Frampton Residential Homes Limited

Brookthorpe Hall Care Centre

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?	**Inadequate**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Brookthorpe Hall Care Centre provides accommodation and personal care for up to 32 older people aged 65 and over. At the time of our inspection 27 people were using the service.

This inspection was unannounced and took place on 13 and 14 January 2016.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People did not always receive a service that was safe. Risk assessments were not always in place and those that were often lacked sufficient detail to safely provide care. Staffing levels were not regularly reviewed. People did not always receive their medicines as prescribed. The registered manager and staff team understood their role and responsibilities to keep people safe from harm. Staff knew how to raise any concerns regarding people's safety. Employment checks were carried out on staff before they started work to assess their suitability to work with vulnerable people.

The service did not always provide effective care and support. Some staff had not received training on caring for people living with dementia. The service was not adhering to the principles or requirements of the Mental Capacity Act 2005 (MCA) or Deprivation of Liberty Safeguards (DoLS).

People seemed to enjoy the food and menus were planned in advance. People did not always have easy access to drinks. Arrangements were made for people to see their GP and other healthcare professionals when they needed to do so. The service had made some adaptations to the environment to meet the needs of people living with dementia.

People did not always receive a caring service. Staff did not always give people the care and attention they wanted or needed. Staff did not always treat people with dignity and respect. People generally spoke positively about the staff caring for them.

The service was not responsive to people's needs. Care plans were not person centred and lacked the detail required to provide consistent, high quality care and support. Daily records were not completed thoroughly and immediately following care being given. There were not enough activities for people. Comments and complaints from people, relatives and others were not recorded. People's views and opinions had not always been acted upon.

The service was not consistently well-led. The registered manager had not always submitted notifications to the Care Quality Commission (CQC) as required by law. The registered manager was well liked and respected. Quality checks were in place and the registered manager was planning to ensure these were

better used to improve the service provided. However, these audits had not identified shortfalls in areas such as medicines management and record keeping.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and a breach of the Care Quality Commission (Registration) Regulations 2009.
You can see what action we told the provider to take at the back of the full version of this 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.

Risk assessments were not always in place and those that were often lacked sufficient detail to safely provide care.

Staffing levels had not been reviewed for more than 12 months.

Medicines were not well managed and people did not always receive their medicines as prescribed.

Accidents and incidents were not always thoroughly investigated.

The registered manager and staff team understood their roles and responsibilities to keep people safe from harm. Staff knew how to raise any concerns regarding people's safety.

The provider carried out checks on staff before they started work to assess their suitability to work with vulnerable people.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not all received training on caring for people living with dementia.

The service did not comply with the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). This meant people's rights were not protected.

People seemed to enjoy the food and menus were planned in advance. People did not always have easy access to drinks.

People's healthcare needs were met and staff worked with health and social care professionals to access relevant services.

The service had made some adaptations to the environment to meet the needs of people living with dementia.

Is the service caring?

Requires Improvement

People did not always receive a service that was caring.

Staff did not always give people the care and attention they wanted or needed.

Staff did not always treat people with dignity and respect.

People generally spoke positively about the staff caring for them.

Is the service responsive?

Inadequate

The service was not responsive to people's needs

Care plans were not sufficiently detailed or written in a person centred manner. Daily records were not completed thoroughly or immediately following care being given.

There were not enough activities for people.

People's views and opinions had not always been acted upon.

Comments and complaints from people, relatives and others were not recorded.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The registered manager had not always submitted notifications to the Care Quality Commission (CQC) as required by law.

People, relatives and staff said they liked and respected the registered manager.

Quality checks were in place and the registered manager was planning to ensure these were better used to improve the service provided. However, these audits had not identified shortfalls in areas such as medicines management and record keeping.

Brookthorpe Hall Care Centre

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 13 and 14 January 2016 and was unannounced. The inspection team consisted of three people. One adult social care inspector, a specialist advisor with professional knowledge of services for older people and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The last full inspection of the service was on 22 April 2013. At that time we found the service was compliant with regulations.

Prior to the inspection we looked at the information we had about the service. This information included the statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by law.

We contacted six health and social care professionals, including community nurses, social workers and commissioners. We asked them for some feedback about the service. We were provided with a range of feedback to assist with our inspection.

