Goodcare Limited

Almadene Care Home (Goodcare Limited)

Inspection report

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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 inspection took place on 5, 9 and 11 January 2017. The first day of the inspection was unannounced.

Almadene Care Home is a care home for older adults many of whom are living with dementia. At the time of our inspection 14 people were living in the home. The home was a converted property consisting of two terraced houses that had been joined together to become one large property.

The home had 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. At the time of our inspection the registered manager was absent from the service. The provider had submitted the required notification to CQC to inform us of this and had appointed an interim manager to run the service during the absence.

The home was last inspected in October 2014 when it was rated Good overall.

People told us they felt safe at the home. The home had policies and procedures in place to ensure that people were protected from avoidable harm and abuse. Staff had a good understanding of safeguarding adults processes and knew how to raise any concerns they had.

People's care plans and risk assessments lacked details regarding the exact nature of support to be provided and the regular meetings people had attended to discuss and provide input into their care and support had lapsed in recent months. People who had recently moved into the service did not have care plans in place. The provider took action to update care plans and risk assessments in response to feedback.

People were supported to take their medicines as prescribed, and were encouraged to take their medicines independently where it was safe for them to do so. Systems to ensure the safe management of medicines through regular audit and stock counts had not been sustained. The provider took immediate action to address these issues.

The service had enough staff to meet people's care and support needs. However, staff told us they did not have enough staff to provide activities to people. People gave us mixed feedback about activities provision within the home and observations showed people were not provided with stimulation or engagement for long periods during the day. The provider placed an advert to recruit an activities coordinator during the inspection. We have made a recommendation about activities provision.

People told us the staff were kind and caring. Staff spoke about people with kindness and affection. Staff recognised the importance of supporting people as individuals. Where people followed a religious faith this was recorded and a priest regularly visited the home and met with people who wished to see them. Needs assessments and care plans did not include information about people's sexuality and this meant there was

a risk that people who identify as lesbian, gay, bisexual or transgender (LGBT) were not having their needs met as there was a presumption of heterosexuality. We have made a recommendation about supporting people who identify as LGBT.

People told us the food was tasty. We saw people were supported to have their dietary needs met and people's dietary preferences were respected. People were offered drinks and snacks throughout the day as well as a freshly cooked main meal at lunchtime.

Care plans contained details of people's health needs and the support required to maintain their health. However, input from health professionals was not always recorded.

Where people could consent to their care this was appropriately recorded. However, two people who had recently moved to the home were being unlawfully deprived of their liberty as appropriate applications to deprive them of their liberty had not been submitted in line with the requirements of the Mental Capacity Act 2005.

Records of training were incomplete as they did not include staff who had recently joined the service. Staff supervisions had not been completed in line with the provider's policy. The provider implemented a new training programme and supervision schedule in response to this feedback.

The home had systems in place to monitor and improve the quality of the service through various audits. These had not been maintained in the registered manager's absence. Although the provider responded positively to feedback regarding this and immediately put systems in place to monitor and improve the quality of the service, this had not been identified or acted upon until the inspection took place.

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. The home had not maintained a complete record of incidents that occurred in the home.

People told us they felt safe and staff had a good knowledge of safeguarding adults procedures.

Risks faced by people had been assessed with plans in place to reduce risks. However, these had not always been reviewed and updated.

People were supported to take their medicines as prescribed, however, checks to ensure the safe management of medicines had not been consistently completed.

There were sufficient staff who had been recruited in a safe way to meet people's needs.

The home was clean and people were protected by the prevention and control of infection.

Is the service effective?

Requires Improvement

The service was not always effective. People who lacked capacity to consent to their care and treatment had been unlawfully deprived of their liberty.

Staff received the training required to perform their roles, but had not always received supervision in line with the provider's policy.

People were supported to eat and drink enough and maintain a balanced diet. People spoke highly of the food.

Care plans contained details of people's health conditions and the support people required to maintain their health. The involvement of health professionals had not always been recorded.

Is the service caring?

Requires Improvement

The service was not always caring. People were not always

involved in making decisions about their care and treatment.

The service did not ask people about their sexuality and so did not ensure that people who may identify as lesbian, gay, bisexual or transgender received appropriate support.

