

Ashville Care Limited

# Ashville Care Home

## Inspection report

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## Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?	<b>Requires Improvement</b> ●
Is the service effective?	<b>Good</b> ●
Is the service caring?	<b>Good</b> ●
Is the service responsive?	<b>Requires Improvement</b> ●
Is the service well-led?	<b>Requires Improvement</b> ●

# Summary of findings

## Overall summary

This inspection took place on 12 April 2016 and was unannounced. At the last inspection on 7, 8 and 13 May 2014 we found the service was meeting the regulations we looked at.

Ashville Care Home provides personal care for up to 29 older people, some of who are living with dementia. There were 25 people using the service when we visited. Accommodation is provided on two floors with lift access between each floor. There are four communal areas on the ground floor which includes a large dining area.

The home has a registered manager. 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.

Although no concerns were raised with us about staffing levels, we concluded there were not always enough staff to meet people's needs as there were only three care staff on duty during the day and two at night for 25 people. There were ancillary staff, an activity co-ordinator, an administrator and managers on duty at times in addition to these numbers. However, there was no system in place to calculate safe staffing levels or evidence to show that people's dependencies and the layout of the building had been considered when determining staff numbers.

Overall we found the systems in place for managing medicines were safe, although some of the records required improvement.

Staff had a good understanding of safeguarding and knew the procedures to follow if abuse had occurred or was alleged. We saw safeguarding incidents had been dealt with appropriately.

Risks to people were not always well managed. For example, we found where incidents such as falls had occurred there was a lack of information to show what action had been taken to prevent a re-occurrence. There was also a lack of environmental risk assessments. For example, free standing heaters which were hot to touch had not been risk assessed, although immediate action was taken when we brought this to the registered manager's attention.

The building was generally clean and well maintained. However, there were some issues relating to beds not being properly made and stained bed linen which had not been identified until we raised them. However, the deputy manager told us daily checks of rooms were being introduced to address this issue.

The home was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS) and acting within the legal framework of the Mental Capacity Act (MCA). People were cared for by staff who received the induction, training and support they needed to fulfil their roles and meet people's needs.

People enjoyed the food and were offered a choice with drinks and snacks available and provided at any time. People had access to healthcare services and had input from professionals such as community nurses, GPs and dieticians. Complaints were managed and dealt with appropriately.

People and relatives praised the staff for their kindness and caring attitude. People were comfortable and relaxed around staff and we saw people laughing with them. We saw people enjoyed walking freely around the different communal areas on the ground floor. People's privacy and dignity was respected and maintained.

People and relatives expressed satisfaction with the care provided. Yet we found improvements were needed to ensure the care documentation was person-centred and reflected people's needs and preferences.

People, relatives and staff spoke highly of the registered manager and had confidence in them. Some of the systems and processes which audited the quality of care provided needed improvement. For example, there was no staffing tool, medicine audits had not identified the issues we discovered and there were no systems in place to audit the care records. Improvements were also required in documentation such as risk assessments, care plans and medicines recording.

We identified three breaches 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?

**Requires Improvement** ●

The service was not always safe.

Overall medicines were managed safely, however documentation needed to be more robust to provide clear evidence medicines were managed appropriately.

Safeguarding procedures were in place which were understood and followed by staff.

Recruitment processes ensured staff were suitable to work with people who used the service.

There were not always sufficient staff deployed to meet people's needs. Risk management needed to improve to ensure people were kept safe at all times.

The home was generally clean and well maintained. Although we found beds not made properly and stained bedding in a small number of rooms.

### Is the service effective?

**Good** ●

The service was effective.

Staff received the training and support they required to fulfil their roles and meet people's needs

The service was meeting the requirements of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

People's nutritional needs were met.

People's healthcare needs were assessed and staff supported people in accessing a range of health professionals which ensured people's needs were met.

### Is the service caring?

**Good** ●

The service was caring.

People and relatives told us staff were kind, caring and

considerate and this was confirmed through our observations.

People's privacy and dignity was respected and maintained by staff.

People's views were listened to and acted upon

### **Is the service responsive?**

The service was not always responsive.

Although we saw care plans were in place these lacked specific detail about people's individual needs and preferences which put people at risk of not receiving the care they required in the way they preferred.

A activities programme was in place tailored to meet the needs of people living with dementia. We saw people enjoying activities on the day of the inspection.

