be living with dementia, staff visually showed them an example of each meal on offer. This helped people make an informed choice about the meal they were selecting at the time it was given, considered to be an area of best practise. When people finished their meal, they were then asked if they had eaten sufficient and offered second helpings if wanted. We saw that the chef observed lunch and sought feedback on the quality of meals provided to people. One person said, "The dinners are lovely, all home cooked, fresh and tasty, and if I want something else then it's no bother to them to make me something."

People at risk of dehydration of malnutrition were monitored and weighed regularly. Staff were quick in referring people to the GP and dieticians, and the recommendations from these professionals were followed. We saw that if people had been prescribed supplements to aid weight gain staff ensured these were provided. A range of health professionals regularly visited the home; including two GP's and district nurses. One GP told us, "You cannot question the care here, people are well looked after by the staff who will inform us the minute there is anything of concern." A range of professionals supported people's varying needs, including physiotherapists, district nurses, consultants and tissue viability nurses. We observed the GP and senior carer discussing a referral to a physiotherapist for a person who required support with their mobility and also for a person to be supported with their nutritional needs.

Requires Improvement

Is the service caring?

Our findings

People told us they were treated with kindness and compassion by staff. One person told us, "I like the staff very much, they are exceptionally warm, friendly and tender with me." One person relative told us, "I always feel guilty that [Person] is in here, but I know she is getting the very best care." A visiting GP told us, "The care here is very good indeed; it is one of my favourite homes in the area."

Staff had developed positive relationships with people; we saw through our inspection that staff and people shared smiles, jokes and conversation. People looked to be comfortable and at ease with the staff which promoted a relaxed and comfortable atmosphere within the home. We observed throughout the inspection that staff spoke to people in a respectful and friendly manner.

When we arrived at The Hollies, those people who were up and dressed were presentable, well-groomed and dressed in clean clothing. When people ate their meals and required assistance because they may have spilled some of their food staff quickly ensured they were attended to. Staff were seen to constantly ensure people's privacy and dignity was maintained. For example, one person had spilled a drink over themselves. Staff spotted this quickly and discreetly took the person to their room to get cleaned up and changed. Later in the day, we saw one staff member sensitively remove a person from the lounge to assist them with personal care. They did this in a manner that did not alert others to their need and was very sensitively carried out.

People and their relatives had been fully involved in the planning and reviews of the care. However some families were consulted without the appropriate processes being followed. We saw one person's family telephone the home to check on how their relative was. They had been concerned that they were unwell. The staff member gave an overview of the person and how they had been and went to get the person so they could speak privately on the phone to discuss their needs. We were told by both relatives and people that staff would regularly keep them informed about their care needs with updates and feedback around appointments or their general well-being..

However in some cases we found that the care was not always centred on people's individual wishes and preferences. Staff we spoke with told us about one person who required longer to bath and dress in the mornings. They told us the person had to wait for staff to get everybody else ready before they could spend the time with this person due to lack of staff. The further told us that this person woke early and would like to be assisted earlier however this was not always possible. A second staff member said, "Some mornings there are a few to get up from the night shift, so that means we get behind and have to get them [people] up when we are ready."

We saw that people chose who to spend their time with, where to sit for lunch, what drinks they wanted to have and when. One person said, "Person] is my friend, I have lots of friends here I can spend time with, including the staff, but, there's no point asking about anything else, if you don't have family you can't go out it's just the rules." People were left for long periods without any interaction from staff, leaving them to look out of the window, falling asleep at the dining tables, or sit lethargically with little to do. We observed people

looked bored. This did not promote people's dignity or empower people to make choices about how they spent their day or developed relationships within the home. One staff member told us, "We do the best we can for them [people], it's not perfect at the minute and they don't all get the time they need, but the care we give them is good."

We were told by the GP that they were supporting staff to begin end of life discussions at an earlier stage with people, and their families. They said that staff would enquire with people sensitively whether they had considered areas such as do not resuscitate requests, and end of life arrangements. The GP was clear that this had positively prompted open discussions with families and people about their end of life arrangements, and meant that all parties were better informed and involved regarding these decisions. This was a recently introduced initiative; however, there were further improvements required for staff to develop their knowledge and understanding of supporting people to have a pain free and dignified death. Staff were not particularly aware or confident in supporting people to consider their end of life options for when they came, and were not aware of areas such as advanced care planning to assist with these decisions.

Requires Improvement

Is the service responsive?

Our findings

Activities were taking place in the communal lounge on the day of our inspection and people were encouraged to join in with an armchair exercise program. People who were joining in enjoyed themselves and were engaged, smiling and entertained. There were other communal activities that were provided throughout the week; however these were heavily reliant on the care staff, as the home did not specifically employ an activity worker. This meant it was largely dependent on the staffing numbers and fluctuating needs of people on a given day, whether there were any activities provided. We observed that between nine o'clock to eleven o'clock in the morning, people sat in the dining room, with little to do to occupy them, and little interactions from staff. One staff member said, "Sure, they are bored, but we are always busy so it's hard to do those little things. I would love to spend time doing their nails, listening to music or looking at their old photos, but those are the things we have to do without sometimes because we don't have the time."

One person told us how they had been able to celebrate the Queen's birthday, had been making a jacket for one of the staff member's baby, and was planning a party for their birthday. Another person had been planting flowers with staff support. However, for the majority of people living at The Hollies, their individual care was provided in a task led manner, managed on a day to day basis and did not support their individual social needs.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us they felt staff listened to them and their views about their care mattered. One person said, "We talk all the time about what's going on, and they listen to what we have to say." A visiting health professional said, "They tread a very fine line between trying to keep the relatives happy and also the residents, and they do it by listening to them and their wants and needs and trying where possible to deliver these."

