City of Bradford Metropolitan District Council

Norman Lodge

Inspection report

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Date of inspection visit:
31 August 2016

Date of publication:
05 October 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 31 August 2016 and was unannounced.

At the last inspection in April 2014 we found the provider was meeting the regulations we assessed.

Norman Lodge provides accommodation and personal care for up to 35 people. Accommodation is provided in four units at ground floor level and each unit has a lounge, dining and kitchen area. Norman Lodge offers a mixture of placements which includes permanent places, rehabilitation, assessment and respite care. There were 29 people using the service when we visited. This included nine people who lived there permanently, two people receiving respite care, 15 people in for assessment and three people for rehabilitation.

The home has a registered manager who registered with the Commission in May 2010. 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.

We found the systems in place to manage medicines were not always safe, which meant people did not always receive their medicines as prescribed.

People told us they felt safe. Safeguarding incidents were recognised and action was taken to keep people safe. Incidents were reported appropriately to the Local Authority safeguarding team and notified to the Care Quality Commission.

Risks to people were generally managed well although this was not always reflected in people's care records which could lead to inconsistencies in staff practices.

People gave mixed feedback about staffing levels as some felt there were not enough staff while others said there were. During the inspection we found there were sufficient staff to meet people's needs. Safe recruitment procedures were followed which made sure checks had been completed before new staff started work.

The environment was clean and well maintained. The décor was bright, cheerful and comfortable following extensive refurbishment throughout the home.

People and relatives praised the staff and the care they received. There was a relaxed and friendly atmosphere in the home and we saw staff took every opportunity to engage with people. People told us they were treated with respect and this was confirmed in our observations.

People told us they enjoyed the food. We saw mealtimes were a pleasant and sociable occasion with people being offered a choice of meals and drinks. Staff provided people with assistance where needed.

A wide range of activities were available although the provision of these varied on each unit. Some people said they felt this was an area that could be improved.

Staff told us they received the training they required, however the training matrix showed significant gaps where some staff had not received regular updates. Systems were in place to ensure staff received regular supervision and appraisals.

The home was not meeting the requirements of the Deprivation of Liberty Safeguards (DoLS) and acting within the legal framework of the Mental Capacity Act (MCA). Restrictions in place suggested some people who lacked capacity may be being deprived of their liberty, yet no assessment had been carried out or applications made for DoLS authorisations.

People were aware of how to make a complaint and we saw complaints received had been dealt with appropriately.

People received the care they needed however the care records did not reflect people's need accurately. We saw people had access to healthcare professionals such as GPs and district nurses.

We found the home was well organised and the registered manager was open and transparent. However, the effectiveness of some of the quality assurance systems needed to improve which is evident from the breaches we found at this inspection.

We identified four breaches in regulations – regulation 18 (staffing), regulation 12 (safe care and treatment), regulation 11 (consent) and regulation 17 (good governance). 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.

Medicines management was not consistently safe, which placed people at risk of not receiving their medicines when they needed them.

People gave mixed feedback about the staffing levels and there was no system in place to show how safe staffing levels had been determined. Safe staff recruitment processes ensured new staff were suitable to work in the care service.

Risks to people's health, safety and welfare were not always managed safely by staff or recorded accurately.. Safeguarding incidents were recognised, dealt with and reported appropriately.

Effective systems were in place to keep the premises clean, secure and well maintained.

Is the service effective?

Requires Improvement

The service was not always effective.

Not all staff had received the up to date training they required to fulfil their roles and meet people's needs

The service was not 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 people had access to a range of health professionals.

Is the service caring?

Good

The service was caring.

People and relatives told us staff were kind and caring and this was confirmed through our observations.

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

Is the service responsive?

Requires Improvement

The service was not always responsive.

Although staff were aware of individual needs, care records did not reflect people's current needs or detail the support they required from staff.

Activities were provided although this was not consistent throughout the home.

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

Is the service well-led?

Requires Improvement

The service was not always well-led.

Systems to assess, monitor and improve the quality of the service were not always effective. However, the registered manager took prompt action to address the areas of concern raised during the inspection.

There was an open and inclusive culture led by the management team who were willing and committed to make improvements where needed.

Norman Lodge

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 31 August 2016 and was unannounced. The inspection was carried out by two inspectors and an Expert by Experience with experience of services for older people. 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.

We asked the provider to complete 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. The registered provider returned the PIR and we took this into account when we made judgements in this report.