People told us the staff were kind.

Staff spoke about people with kindness and affection. Staff told us how they supported people to maintain and uphold their dignity.

Is the service responsive?

Requires Improvement

The home was not always responsive. People's care plans did not contain the information needed to provide them with personalised support that met their needs. Not all people had care plans in place.

External activities providers visited the home on a weekly basis. At other times people appeared bored and were under-stimulated.

Meetings for people who lived in the home had not been sustained in recent times.

People knew how to complain and told us their problems were resolved quickly.

Is the service well-led?

Requires Improvement

The service was not always well led. People and staff told us they liked the registered manager.

There were systems in place to ensure regular audits of the quality of the service were completed. However, the systems had not been followed in the absence of the registered manager.

The provider had not identified the issues raised during the inspection, but took immediate action to address them.

Almadene Care Home (Goodcare Limited)

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 5, 9 and 11 January 2017. The first day of the inspection was unannounced. The inspection was completed by one inspector.

Before the inspection feedback was requested from local authority commissioning teams and the local Healthwatch. 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 the information we already held about the service, including statutory notifications we had received.

During the inspection we reviewed six people's care files including care plans, risk assessments, medicines records and records of care received. We reviewed three staff recruitment files and six staff supervision records as well as staff training records. We spoke with eight people who lived in the home and one relative of a person who lived in the home. We spoke with seven members of staff including the business manager, the interim home manager, the chef and four care workers. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We also viewed various documents, policies and records relevant to the management of the service.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at the home. One person said, "They check on you to make sure you're alright." A relative told us, "My family member is safe here."

Care files contained various risk assessments relating to areas of support where people might be exposed to the risk of harm. These included risks related to people's mobility, moving and handling support, nutrition, and skin integrity. Records showed risk assessments had been reviewed and updated on a monthly basis by the registered manager until October 2016. However, the registered manager was absent from the service and since their absence began risk assessments had not been reviewed. This was discussed with the interim manager who advised they had been focussing on reformatting the care plans so they had not reviewed risk assessments during their time in post. The provider took action and submitted confirmation they had reviewed and updated all risk assessments within two weeks of the inspection.

The provider sent us copies of updated risk assessments which included clear measures to mitigate risks to people while encouraging and facilitating their independence. For example, one person was identified as being at high risk of falls. Their updated risk assessment informed staff how to support the person to use their zimmer frame to mobilise and also recognised the person might forget to use their frame due to their health conditions. The updated risk assessment included measures to ensure risks were minimised if the person forgot to use their frame. These included regular monitoring and supervision as well as ensuring the environment was clear of trip hazards.

The provider calculated staffing levels required to ensure they had adequate staff based on the needs of people living in the home. This was based on how much staff input people required to complete personal care tasks and what support they required to ensure their dietary needs were met. This calculation was reviewed monthly, or more often if people's need changed. The provider told us they authorised requests for additional staffing when they were required. At the time of our inspection the staffing levels were set as two care workers at all times. People told us they thought there were enough staff to meet their needs. Staff told us there were sufficient staff to complete care tasks for people, but not always sufficient staff to enable them to spend time with people outside of care tasks. One staff member said, "There aren't enough staff for anything other than tasks, there's no time for things like card games or a chat." Other staff members told us they believed the staffing levels were sufficient when they worked together. One staff member said, "In my opinion if we work as a team we have enough staff." Observations showed there were sufficient staff to ensure people's care needs were met.

Records showed that staff were recruited in a safe way. The home collected employment and character references and completed criminal records checks to ensure staff were of a suitable character to work in a care setting. Staff files did not always contain a record of the interview process used to select staff. This had been identified in an audit by the provider and staff files completed after this audit included interview records with an evaluation of the applicants' answers.

The home was undertaking scheduled redecorations to improve the physical appearance of the communal

areas. The provider supplied the schedule of works which included re-fitting the bathrooms which had become tired in appearance. The home employed a domestic staff member who demonstrated they understood good infection control practice. The home was clean and free from malodour. Records showed there was a cleaning schedule which was monitored on a regular basis. Staff were supplied with personal protective equipment and received training in infection control. This meant people were protected by the prevention and control of infection.