A system was in place to record, investigate and respond to complaints.

**Requires Improvement** 

### **Is the service well-led?**

The service was not always well led.

Improvements were required to documentation before we could conclude the service was well led.

Systems were in place to assess, monitor and improve the quality of the service, although these needed to be more robust to ensure service improvement.

People, relatives and staff provided positive feedback about the way the service was run and said they felt able to go to the registered manager for support.

**Requires Improvement** 

# Ashville 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 12 April 2016 and was unannounced. The inspection was carried out by two inspectors and an expert by experience with expertise in older people living with dementia. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the home. This included looking at information we had received about the service and statutory notifications we had received from the home. We also contacted the local authority commissioning and safeguarding teams.

Before the inspection, 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 this information before the inspection.

We spoke with ten people who were living in the home, four relatives/friends, four care staff, an activity coordinator, the chef, the deputy manager and the registered manager.

We looked at four people's care records, three staff files, medicine records and the training matrix as well as records relating to the management of the service. We looked round the building and saw people's bedrooms and communal areas.

# Is the service safe?

## Our findings

Although staff we spoke with said there were enough staff working in the home, we concluded there were insufficient numbers of staff deployed to meet people's needs at all times.

The service provides specialist care for people living with dementia over two floors. Staff advised there were four people who were nursed in bed and we saw other people moved freely between the four different communal areas on the ground floor. We observed times when both individuals and groups of people were left alone in the communal areas. There was one occasion when a person was becoming increasingly distressed and we sought out a staff member who came and calmed the situation, using distraction techniques. At lunchtime we saw some people in the dining room had to wait for their meals and assistance from staff who were busy helping people in their rooms and other communal areas. For a period of over an hour after lunch, most care staff were engaged in some form of administrative activity and it was the administrator who took on the role of overseeing people, subsequently assisted by the activities co-ordinator.

The registered manager told us the usual staffing levels were one senior care worker and two care staff on duty throughout the day and two senior care staff on duty at night for 25 people. Although there were additional ancillary staff, an activity organiser, an administrator and the registered manager at certain times of the day, this meant if two care staff were required to support one person during the day it meant there was only one care staff member available for other people. At night there would be no care staff available to other people if one person required two staff. When we asked the registered manager how staffing levels were calculated they said they worked on a ratio of one care staff member to every ten people. They were unable to explain how these numbers had been determined and acknowledged there was no tool used to calculate safe staffing levels within the home. They said they were looking to increase the number of care staff in the evening to one senior care worker and three care staff. We considered the staffing levels were insufficient to meet people's needs and there was no evidence to show people's dependencies and the layout of the building had been taken into account to ensure staffing levels were safe. This was a breach of the Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found risk management processes needed to improve as following safety related incidents such as falls, there was insufficient information recorded to show how the provider was mitigating the risk of these incidents occurring again. For example, one person had fallen in the home and had to be taken to A&E. At the time of the incident, the person did not have an up-to-date falls risk assessment and following the incident care plans had not been updated informing staff on how to reduce the risk. We also saw risk assessments such as moving and handling were not always fully completed. For example, one person's assessment contained limited information on how to assist with the different methods of transfer. There was a lack of up-to-date nutritional risk assessments. For example, one person's assessment had not been updated following weight loss and information about whether they were a healthy weight, such as using a body-mass index calculation, was not present.

Personal evacuation plans were in place. However, these did not always contain accurate information. For

example, one plan stated a person had good mobility but staff confirmed they were now bedbound. There was a general lack of individualised information on evacuation plans to assist staff in the evacuation of people.

We also found a lack of environmental risk assessments. For example, one of the boilers was broken when we inspected which had affected the heating in some people's rooms. Free standing heaters had been supplied to ensure the rooms were kept warm, however we found these were hot to touch and there were no measures in place to ensure people were protected from this risk. Although this was addressed when we brought it to the deputy manager's attention, it had not been identified by the provider prior to our intervention. We also observed the access area to the upstairs office was not always secure. The office was accessed via a steep open flight of stairs with a gate at the bottom and sign reminding everyone to ensure the gate was secured at all times. We observed the gate was left open on several occasions and this is an area that is accessed by people who use the service. This was a breach of the Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Overall we found medicines were managed safely and people received their medicines when they needed them. However, there were some areas relating to documentation where improvements were required. We found there were safe systems in place for the storage of all medicines and the management of controlled medicines. We observed good administration practices and saw a senior staff member administering medicines to people which was done in a calm, caring and professional manner. People were given their medicines with a drink and supported to take them. People were asked if they required any pain relief. We saw the medication administration records (MAR) were signed after the staff member had seen the person take the medicines.