Some people were able to talk with us about the service they received. We spoke with 14 people using the service. Not every person was able to express their views verbally. Therefore we carried out a Short Observational Framework for Inspection session (SOFI 2). SOFI 2 is a specific way of observing care to help us understand the experience of people who could not tell us about their life in the home. We also spoke with relatives of three people using the service and a friend of one other person.

We spoke with five staff, including the registered manager, the deputy manager, a senior care worker and care staff.

We looked at the care records of nine people living at the service, three staff personnel files, training records for all staff, staff duty rotas and other records relating to the management of the service. We looked at a range of policies and procedures including, safeguarding, whistleblowing, complaints, mental capacity and deprivation of liberty, recruitment, accidents and incidents and equality and diversity.

Requires Improvement

Is the service safe?

Our findings

People and relatives gave mixed feedback on whether they felt the service was safe. One person said, "I know they'll come to my rescue if necessary, the staff are very pleasant with me, I can't say they're the same with everybody". Another person said, "I feel safe here, it's very homely". One relative said, ""I know (Person's name) is safe and (Person's name) knows they're safe, we take (Person's name) out and they want to come back in, (Person's name) is reluctant to come out because they feel secure here".

Risk assessments were not always in place or sufficiently detailed. For example, one person at risk of falling and injuring themselves did not have a risk assessment in place to keep them safe. People who needed assistance to move from one place to another, did not always have a clear plan for their moving and handling in place. Plans in place did not give sufficient detail on the use of equipment for staff to follow. On one occasion we saw staff using an under arm lift that did not look comfortable for the person. This person's care plan gave no guidance on how to safely move them.

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

During our inspection medicines were administered by two staff. When talking to staff we were told, "There is always two people administering medicines" and, "Sometimes on weekends one person does it". The registered manager said the policy was for two staff to administer medicines. Whilst administering the medicines one staff member wore a tabard stating, 'Do not disturb drug round in progress'. Despite this other members of staff did approach them and asking for guidance about other aspects of care for people, unrelated to the administration of medicines.

We saw an example of a person not receiving their medicine safely. This person was prescribed a controlled drug. Their medicine chart had not been signed for when staff commenced the medicine round. The staff did not give the medicine but then signed the chart. We asked about this and were told they had already given the person this medicine and had signed the controlled drug book. The person's medicine administration record should be signed at the same time as the controlled drug book and immediately following the medicine being given.

We saw examples of people not receiving their medicines as prescribed. One person had not received one of their medicines between the 2nd and 5th January 2016. Staff had written 'G' on the chart. We asked about this and were told the medicine was, "Not available", on those days. A second person had not received one of their medicines for the four days immediately before our visit. We asked about this and were told, "We're out of it at the moment". A third person prescribed pain relief medication was not offered it. We saw this medicine was prescribed to be taken four times a day. The person had only received it once a day from 21 December 2015. We asked about this and were told, "It makes her too sleepy". There was no record of this medicine being reviewed with the GP.

A number of people were prescribed medicines 'as required'. The process for offering people these

medicines was haphazard and poorly managed. There was insufficient guidance on how and when these should be administered. The practices explained by staff were not consistent with how the medicines were prescribed by their GP.

When we discussed our findings with the registered manager they took action to put in place further checks on this area and assured us they would follow up each area to ensure these improved.

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

People were kept safe by staff who knew about the different types of abuse to look for and what action to take when abuse was suspected. Staff completed safeguarding training as part of the induction and on-going training programme. They were provided with information regarding what is meant by safeguarding people, what constitutes abuse and what their responsibilities were to keep people safe. Staff told us they would report any concerns they had about a person's safety or welfare to the nurse in charge, the deputy or the registered manager. They knew they could report directly to the local authority, the Care Quality Commission (CQC) or the Police. Staff we spoke with knew about 'whistle blowing' to alert management to poor practice.

We received mixed feedback from people using the service regarding whether there were enough staff to meet their needs. People said, "I had a fall and had to use my buzzer and they came very quickly. I fell in the en-suite toilet" and, "At times I don't think there's enough staff, especially lunchtimes. The food's not always hot. I send it back and they put it in the microwave for a few minutes". Relatives we spoke with felt there were enough staff. One said, "They're very busy all the time. I'm sure that there is an adequate number of staff and they are aware of what people are doing".

When we visited, six staff were providing care to people in the mornings and three in the afternoons. We were told two staff were available at night. Staff rotas showed these staffing levels were provided consistently. Staff said they felt there was enough staff. Our observations showed people were left in communal areas with little involvement from staff for some time. On one occasion we had to find staff and prompt them to assist a person who was clearly uncomfortable. This followed another person using the service requesting staff support for this person. Staff had assisted the person but had not ensured they were fully comfortable.