People were supported to take their medicines as prescribed. One person told us, "Staff help me with my medicines." Where people were able to take their medicines independently the home supported them to do so. Where people were not able to take their own medicines safely the home had systems in place to ensure they received their medicines as prescribed. The service used a monitored dosage system where medicines were supplied by the pharmacy in blister packs. Staff received training on administering medicines and were confident in describing the measures they would take if they discovered an error with medicines. Care plans contained details of what medicines people were prescribed and the purpose of these medicines. Observations showed staff supported one person with kindness and sensitivity when they refused their medicines. The staff encouraged the person to take their medicines, and after being given some time the person took their medicines as prescribed. However, the details of the approach to take when this person refused their medicines was not included in their care plan. This was discussed with the provider who updated the medicines plan and risk assessment to reflect the approach taken by staff.

The registered manager had established a system for auditing medicines including recording medicines arriving in the service and weekly stock counts of medicines. These systems had not been maintained in their absence. On the first day of the inspection the interim manager was unable to locate records relating to medicines stock counts or incoming medicines. The most recent stock count available had taken place on 12 December 2016 so did not include the most recent medicines delivery. The medicines stock counts had been located on the second day of the inspection but did not show the balance of medicines had been checked against actual medicines stocks. In addition, the weekly count of medicines that were supplied in their original packaging rather than in blister packs had not been maintained. This meant the service did not have clear records of what medicines were in stock and there was a risk that people's medicines supplies may not be sufficient. The provider completed a full audit of medicines in response to this feedback and this showed the correct amount of medicines were in stock.

The home had safeguarding policies and procedures in place and the emergency contact details were available to staff. Records showed that staff had received training in safeguarding adults, however, the training matrix did not include staff who had recently joined the service so it was not clear that they had received training in safeguarding adults. The provider sent us records showing they were re-training all their staff in safeguarding adults.

Staff were knowledgeable about safeguarding adults processes and told us they would report any concerns about possible abuse or neglect of people living in the home to their manager. One staff member said, "I'd go to the manager and they investigate it." Another staff member said, "I'd blow the whistle, report any concerns to the manager or the senior on duty. If I wasn't happy with their response I'd call [local advocacy charity] or CQC." This meant that people were protected from abuse and avoidable harm as the service had appropriate policies and procedures in place and staff knew how to respond to concerns.

The home had a policy regarding the reporting and recording of incidents. Records showed that incidents had been recorded and investigated by the registered manager in an appropriate way. The issues regarding the reporting and investigating of incidents identified at the last inspection in October 2016 had been addressed. Where necessary, the registered manager had made referrals to other professionals in response

to incidents. The incidents folder was reviewed and showed no recorded incidents since October 2016. However, one person's records of care showed they had fallen on 30 November 2016 but there was no incident form and record of this on the falls audit the home had previously maintained. This meant the previous progress had not been maintained and there was a risk that incidents involving people had not been appropriately recorded and escalated and meant it was not clear that appropriate support had been put in place in response to incidents.

We recommend the service seeks and follows best practice guidance on recording and responding to incidents.

Requires Improvement

Is the service effective?

Our findings

People told us they liked the meals provided at the home. One person said, "[Chef] does nice dinners, I can choose what I want." Another person told us, "The food is nice." Records showed the chef provided a range of menu options each day and people made choices from menus that were placed on the dining room tables. If people did not want any of the options on the menu they were prepared something different of their choosing. Records showed the menu varied regularly.

People told us they had previously talked about the menu in residents meetings but these had not happened since the registered manager had been absent. The provider scheduled a residents meeting for after the inspection and the agenda included menu options.

Staff demonstrated good knowledge of people's dietary preferences. For example, one person was offered a meal from the menu each day, but frequently refused it and they were then prepared a soup of their choice. People had a nutritional assessment completed on admission to the home and people's dietary needs and preferences were recorded. Where people had specialist dietary requirements due to health conditions the chef prepared options that were suitable. Observations showed people were offered drinks and snacks throughout the day. This meant people were supported to eat and drink enough and to maintain a balanced diet that met their needs and preferences.