We found the MARs were generally well completed with stock balances recorded, although we saw some handwritten entries had not been signed by staff and there was no start date or stock balances recorded for these entries.

We looked at the records for two people who received their medicines covertly and found inconsistencies. For one person the documentation was well completed and a best interest decision making document showed the involvement of the GP and pharmacist and listed the medicines to be given covertly and how. However, the other person was prescribed a medicine to reduce distress which the medicine profile stated was to be given covertly. There was no information on the person's MAR about covert administration of this medicine. There was a best interest decision making document which had been signed by the GP, pharmacist and next of kin, however the record did not state what the decision was or how or which medicines to give covertly. We raised this with the registered manager who told us they would address this straightaway.

Some people were prescribed medicines to be given on an 'as required' (PRN) basis and we found there were not always protocols in place to guide staff as to when these medicines should be given. For example, where people were prescribed pain killers to be given 'as required' there was no information to guide staff about how to identify when people were in pain. We saw one person had a PRN protocol in place for a medicine prescribed to help reduce distress. However, this did not provide staff with specific guidance around when to give this medicine or what other measures should be tried to reduce agitation prior to giving the medicine. The senior staff member told us topical medicines creams and lotions were kept in people's rooms and applied by the senior care staff. Whilst we found no evidence people were not receiving their topical creams medicines as prescribed there was a lack of consistent evidence of this. There were no signatures on the MAR to show these creams had been applied and no protocols in place to show where and when the cream should administered. This was a breach of Regulation 17 (2) (c) of the Health and Social



Staff we spoke with had a very good understanding of safeguarding and how to identify and act on allegations of abuse. This provided assurance that any concerns would be appropriately dealt with. We saw the registered manager had taken appropriate action where safeguarding concerns had been identified, liaising with the local authority. Where people had displayed behaviours that challenge and had altercations with other people, the manager was able to clearly describe the action taken to keep people safe. However, this was not always reflected in care plans. For example, one person had an altercation with another person who used the service, but the care plan had not been updated to include this and their behavioural plan was generic with no personalised information.

Safe recruitment procedures were generally in place. We looked at three staff files. There was evidence of an application form, identity checks, disclosure and barring service checks and at least two references provided. Previous qualifications had been checked. We identified one person had a criminal conviction recorded, however the service had not clearly documented how they had determined this staff member was suitable to work with vulnerable people or undertaken a risk assessment. Staff we spoke with confirmed they had been subject to the required recruitment checks.

We looked round the building with the deputy manager. We found overall the building was well maintained and clean, although one room had a strong odour which the deputy manager told us was being addressed. However, we found a small number of bedrooms where beds had not been made properly and the bed linen was stained. The deputy manager took action to address these issues straightaway and told us they were in the process of putting in place daily room checks which would be completed by senior care staff to ensure every room was an acceptable standard. In three rooms the carpets were stained and the deputy manager told us they would arrange for these rooms to have the carpets shampooed. We saw a new assisted shower room had been created which the deputy manager told us people enjoyed using. They said the assisted bathroom was currently out of use as the bath was broken but this was in the process of being upgraded.

We looked at records of servicing and maintenance and saw regular checks and tests had been carried out as required. At the time of the inspection the registered manager was unable to locate the gas landlord safety certificate and the electrical installation certificate. However, following the inspection we received information from the registered manager which confirmed both of these had been completed and a new boiler had been installed.

# Is the service effective?

## Our findings

Staff were provided with regular training to support the development of skills and knowledge. New staff were required to complete the Care Certificate. The Care Certificate provides care workers with standardised training which meets national standards. Other long standing staff had also completed the Care Certificate to help ensure they also had the same skill and knowledge base.