We spoke with nine people who were using the service, two visitors, two senior care workers, three care workers, the cook, the assistant manager, the deputy manager and the registered manager. We also spoke with a visiting healthcare professional.

We looked at four people's care records in depth and one other person's for specific information, two 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.

Requires Improvement

Is the service safe?

Our findings

We found systems and processes in place to manage medicines were not always safe or effective. We looked at the medicines with two senior staff members who told us no one received their medicines covertly.

Medicines were stored safely and securely. Temperatures of the medicines fridge were monitored daily and were within the recommended safety range. However, the room temperature of the clinical room where medicines were stored was not monitored, although the senior staff member told us they would address this straightaway.

We looked at a sample of medicine administration records (MAR) on two units. Generally these records were well completed, however we found some anomalies which had not been identified or resolved through the provider's internal audit processes. For example, one person was prescribed an anti-coagulant (a medicine to thin the blood) and the dose of this medicine varied according to the day of the week. There were clear instructions on the MAR to show the dosage to be given each day. However, the MAR showed the person had been given the wrong dose on two consecutive days. There was no record on the MAR or in the person's care records to explain why this had occurred. We discussed this with the registered manager who was unaware of this error. They took appropriate action when we brought this to their attention, however we were concerned this had not been identified prior to our intervention.

Another person's MAR showed they were prescribed an analgesic to be administered three times a day. The MAR recorded this medicine had not been given on eight occasions over the previous four days as it was either 'not required' or the person was 'sleeping'. There was no record to show why this medicine was not required and senior staff we spoke with were not able to provide an explanation. When we brought this to the attention of the registered manager they spoke with the person who said they had refused the medicine and explained why they did not want to take it. The registered manager told us they would discuss this with the person's GP.

We found one person had not received a medicine prescribed to treat Parkinson's Disease for three days as the medicine supply had run out. The registered manager told us this was due to a mix up with the pharmacy who had delivered the medicine to the person's previous address and they were unable to obtain further supplies over the bank holiday period. This person's supply of a prescribed painkiller had also run out the day before the inspection although staff confirmed it was due to be delivered on the day of our inspection. This meant there were not effective systems in place to ensure people had sufficient supplies of their prescribed medicines.

We found protocols were not in place to guide staff as to when and how often to administer 'as required' medicines. Although staff recorded the number of tablets administered when the dose was variable they did not record the actual time of administration which meant we could not be assured there was a sufficient gap between doses.

We looked at the MARs maintained for topical medicines such as creams. These were hand-written and contained insufficient information on how often and where to apply the cream. There were also numerous gaps on these charts and inconsistent use of codes making it difficult to establish the support provided by staff. This was a breach of Regulation 12 (g) of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations.

We observed senior staff administering medicines and they were patient and kind with each person giving them support where needed and stayed with them until the medicines had been taken. We checked the stock balances of two boxed medicines and found they tallied with the amounts recorded on the MAR.

Some prescription medicines contain drugs that are controlled under the Misuse of Drugs legislation. These medicines are called controlled drugs (CD). We found these medicines were kept securely and records were completed correctly. We checked the stock balance of one person's CD which was correct.

Staff we spoke with aware of this risks people presented and had a good understanding of how to keep them safe. Risk assessments were in place which considered the risks associated with people's care and support. These covered areas such as manual handling, skin integrity and nutrition. However, some assessments needed updating or modifying to ensure they reflected people's care and support needs. For example, one person's manual handling risk assessment said they were "independent with transfers" despite us confirming through speaking with staff, observing care and reviewing their mobility care plan that they now needed staff for all transfers. This person had also experienced a high level of falls within July and August 2016. Although a pressure mat had been put in place to alert staff to their movements, this was not stated within their risk assessment/care plan and there was no acknowledgement within their care plan of the high number of recent falls or details of the falls prevention strategy in place. We also found one person had bed rails in place however there was no risk assessment in place detailing how they were to be safely used.

We saw one of the care staff and one of the domestic staff assisting a person to the dining table. The person's mobility was impaired and they were struggling to stand. No handling aids were used and we saw staff were holding the person up by pulling them upwards under their arms. When the person was in the chair staff lifted them back using a 'drag lift'. This unsafe handling practice placed both the staff and person being lifted at risk of injury. We looked at this person's care records and found there was no clear guidance for staff as to what equipment should be used to move this person safely. We raised this matter with the registered manager who told us they would investigate this matter. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations.