Staff told us, and records confirmed staff received regular supervision from the registered manager. These were used to discuss work performance and any issues with people living in the home. Records showed that the interim manager had held supervision meetings with six staff since the registered manager had been absent. This meant supervision had not been maintained in line with the provider's policy. The provider submitted a schedule for supervision after the inspection and records of a supervision that had taken place immediately after the inspection in order to ensure that staff received the support they needed to perform their roles.

Staff told us, and records confirmed they received regular training in areas relevant to their roles. These included safeguarding, infection control, moving and handling, the Mental Capacity Act (2005), fire safety and food hygiene. Staff spoke particularly highly of the training they had received in dementia. Records of training did not capture the date that training had been completed, and the records did not include staff who had been recruited since October 2016. The provider initiated a new programme of refresher training for staff in response to this feedback.

People told us they received support to access healthcare services when they required. One person said, "They take you to the doctor." A relative told us, "The home is on top of all the health stuff." Care plans contained details about people's health conditions and the support they required to maintain their health. Records included records of GP appointments and other medical professionals' input. Staff told us and records confirmed this information was shared across the staff team through daily handover meetings.

Observations showed that one person complained of a sore tooth during the inspection. Staff responded

with kindness and concern and arranged for them to see the dentist the next day. Another person had recently experienced poor health and had been admitted to hospital. However, there were no records of the input of health professionals prior to their admission. This meant it was not clear what actions had been taken to support this person with their health needs. The staff had not followed the existing recording processes to ensure this person's health needs were clearly recorded. The provider updated this person's care plan during the inspection and completed a review with the GP to ensure the service had up to date information about how to meet this person's health 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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.

People living in the home were subject to restrictions on their liberty as the front door was locked with a code that people were not given access to. People who had capacity had provided consent to this arrangement and told us they were able to go out when they wished. One person said, "I can come and go as I want." Where people lacked capacity to consent to this restriction this should have been authorised through DoLS. Records showed that two people had moved into the home since October 2016 and appropriate applications to deprive them of their liberty had not been made. This meant these people had been illegally deprived of their liberty since living in the home. This was discussed with the provider who immediately submitted the appropriate applications.

Care plans contained information regarding people's ability to make decisions and choices. These included details of the type of decisions people were able to make. For example, one person's care plan stated, "Able to make basic choices and preferences about her daily needs, but needs assistance to make best interests decision about areas of her health and well-being." This demonstrated a lack of understanding about the best interests process, as best interests decisions are made on a person's behalf after they have been assessed as lacking capacity to make the specific decision themselves. Following feedback to the provider updated care files were submitted which included assessments of people's capacity regarding specific decisions and the support people required to be able to make their own decisions.

Requires Improvement

Is the service caring?

Our findings

People told us they thought staff had a caring attitude. One person said, "The staff are ever so kind to you. They're marvellous what they do." Another person said, "[staff member] is very nice. She takes me out to the café." A third person told us, "The staff are very kind."

Staff told us they would ask people and their relatives questions about their pasts to build up their relationships with people. Staff spoke about the people they supported with kindness and affection. They recognised people's individuality and the importance of individual communication in building up relationships with people. One staff member said, "You have to make people feel like they are the first and most important person you've spoken to today." Another member of staff said, "The most important thing is to listen to people, they will be able to answer." A third member of staff explained how the best way to get to know one person was through shared one-to-one activities. They said, "[Person] is much better away from the group. If we can have a one-to-one we can have a really good chat. We had a lovely time taking down the Christmas decorations together."

Care plans contained a section which recorded people's views on their care and any comments they had on their care plan. These showed people had said they were happy with the care they received. People told us they used to have regular meetings with the registered manager about their care, but these had not happened since they had been away. This meant the service was not consistently supporting people to express their views on their care.

Observations showed staff supported people sensitively and in a way that maintained their dignity. For example, we observed people being sensitively prompted to attend to their personal care. Staff told us how they ensured people felt they were respected while receiving care. One staff member said, "Each person is different. There's the obvious things like shutting the doors. You must always remember that the service you give to John you can't give to Mary."