New staff also received a local induction to the service which provided familiarisation with the service's policies and procedures and ways of working. Staff received regular training updates in subjects such as dementia, medication, safeguarding, infection control and manual handling. This was done face to face by an external training provider. We saw training was mostly up-to-date. Staff also received specialist training in subjects such as pressure area care undertaken by local health professionals. Competency checks or quizzes were periodically done to see if staff had learnt the required knowledge. For example, in 'how to put in a safeguarding alert'. We saw this was effective as staff we spoke with had a good understanding of how to put in a safeguarding alert. Staff we spoke with told us they had been given appropriate training to meet the needs of the people they were caring for.

Staff received periodic supervision and appraisal to help meet their developmental needs. These were slightly behind schedule but we saw a plan was in place to address. We also saw supervision records were very brief with a lack of information recorded on people's performance and developmental needs.

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). DoLS requires care homes to make applications to the local authority where they suspect they are depriving people of their liberty.

The registered manager had submitted DoLS applications for all of the people living at the home, as they had assessed that everyone lacked capacity to consent to their care and treatment and they suspected they may be depriving these people of their liberty. The registered manager demonstrated a good understanding of the safe application of DoLS which gave us assurance that the correct processes would continue to be followed.

The four DoLS authorisations we looked at were all managed appropriately, within date and action had been taken to reapply before the expiry date. One of these authorisations had conditions attached. We saw the service had taken action to ensure the condition was met. Care was delivered in the least restrictive way, with people encouraged to walk around the home to experience the different environments on offer.

Where people lacked capacity to make decisions we saw their capacity had been assessed and the best

interest process followed, demonstrating the service was working with the legal framework of the MCA. We saw examples of this around the provision of bed rails and the administration of covert medicines.

The service had signed up to the 'Telemedicines' system run by a local NHS Trust. This gave immediate access to video consultation from a qualified nurse when needed. Care plans provided evidence people had access to a range of health professionals including community nurses and GPs. We spoke with a community nurse who was visiting during our inspection. They told us they visited the service frequently and always found the staff were very good and knew people well. They said staff contacted them promptly and acted on advice they gave.

People were complimentary about the food and described it as 'good' and 'very nice'. We saw mealtimes were flexible with people coming into the dining room for breakfast throughout the morning and being offered a choice of cereals, toasts or a cooked option. One person said, "The breakfast is good." The chef was present in the dining room and promoted a happy atmosphere, greeting people as they came into the room and we saw people laughing and joking with them. Drinks and snacks were available and offered throughout the day.

We observed lunch and saw most people chose to eat communally in the dining room and were encouraged to manage their meals independently, although staff provided support where needed. The registered manager was present during lunch and told us they monitored what people ate to ensure people were getting sufficient food and drink. We saw arrangements had been made for one person to have lunch in the quiet lounge with their relatives who were having a meal with them. This offered them some privacy and the opportunity to interact privately.

We saw most people enjoyed their meals and ate well. One person said, "Lunch was lovely, I've cleared my plate." Another person said, "The food is plain but good, he's a right good cook, there's lots of variety." Relatives also made positive comments. One said, "The meal was nice, we both ate it all up, (my relative) will be happy with the food." Another relative said, "Mum's appetite is poor, but they help her."

Adaptions had been made to the building to assist people living with dementia, albeit the overall environment was tired and required modernisation. For example, a range of different environments had been created including a bus stop and sensory material was on display. People could walk a route around the downstairs without meeting a dead-end and we saw this route was enjoyed by several people during the inspection. We observed care and saw people appeared calm and happy in their surroundings. The manager told us they consulted National Institute of Health and Care Excellence (NICE) guidance on dementia as part of a strategy to provide effective dementia care. All staff had received training in dementia. Thought had gone into the provision of activities to help ensure they met the needs of people living with dementia. This included activities which stimulated the senses such as taste and touch.

## Is the service caring?

### Our findings

We asked people and their relatives if staff were kind and caring and the overall response was staff were kind, considerate, sensitive and approachable. People we spoke with praised the staff. One person said "I am happy here." Another person said, "They're always kind to me." A further person pointed to a staff member and said, "I like them. They're lovely."

Relatives were also complimentary. One relative said, "The care staff are very attentive, I'm pleased that mum is here." Another relative said, "Mum settled after a couple of weeks, the staff are very attentive, they help her with eating." A further relative said, "They look after them lovely here, they're very caring, there's always someone to give them a love and hug."

We saw staff were kind and treated people with dignity and respect. People looked clean, well dressed and well groomed. Staff were discreet and ensured any personal care was carried out in private.