People we spoke with told us they felt safe in the home and relatives also expressed this view. However, two people told us other people who lived in the home had entered their rooms during the night, one of these people said they had reported this to the staff. Another person told us, "People wander about at night and often knock on doors and shout out, but I know they can't help it." A relative told us their family member found the home was noisy in the evenings. We passed these concerns on to the registered manager who told us they would address these issues.

When we asked people and relatives about the staffing levels in the home we received a mixed response. While some people felt there were enough staff, others expressed concerns. One person said, "Not really [enough staff], they are overstretched and the girls have a lot on." Another person said, "The staff are under pressure and overworked." A further person said, "Odd times I notice a shortage, mainly at meal times, but if I pull my cord they are not long in coming." Another person said, "Enough staff? Yes I'd say so."

One relative told us, "Sometimes there are enough but not always and they are sometimes late responding to calls", whilst another relative said, "There are adequate numbers [of staff] and they are always very polite and friendly."

Staff we spoke with told us there were enough staff on at all times to ensure people's needs were met. During our inspection we observed staff were present in communal areas and people needs were attended to in a timely manner. The registered manager told us staffing levels were kept under review and increased according to people's dependencies. However, they were unable to explain how the staffing levels had been determined and acknowledged there was no tool in place to assess people's dependencies or calculate safe staffing levels.

Safe recruitment procedures were in place. We looked at two staff files. We saw checks had been completed which included two written references and a criminal record check through the Disclosure and Barring Service (DBS). Any gaps in employment were checked. Interview notes were recorded and when all documentation had been reviewed a decision was made about employment. This meant staff were suitably checked and should be safe to work in the care service.

The manager and staff we spoke with had a good understanding of safeguarding and how to identify and act on allegations of abuse. This provided us with assurance that action would be taken to keep people safe. We reviewed past safeguarding incidents and found they had been correctly reported to the Adult Protection Unit and the Care Quality Commission. The registered manager described to us the action taken to keep people safe following these incidents. This included ensuring staff received additional training and risk management plans had been put in place.

Personal Emergency Evacuation Plans (PEEP) were in place for each person who used the service. These were clearly displayed on people's bedroom doors and also within their care plans. However, these were not kept centrally in one location, which would be of benefit should people need to be promptly evacuated. We raised this with the registered manager who agreed to put these in place.

The premises was safely maintained and appropriate for its use. The home had been recently refurbished to a high standard and we found it was kept in a safe state of repair. Regular maintenance and checks were undertaken on the building. This included checks and maintenance of the fire, water, electrical and gas systems and of any lifting equipment. Risk assessments were in place which assessed the hazards in the building and ensured measures were in place to keep people safe.

We saw the food standards agency had inspected the kitchen and had awarded them five stars for hygiene. This is the highest rating which can be awarded and meant food was being prepared and stored safely and hygienically. We found the home to be clean and hygienic with no offensive odours.

Requires Improvement

Is the service effective?

Our findings

The 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 so that they can 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.

The registered manager told us nobody at the home was subject to a DoLS authorisation and no applications had been made for any of the people currently living in the home. Our assessment of people's care and support led us to believe some people in the home were being deprived of their liberty without authorisation. Some people lacked capacity to consent to their care and treatment and the accumulation of restrictions such as locked doors, sensor mats and continuous supervision and control over their lives meant it was likely they were being deprived of their liberty.

The registered manager had not undertaken an assessment of the restrictions placed on people to determine whether DoLS applications should be made. They told us they had only previously made applications where people had expressed an active desire to leave the home, which is inconsistent with the legal framework and recent case law on DoLS. We asked the registered manager to ensure an assessment of the restrictions placed on people was undertaken and, where appropriate, to make DoLS applications. We concluded the service was not working within the principles of the MCA. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations.

We saw staff encouraged people to make choices in relation to their daily lives such as what they wanted to do and what they wanted to eat. People's ability to make decisions was described within care plans to help staff support these people appropriately. In some cases people's capacity had been assessed and where they lacked capacity we saw evidence best interest decisions had been made and embedded into care plans. However, one person had bed rails in situ, but there was no evidence their capacity to consent to this equipment had been assessed.

Where people lacked capacity but had no relatives we saw the service had supported people to access Independent Mental Capacity Advocates (IMCA) to help ensure their rights were protected.