Care plans contained a section about people's backgrounds and lifestyle. The level of detail varied, with newer care plans containing less detail about people's lifestyle and relationships. Older plans contained details of people's past relationships, where they grew up and occupations as well as favourite pastimes. Where people had a religious faith this was recorded in their care plans and a priest from the local church visited weekly to support people to meet their religious needs.

Although plans contained information on family members, they did not explore people's sexuality and this was not included in part of the assessment of people's needs when they moved to the service. Staff were asked if they supported anyone who identified as lesbian, gay, bisexual or transgender (LGBT). All the staff we spoke with told us they did not currently and had never previously supported anyone who identified as LGBT in the home. However, they also all recognised that this information was not recorded in care plans. Staff told us they would know if people identified as LGBT in various ways. One staff member said, "You would see the reaction." Another staff member said, "There would be different communications. We would catch up eventually but wouldn't ask people [about their sexuality] directly." A third member of staff said,

"We don't have anyone [who identifies as LGBT] because I've never seen anything to suggest that's a situation." This meant the service risks not identifying people who identify as LGBT which meant people might not receive the support they require with their sexuality.

We recommend the service seeks and follows best practice guidance on supporting people who identify as Lesbian, Gay, Bisexual and Transgender.

Requires Improvement

Is the service responsive?

Our findings

People told us they used to have meetings to discuss their care but that these had stopped since the registered manager had been absent. This was also the case with residents meetings. Records showed these meetings had been used to provide feedback about general issues to do with the running of the home, including the menu, activities and attitude of staff. In response to feedback that these meetings had stopped happening the provider arranged for a meeting to take place immediately after the inspection. The provider sent records of the meeting which showed they discussed the recent re-decoration of the home and the changes in the management arrangements for the service.

People told us they had not been asked their views on the colours chosen for the recent redecoration of the shared areas of the home. One person said, "No [we weren't asked]. They chose sunshine colours but weren't involved. It's not to my taste" Other people told us they liked the colours that had been chosen. The lack of involvement of people who lived in the home in the decisions about the appearance of the home was discussed with the business manager. The business manager advised that last time the home had been redecorated people had chosen the colours and the home had been painted in muted dark tones. The business manager said the decision was made to choose bright colours. They recognised that there was a missed opportunity to involve people in decisions about their home.

Although people had not been involved in the decoration of the shared areas of the home, they had been involved in making choices about their bedrooms. People showed us their bedrooms which were highly personalised with their possessions and personal photographs and pictures.

The home had a complaints policy with clear timescales for response and investigation of concerns. People and relatives told us they knew how to make complaints, but had had no cause to do so. One person told us they had had an issue with their bedroom radiator but this had been resolved quickly.

People had their needs assessed before they moved into the service. Records showed the assessment covered areas that people required support with including personal care, medicines, mobility, and nutrition. Where people were able to communicate clearly information was also collected regarding their preferences and life stories. Where people were not able to communicate this information clearly during the assessment the service collected it over time from the person and their relatives where possible.

The needs assessments led to the creation of care plans. These included plans relating to personal care, nutrition, lifestyle, night time support and where appropriate health and mental health support. The interim manager told us they had been completing work on updating the care plans of people living in the home. The plans that had been updated contained limited information on how to support people to have their needs met. For example, one person's personal care plan stated planned care was, "To continue to support [person] in order to meet all her personal care needs at all times." Likewise, their lifestyle plan instructed staff "To continue to support [person] to engage in her lifestyle needs in order to maximise her independence and quality of life." These were not clear instructions for staff about how to ensure personal care or lifestyle needs were met.

Staff told us they learned about people's support needs by talking to them, or from more experienced colleagues. One staff member said, "The information [about how to support people] isn't in the care plan. I get it from the registered manager or the family." Another member of staff said, "The files are lacking. You pick it up from spending time in their company or from colleagues." A third member of staff said, "I have all the details of how people like to be supported in my little book." Staff agreed it would be more helpful if this information was contained in the care plan documentation.