Staff were attentive during mealtimes. For example, one person was not eating much of their meal and we saw they were gently encouraged by staff and an alternative was offered and when they refused this a dessert was brought for them.

We saw people were relaxed and comfortable around staff. Staff interacted positively with people sharing a laugh and a joke with them. For example, we saw care staff singing and dancing with one person who liked to dance within the living room. We saw staff took every opportunity to engage with people and provided reassurance and comfort. For example, we heard one person expressing concerns about where their relative was and a staff member reassured them explaining the relative would be coming in the afternoon and reminded them of the nice time they'd had when the relative had visited previously. We saw the person smiled and looked more relaxed.

Staff we spoke with said they enjoyed working in the home and we found there was a warm and friendly atmosphere. One staff member said, "I love my job. Going home knowing I've made someone smile, that's what it's all about."

Relatives were encouraged to visit and were able to visit when they wanted, the service discouraged this during mealtimes to help ensure people's mealtime experience was not disrupted.

The activities co-ordinator was in the process of creating detailed life histories of people who used the service to aid staff understanding of the people they were caring for. This process was currently about 50% complete. Staff and the management were able to give us examples of how they had learnt about people's histories to explain behaviours and routines of people who lived in the service. We concluded staff knew people well and how to ensure compassionate care.

## Is the service responsive?

### Our findings

People had care records in place which provided evidence their needs were assessed prior to admission. After admission, a range of care plans and risk assessments were put in place which were organised into general care files and a 'tough box' which contained summarised information which staff could quickly consult. However, the 'at a glance' care plans within the 'tough box' did not contain enough personalised information about people. For example, they failed to mention the key risks which people presented such as falls or behaviours that challenge.

A more detailed set of care records was also in place. However, these also contained a number of very generic care plans which lacked personalised information. For example, one person's 'lacking capacity care plan', 'dignity and respect plan' and 'personal cognitive care plan' contained no personalised information. Personalised plans of care for people living with dementia are essential to ensure they received appropriate care and support. People's care plans stated they had 'dementia' but there was no further information on the type of dementia that they had to assist staff in understanding their condition.

One person had recently suffered bereavement, but their care plans still made reference to their deceased relative. Although staff were fully aware of this and offered appropriate support, we concluded the service should have been more responsive in updating care records. One person was on end of life care. We saw a number of the person's care plans were not relevant following their deterioration in condition. For example, the 'at a glance' care plan said, "You have great mobility" when they were bed bound. We spoke with staff about this who said all care plans were now contained within the End of Life care plan. We looked at this, it provided some good information about the person's end of life arrangements but there was a lack of person centred information about other aspects of their care and support such as nutrition and mobility. However staff we spoke with understood people's needs well and how to deliver appropriate care. Although the documentation issues needed addressing, we identified these did not result in a significant impact on people who used the service. This was a breach of the Regulation 17 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Two people told us they enjoyed the activities. One person said, "The activities are very good." Another said, "The music man comes in sometimes."

An activities co-ordinator was employed who undertook a range of bespoke activities to help meet the needs of people living with dementia. This included group and individual activities. An activities schedule was organised which focused on people's sensory needs in areas such as taste, touch and smell. These provided stimulation for people but also helped ensure people took on extra calories. For example, we saw people partaking in an activity which involved dipping pink wafers into chocolate and then transferring into a bowl of hundreds and thousands before leaving to dry. These biscuits then formed part of people's afternoon tea.

A sensory apron had been made by the service for people to wear which provided a range of different

textures and materials to stimulate the senses. We saw people playing with the sensory material during the inspection and they looked happy

Each person had a personalised activity plan which provided evidence the service thought about people's individual needs. Staff we spoke with told us the activity provision had greatly improved since the co-ordinator was employed several months ago. Students also undertook frequent work experience placements at the service and this helped improve the capacity of the service to provide person centred activities.

Complaints were appropriately managed. A system was in place to record and respond to people's complaints about the service and steps had been taken to bring the complaints system to the attention of people who used the service. We saw four complaints had been received within the last 12 months. These had been responded to promptly by the registered manager and action taken to prevent a re-occurrence. We also saw there had been some positive feedback following complaints investigations. For example, one person had stated, "Thanks for investigating this and responding so promptly."