Care plans we looked at relating to personal care matters and social activity were written in a person centred manner and contained information regarding likes and dislikes, activities, and daily living, for example people's preferences around areas such as washing, bathing, eating, drinking, sleeping, and mobility. The care plans when completed documented how the person wished to receive support for each of these identified areas.

People and relatives we spoke with told us that the staff involved them with developing a plan of support that addressed and managed their needs positively. For example one person living with complex needs told us how they had recently reviewed their changing care needs with their relatives, the GP and staff from The Hollies, including the registered manager. This person told us they were happy with how staff had supported them and felt that their views and opinions and those of their relative had been listened and responded to.

People we spoke with were aware of how to raise a complaint and were provided with the provider's policy

in doing so should they wished to. People's relatives knew who to contact if they had any concerns and we witnessed one person's family raise concerns about their relatives care. The registered manager dealt with each complaint they received appropriately and ensured they communicated to people the outcome of their complaint. One person told us, "[Manager and Deputy Manager] are always around and are here in case I wanted to complain, and I know they would take it seriously." A relative told us, "If I wanted to I know I could go to [Manager] but I have not needed to."

Requires Improvement

Is the service well-led?

Our findings

There was not a robust or effective system in place to assess, monitor and review the quality of the service provided.

The local authority had carried out a monitoring visit in 2014 to look at the quality of services provided at The Hollies. During this visit they set a number of actions relating to completion of mental capacity assessments and DoLS applications. They also required that staff training was brought up to date and actions plans were developed with deadlines for auditing and completion of areas for improvement. At this inspection we found that MCA and DoLS applications continued to be incomplete, that staff training had not been updated, and that actions were not addressed specifically when issues were identified.

The Registered Manager told us they did not have a service improvement or action plan that brought together all the areas in the home that required improvement. They had no management plan they could review and monitor with the provider to measure and monitor improvement to the quality of the service provided. For example in January 2016 they identified through an audit of infection control practises that staff required updating with regard to managing infection control. In March 2016, 15 staff still required this training. When we carried out this inspection we found that 14 staff members training was still outstanding. We asked the registered manager to show us how many care hours were required during the morning to deliver personal care to people. They were unable to tell us this as they had not reviewed regularly people's dependency needs and were surprised when they began to look at the varying needs of people, and the number of hour's support each requires.
The last care plan audit was completed in February 2016, and the management team did not review incidents or accidents, slips, trips or falls to understand themes or trends of the falls. We saw when audits of medicines were carried out; the same patterns were identified, however no actions were taken to improve practice. We found one the first day of our inspection, errors in recording whether medicines were administered had continued on the second day with little improvement or sufficient action to address the issues. In both examples, where medicines recording errors were identified, comprehensive actions, investigations and remedies had not been implemented to address the concerns.

However during the inspection, the registered manager implemented a system of analysing call bell response times. They were able to investigate why call bells went unanswered for such a long period of time, however had not at that time made any improvements to the staffing deployment to mitigate the risks of people not receiving care when needed.

The registered manager had responded to the training concerns by contacting a local training provider and organising a meeting to discuss the concerns and implement a modified training package.

This demonstrated to us, that although the provider and registered manager had sought to identify the concerns, they had not ensured there was a robust and systematic method of reviewing, assessing and responding to concerns which affected the quality of service provided to people.

We reviewed people's care records and found that these were generally well written and comprehensive. Daily records of care such as food and fluid records, repositioning charts were completed when care was carried out. However, we also found that assessment tools were not calculated correctly giving a misleading calculation of the identified risk. For example one person's nutritional assessment had been calculated incorrectly and when rechecked provided a higher risk of weight loss. There were anomalies in other records also. However, the care provided to people met their needs; the record of care required was not accurate.

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

We have reported our findings to the Local Authorities Commissioning Team for further monitoring and review.

The registered manager had sought the views of people who used the service. We saw the results of the recent survey carried out, which demonstrated people felt the service they received was of high quality. The registered manager had yet to collate the results and review ways in which they could further improve the service, however, they had sought to seek people's views.

People, relatives, staff and health professionals told us that the registered manager was approachable and willing to listen to their views about the running of the home. They said that they felt comfortable in approaching the manager who had an, "Open door policy and was always in the home if we want to talk." The registered manager held frequent meetings with staff, and informally collated feedback from people and their relatives.

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 9 HSCA RA Regulations 2014 Person-centred care Regulation 9 (1) (2) (3) (b) People were not always supported to maintain their independence through being provided with a range of activity that met their needs and individual preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Regulation 11 The registered person had not always acted in line with the requirements of the MCA 2005 when dealing with matters of consent and best interest decisions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 (1) (2) (g) People's medicines were not managed safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment

	Regulation 13 (1) (2) (3) (4) (b) People were controlled in a manner that was not proportionate to mitigate the risk of harm posed to them.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 (1) (2) (a) (b) (c) There was not a robust system in place to assess, monitor and improve the quality and safety of the services people received an to mitigate any risks identified through these processes. An accurate record was not maintained of the care and support people required.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 (1) (2) (a) There were not sufficient numbers of staff deployed to support peoples needs when they required this. Staff had not received appropriate training and development. Staff were not afforded the opportunity to obtain further qualifications relevant to their role.