Two people had moved into the home since the interim manager had been in post. One of their care files was reviewed and it did not contain any care plan or information for staff on how to meet this person's needs. This meant staff did not have any information on how to support this person or details on their preferences. This meant there was a risk they did not receive support to meet their needs. This was discussed with the provider, who took immediate action to complete care plans for people where they were not in place. These were submitted to us within 48 hours and contained details for staff on how to support people. The provider also started to update the care plans of all people living in the home so they contained more detailed information on people's needs and how staff should support people.

Updated care plans contained details of what aspects of care people could complete for themselves, ensuring that independence was promoted and encouraged. For example, an updated care plan instructed staff, "[Person] needs one staff member to assist her with her personal hygiene needs. [Person] can wash their face, neck, arms and front of their body. They need staff to wash their back. [Person] likes to have a bath once a week and have their hair done by the hairdresser once a week."

The home arranged for external providers to come to facilitate group activities on a weekly basis. These included music and exercise classes. Feedback about the activities was mixed. Some people told us they enjoyed them. One person said, "I do exercise now, a lady comes and does it. They've got a balloon and we push it." However, other people were less positive about the activities provided. One person said, "They aren't really for me." On the third day of inspection we observed care workers facilitating a bingo session for people living in the home. This took over 45 minutes to set up and people were observed to be passive in their engagement with the activity. There was no alternative activity provided for people who did not wish to engage in a group activity. On the other two days of the inspection no activities were supported and people were observed to fall asleep unless they were able to independently find an activity to entertain themselves. A member of staff told us, "Boredom is a problem here. People fall asleep because they are bored."

The lack of activities and engagement for people living in the home was discussed with the provider. The director of the company immediately authorised the recruitment of a part-time activities coordinator to be based in the home on a daily basis. The provider sent us a copy of the advert that had been posted to recruit to this post. However, until this post is filled there remains a risk that people are bored and under-stimulated while living at the home.

We recommend the service seeks and follows best practice guidance on providing activities and stimulation for people living in care homes.

Requires Improvement

Is the service well-led?

Our findings

People and staff spoke highly of the registered manager. A member of staff said, "[Registered manager] is always very supportive of us." Another staff member said, "We are all very close with [registered manager]." The registered manager was absent from work during the inspection, and the provider had submitted the required notification to inform us of their absence. The provider had recruited an interim manager to run the home while the registered manager was away. People and staff gave us mixed feedback about the interim manager which recognised that the registered manager was well liked and had been in post for a long time. One person said, "We do miss [registered manager]. We like [interim manager] too. He's a nice man." Staff expressed frustration that changes had been made to established systems that had not been effective. A member of staff said, "[Interim manager] is trying in his own way. I asked him to try [quality assurance] like we had done it before but he changed it."

The registered manager had completed monthly audits of care plans and risk assessments for all people living in the home. These had ensured that care plans were suitable for meeting people's needs. However, these had not been completed in their absence. In addition, the audits of medicines, infection control, the environment and health and safety had not been maintained. The weekly checklist completed by managers had been continued and this ensured there were weekly checks on accidents and incidents, personal hygiene equipment, appointments for people, staffing rotas and the daily logs.

The interim manager had received a four day introduction and induction to the service from the registered manager when they joined the service. The business manager had continued with their monthly visits to the service and received weekly updates from the interim manager. Records of the visits by the business manager showed they sought feedback from people living in the home, reviewed medicines audits, care plans, complaints, incident and accident reports, health and safety issues and staffing matters including the rota and training. The audits had generated actions relating to these areas. However, they had not identified the issues raised during the inspection such as the lack of care plan for new people, lack of reviews of risk assessments and failure to audit medicines.

The provider was made aware of concerns that quality assurance audits and updates to risk assessments and care plans had not been completed adequately since the absence of the registered manager. The provider took immediate action to address these shortcomings. The business manager attended the inspection and brought in management support from another home in the group. Immediate audits of medicines, care plans and risk assessments were completed and work was completed to ensure care plans and risk assessments were up to date and detailed. Meetings were held with people who lived in the home and staff to discuss the situation and the home and a letter was sent to relatives with an update. The provider has submitted a detailed action plan regarding ensuring audits and quality assurance surveys are completed as well as details of staff training and supervisions. This meant although the provider had not prevented the deterioration in the measurements of the quality of the service, they took prompt action to redress the situation.