## Is the service well-led?

### Our findings

Overall we found the quality assurance systems and records relating to people who used the service required improvement. There were systems in place to assess and monitor the service but some of these needed to be more robust. Audits were undertaken in areas such as the environment and infection control. We saw regular medication audits which showed no issues had been identified in recent months. However, our examination of the medicines management system found a number of issues that needed to be addressed. There were no care plan audits and we found a number of discrepancies with the quality and content of care plan documents. The service was not fully assessing and monitoring whether people were of healthy weight as when weighing people it was not calculated whether people were a healthy weight for their height. One person had a nutritional risk assessment dated September 2014 which had been reviewed in September 2015 which stated they were a 'good weight'. However, they had recently dropped from 58kg to 55kg and it was unclear how this conclusion had been reached without working-out the body mass index. The care plan also said the person was to be weighed weekly when they were actually being weighed monthly. We also found environmental issues we identified during our tour of the building had not been identified through the home's checks.

The registered manager told us there were seven authorised deprivation of liberty safeguards (DoLS) authorisations in place, however there was no overall system to monitor the number of DoLS authorisations in place, the conditions attached and when they would expire with paperwork poorly organised. This meant there was a risk that DoLS would expire without the service being aware. It had also resulted in staff and the registered manager not being clear about who had an authorised DoLS in place. This lack of organisation also resulted in the registered manager being unable to provide us with a copy of a recently expired DoLS authorisation for one person to check its appropriateness and any conditions attached.

We looked at one person's care file and saw a Do Not Resuscitate order was in place. There was no indication on the form whether this decision was to be reviewed or whether it was valid for the rest of the person's life. The only person consulted as part of the process was the registered manager and there was no involvement of the person's relative or advocate. We were concerned this was not queried by the registered manager with the relevant health professional, although they stated they would do this when we brought it to their attention.

Some analysis was undertaken on incidents and accidents. For example, incidents up to December 2015 had been fully analysed with clear preventative measures documented. However, this analysis was not up-to-date and did not provide assurance that risks were being appropriately controlled. For example, the analysis for February and March 2016 was incomplete. As a result there was no evidence of action taken to address any of the incidents such as falls which had occurred within the service recently. This was a breach of the Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home had a registered manager. Staff told us they felt well supported by the registered manager. They said they felt able to go the registered manager with any problems and they were confident they would be resolved. One staff member said, "The manager is a 100% supportive. Anything I've raised has been acted

on."

The registered manager demonstrated they had a clear plan to continuously improve the service. For example, plans were in place to introduce champions in areas such as dignity, pressure area care, continence and safeguarding. These staff would promote and monitor the performance of the home in these areas. This had been included in the Provider Information Return completed by the registered manager prior to the inspection which gave detailed information of other improvements that were planned for the service.

Staff we spoke with told us the home had recently changed for the better and particularly praised the increased range of activities now available. Staff told us they thought communication between staff was good and ideas they put forward to management were listened to. When we asked one staff member if there was anything they thought could be improved in the service they said, "No need. We already talk about this and (the manager) takes on board what we say." Staff we spoke with told us they would be happy for their relative to be cared for in the home.

Although we had received other notifications from the service, the registered manager had failed to notify us of Deprivation of Liberty Safeguards (DoLS) authorisations and also the broken boiler which had been out of action for four days when we visited. We discussed this with the registered manager who said they had been unaware of the requirement for these types of notifications but would ensure it was done without delay in the future.

Periodic staff meetings were held where quality issues were discussed to help address any risks with staff.

People's views were sought. Most of this was done on an informal basis with the registered manager being 'hands on' and in constant contact with people who used the service. Periodic questionnaires were undertaken to ask people and their relatives for their views on the quality of the service. We looked at the results from the 2015 survey which were mostly very positive indicating people were happy with the service.



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 12 HSCA RA Regulations 2014 Safe care and treatment  Service users were not provided with care and treatment in a safe way in relation to assessing the risks to the health and safety of service users of receiving the care or treatment and doing all that is reasonably practicable to mitigate any such risks. Regulation 12 (2) (a) (b)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance  Systems and processes were not established or operated effectively to assess, monitor and improve the quality of the services provided or to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others. An accurate, complete and contemporaneous record of care and treatment was not maintained for each service user. Regulation 17 (1) (2) (a) (b) (c)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing  Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed to meet people's needs. Regulation 18 (1).