Staff told us they received the training they needed to meet people's needs. However, when we reviewed the staff training matrix we found gaps where there were no training dates for some staff and other entries which showed staff had not received updates for some considerable time. For example, six of the 52 staff listed had no dates listed for fire training, the last training date for one staff member was 2011, ten others were 2012 and four more were 2013. We spoke with one staff member who told us they worked between 21 and 35

hours a week in the home on a casual basis. They told us they had received first aid and moving and handling training in the last 12 months which was confirmed by the training matrix. However, they could not remember when they had last received safeguarding training and the training matrix showed they had received this training in 2007. Food hygiene, infection control, health and safety and fire training dates for this staff member showed no updates in the past four years. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations.

People told us they felt staff had the skills and knowledge to meet their needs. One person said, "I think they are marvellous and pretty good at understanding my individual needs." We found the low turnover of staff and stable staff team contributed to staff to being able to build up their skills and knowledge.

One recently recruited staff member described the induction they had received which was tailored to their specific role. They said their induction had included a four week period shadowing a more experienced staff member and they felt this had prepared them well for their role. We saw evidence of staff induction in the staff files we reviewed.

Staff told us they received regular supervision and annual appraisals and this was evidenced in the staff files we reviewed.

People made the following comments about the food. "The food is marvellous and there is plenty of it and we are always asked if we want seconds." "The food is ok but it is spoilt sometimes as it is not hot, more or less every day, but today was not too bad and the pudding was lovely." "There is a good choice of food and I have not had a bad meal yet, but I would prefer a sandwich for lunch and a meal at night, but it is geared towards the elderly." "The food is brilliant, plenty of it and you can always have more."

We observed the lunchtime meal and found a relaxed and inclusive atmosphere with people supported appropriately. Tables were set with condiments and napkins and people had access to hot and cold drinks. People were offered a choice of meals including the number and type of vegetables. Where people needed assistance this was provided by staff in a kind and patient manner. Everyone was asked if they had had enough and seconds were offered. Individual requirements were catered for as one person did not want apple pie and asked for ice cream with their custard and staff provided this. Similarly another person only wanted cereal for lunch and staff respected this choice.

Two cooks were employed by the service, which ensured one was available each day of the week. At breakfast time people had choice of eggs, toasts and cereals provided by care staff. They could request a cooked breakfast from the kitchen which was prepared by the cook. At lunchtime people had the choice of two main options. We looked at the menu and saw there was a varied choice of meals provided over the four week cycle. At teatime people had access to lighter options such as sandwiches and jacket potatoes. A system was in place to inform the kitchen of any special requirements such as people who did not eat beef, diabetics and soft or blended diets.

Care records showed people's healthcare needs and any medical conditions had been assessed. They provided evidence that people had access to a range of health professionals including district nurses, chiropodists and GPs. Their advice was recorded within care records to help staff provide appropriate care. We spoke with a visiting healthcare professional during the inspection. They told us they visited the home most days and found the service was well organised. They felt communication was good and said staff reported any issues promptly and appropriately and acted upon advice given.

Good

Is the service caring?

Our findings

People told us they were cared for well and praised the staff. Comments included: - "They look after us well", "They [the staff] are marvellous people", "Staff are fantastic. I can't praise them highly enough" and "The main thing for me is toilet calls as they will stay with me if I want them to. I also asked for a bath yesterday and got one."

We observed care and support and saw staff were kind, patient and sensitive when interacting with people. For example, we saw staff assisted a person who was distressed, shouting and trying to take clothing off. Staff gently and sensitively escorted the person to their room to change their clothes. We saw the person returned a short time later wearing cooler clothing and staff also opened a window. On another occasion, we saw the power box for a pressure relieving cushion in a person's wheelchair fell off as the person was manoeuvring. Staff attended swiftly, put the brakes on the chair and checked to make sure the person was all right. Staff were gentle and compassionate. We saw they knelt down or crouched to communicate at eye and ear level with those who required it and people were encouraged to take their time and not to rush.

People told us they were treated with dignity and respect and said their privacy was maintained. One person who was on a short stay at the home said this was their first experience of a care home. They said they were very impressed with the way staff treated people which was always with dignity and respect. Our observations confirmed this as we saw staff knocked on doors and waited for an answer before entering, personal care tasks were carried out in private and people were asked discreetly if they required assistance. We saw that dignity issues were discussed with staff at team meetings to ensure that staff interacted with people in a positive manner.

Information was present on people's life histories, their likes, dislikes and personal preferences. This helped staff understand the people they were caring for and provide personalised care. Staff were generally assigned to work on the same unit each shift. This helped the development of good positive relationships between people and staff. Staff we spoke with demonstrated a good understanding of the people they were caring for and how to meet their individual needs. They demonstrated they had positive values and were committed to providing a caring and attentive service to people.

There were mixed responses when we asked people if they were involved in their care planning. Some said they had not been involved. One person said, "I did not know I had a care package until another resident found his in his bottom drawer when he was packing to leave, so I had a look in mine and found one but it has never been discussed with me." Another person said, 'I'm in here for an assessment for an adult care plan ready for when I am discharged. I have been told today that I will be involved in a meeting once my assessment has been completed."

Care records we reviewed showed people's relatives had been consulted about people's care and support. We saw agreements in place describing under what circumstances staff should contact relatives if there had been a change in people's condition. This helped ensure good communication with families.

People's independence was promoted by the service. This was built into care and support plans to help people either maintain or develop their independence for example through plans to prompt people to carry out their own personal care. Aids were in place, for example one person had a deep sided plate at mealtimes to allow them to eat independently without spilling food. We saw people could choose where to spend their time in any of the four units in the home or outside in the garden One person said, "So long as we tell staff where we are going we can go out into the garden." Another person told us, "I like to sit outside it's lovely."

Where appropriate advanced care plans were put in place to help ensure people's end of life care needs were met.

Requires Improvement

Is the service responsive?

Our findings

Care and support met people's individual needs. Staff were knowledgeable about people and aware of recent changes in their condition and how to manage these changes. For example, through the use of equipment such as pressure mats for falls prevention, air mattresses and air cushions. People looked clean, tidy and well-groomed which indicated that their personal care needs were being met by the service.

Care records were in place which demonstrated an assessment of people's needs in a range of areas such as mobility, personal care, social and spiritual needs and night time intervention. However, we found care records did not always contain accurate information on people's care and support needs. This meant there was a risk that inappropriate or inconsistent care would be provided.

In one case we found a person had a catheter in situ. Although staff were aware of their responsibilities in managing this and daily records provided evidence catheter care was regularly provided, neither their personal care or continence plan mentioned catheter care was required. Daily records demonstrated and staff told us this person was also subject to two hour pressure relief by staff whilst in bed, however this was not mentioned in their care plan which said they could reposition themselves whilst in bed. In total, we looked at two people's care records who required two hourly pressure relief, one of these people had turn charts in place evidencing when relief was given whilst the other did not, demonstrating a lack of consistency with regards to record keeping.

Where people were nutritionally at risk we saw evidence action was taken such as increased monitoring of their food intake and more frequent monitoring of their weight. However, we identified a lack of oversight of people's weights when they were on non-permanent placements. For example, one person's weight had been erratic within August 2016, however this had not been identified and investigated by staff to determine whether the weight loss was genuine or as a result of inaccurate measurement.

Nutritional screening was undertaken to determine the risk which each person was exposed to. The risk assessment tool stated dietician advice should be sought where the assessment concluded there was a high risk, but we found this was not always done in practice. We asked the registered manager to review the assessment tool and to ensure clear criteria was in place for referral onto the dietician. Nutritional care plans were in place to help support people to maintain good nutrition. We found some of these could contain more detail, for example they did not state how often people should be weighed.

Food and drink charts were maintained for people who used the service. However, we found these were not consistently completed. For example, one person had no intake recorded in the morning and lunchtime period for the 29 and 30 August 2016. One person's daily records stated they required a fluid intake chart putting in place on 27 August as staff were concerned they were dehydrated. However, this had not yet been put in place by the inspection date of 31 August 2016. We found some confusion amongst staff with one staff member telling us they no longer used fluid charts and put all entries on the 'food and drink' chart. However, there was no record of this person's fluid intake on either of these charts. We saw another person was on a fluid chart however the total fluid intake had not been tallied and analysed. This was a breach of

Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations.
People we spoke with felt there was a lack of activity, interaction and stimulation. The following comments were made, "I have been to bingo once and have been offered lotto, but it would be nice to have more activities to get out of the routine." "We don't have a lot of activities, but most are not interested in joining in." "There has been no mention of activities." One relative was quite concerned that her family member needed more stimulus and was worried in case they became depressed. For example, the relative said the person missed watching sport on television.

During our inspection we found the level of activities varied on each unit. For example, on one unit we saw care staff engaged with people over their choice of film, reading out information about the synopsis and offering to bring snacks for people during the film. We also saw the care worker engaging with people in conversation at regular intervals, and they told us they regularly engaged in games and reminiscence with people. On the other units we saw no activities taking place, although staff took time to chat with people whenever they could. An activities co-ordinator was employed who engaged with people in a range of activities. These included bingo, film nights, dominoes, quizzes and reminiscence sessions. Care staff told us they got involved in activities on each of the units on a daily basis. Some care staff told us they would like to see more external activities such as trips out which had not happened for a considerable time due to budget restraints.

People we spoke with said they were not aware of any formal complaints procedure, but said if they had any issues then they would ask a family member to raise the matter on their behalf. One person told us they had raised an issue and they said it had been dealt with straightaway and felt it had been handled very well.

The complaints procedure was on display within the home to bring it to the attention of people who used the service. We saw a low number of complaints had been received by the service with two received within 2016, one from a relative and one from an anonymous source. A small number of complaints had also been received within 2015. Overall we concluded these had been responded to appropriately and in a prompt manner.

Requires Improvement

Is the service well-led?

Our findings

We saw audits were undertaken in areas such as fire, health and safety and infection control. Where audits had been carried out we saw action plans were worked through by the registered manager to ensure improvement of the service. However, we found some audits required improvement as issues we had identified during the inspection had not been picked up by the provider. For example, we saw a monthly audit of one person's medicines had not identified they had been given the wrong dose of medicine the day before the audit took place. Daily medicine checks took place at each shift change where two staff checked the MARs to ensure they had been signed and medicines had been given correctly. None of the errors we found had been identified. We saw the provider had carried out a comprehensive medicine audit on 29 July 2016 which identified a number of areas where improvements were needed which included issues we had identified with topical medicines.

Similarly we found care plan audits were completed which identified where there were shortfalls. However, it was not clear who was responsible for rectifying these matters or how this was being followed up.

We looked at accident and incident reports and saw these were audited monthly. However, the analysis was limited as the audit only listed the number of accidents that had occurred during the month. Trends and themes such as the time the accident occurred or number of accidents people were having or the variation in the number of accidents from month to month had not been identified. This was a missed opportunity to consider what action could be taken to prevent further recurrences and reduce risks to people. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations.

A registered manager was in place who had worked at the service for a number of years. They had a good understanding of how the service operated, its limitations and were clear on the areas where further development was required. The day after the inspection the registered manager sent us a detailed action plan which showed the action they had taken to address the issues we had raised during the inspection. This swift action demonstrated a commitment to improving the service for people.

We observed a pleasant and inclusive atmosphere within the home with some good interactions between people and staff. Staff we spoke with told us the staff team and morale was good. They said they felt able to raise any issues with the registered manager who they described as effective and supportive. One staff member told us, "We have a good team and good relationships, I love the managers we can go to them with anything."

People's views on the quality of the service were regularly sought. People staying at the home for short periods were asked to complete a questionnaire at the end of their staff, and longer stay residents were asked about the service on a periodic basis. Relatives and carers were also asked for their views on the service. We reviewed a selection of recent quality surveys and found the responses to be overwhelmingly positive demonstrating people and relatives were very satisfied with the quality of the service. People were also able to air their views through regular resident meetings where topics such as activities and food were discussed.

Regular quality audits were also undertaken by the provider. These were conducted by a 'Quality Visitor' who looked at areas such as dignity and respect, activities, décor and food. We saw the results of the most recent audit were mostly positive.

The views of visiting health professionals had also been sought and staff had been surveyed about their understanding of key topics linked to the Care Quality Commission's five domains as part of a system of quality assurance to determine where further support and development was required.

Regular staff meetings took place. This included a range of meetings for care staff which included senior care staff meetings, unit meetings and an overall home staff meeting. It was evident that these were used as an opportunity to discuss quality issues which had occurred within the home to ensure improvement of staff practice. For example, we saw at recent meetings it had been identified that care records were not of the required standard, so staff had been reminded of their duty to ensure accurate and complete records were maintained.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	The registered person was not acting in accordance with the 2005 Mental Capacity Act when service users were unable to give such consent because they lack capacity to do so. Regulation 11 (1) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	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 and in relation to the proper and safe management of medicines. Regulation 12 (1) (2) (a) (b) (c) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	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 who may be at risk. A complete and accurate record of each service users care and treatment was not in place. Regulation 17 (1) (2) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Suitably qualified, competent, skilled and experienced persons had not received appropriate training and professional development to enable them to carry out the duties they were employed to perform. Regulation 18 (2) (a).