A dependency tool to assess the staffing levels to ensure people were safe had been completed. However, this had not been reviewed for 12 months. This requires improvement in order to ensure people are provided with sufficient staff to keep them safe.

Investigations into accidents and incidents were not always sufficiently detailed and follow up information on people's wellbeing not clearly recorded. For example, one person had recently fallen and sustained a cut to their head. This person's care records contained little information on how the injury had been sustained or how it was healing. Another person had fallen and sustained a fracture. Again their care records contained little information on the injury and the person's progress. A relative said there had been some confusion regarding an incident when their family member had sustained an injury. They said, "I have never been able to get to the bottom of this". There were further examples of accidents and injuries not being followed up and recorded clearly.

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

People were protected from the risk of unsuitable staff being employed because relevant checks were carried out before staff started work. These checks included a Disclosure and Barring Service (DBS) check. A DBS check allows employers to check an applicant's police record for any convictions that may prevent them from working with vulnerable people. References were obtained from previous employers. Recruitment procedures were understood and followed by the registered manager.

The provider had an infection prevention and control policy. Staff had received training in infection control. There was an infection control lead person identified. Staff told us they had access to equipment they needed to prevent and control infection. They said this included protective gloves and aprons. We saw staff using protective equipment to minimise the risk of infection. The service was clean and odour free.

Requires Improvement

Is the service effective?

Our findings

People and relatives gave mixed feedback on the service they received. For example, one person said, "What the bloody hell am I doing here? I get so bored, I used to read a lot but as you get older, your eyes get tired, I think I used to have some glasses but I don't know where they are". Another person said, "It's OK here, I'm well looked after". Comments from relatives included, "(Person's name) strength and health have improved a lot", "They really look after them here" and, "I'm not confident (Person's name) needs are being met".

Training records showed staff received a range of training to meet people's needs. Staff told us they had received training in basic first aid, safeguarding vulnerable adults and moving and handling. However, some staff had not received training in working with people living with dementia. One care worker said, "I have worked here for over a year and have not had training in dementia". Another said, "We could do with more training on dementia. Speaking with staff and observing their practice, it was evident they did not have a good understanding of caring for people living with dementia.

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

The service had a programme of staff supervision in place. These are one to one meetings a staff member has with their manager. Staff supervision was delegated appropriately to each staff member's immediate supervisor. Staff members told us they received regular supervision. Staff records showed these were held regularly. Supervision records contained details of conversations with staff on how they could improve their performance in providing care and support. Staff said they found their individual meetings helpful.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA) and whether any conditions on authorisations to deprive a person of their liberty were being met. 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 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 are called the Deprivation of Liberty Safeguards (DoLS).

The provider had policies and procedures on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Senior staff had received training on MCA and DoLS. However, people's capacity to make choices and decisions had not always been assessed. Staff did not have an understanding of the principles of the MCA and did not demonstrate an understanding of their responsibilities to promote people's choice and decision making. The provider had not identified where people's freedom and liberty was being restricted. We did see one example of a person's capacity being assessed but this had not resulted in the provider submitting a DoLS application to the appropriate authorities.

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

During our lunchtime observations we saw the food was well presented and that people seemed to enjoy their meals. People had chosen their main course the day before from a choice of three dishes which included a vegetarian option. Some people had changed their mind and their revised choice was accommodated. Menus were available on each table. However, the menu on display in the dining room had not been changed since Christmas. Staff did not know what was on the menu and needed to check when people asked. People who required assistance to eat their lunch were helped. However, some staff did not communicate or engage positively with people whilst doing this. Staff seemed to view this as a task to be completed rather than an opportunity to spend time with the person.

People gave mixed feedback regarding the food. Comments included, "Personally, I don't think much of the dinners, tea's fantastic. There's always a choice of sandwiches. For dinner, there's a choice of meat, fish, or vegetarian. I'm vegetarian so I'm having cheese and onion flan today. You have an awful lot of sponge and custard. I get fed up with sponge, right the way through the summer. I have yogurt instead" and, "I like the food and there's usually plenty of it". Relatives also gave mixed feedback. One relative said, "The food's not that good, for the money". Another said, "My (Family member) enjoys the food".

People were served a cup of tea with their lunch but were not offered any alternative. During the morning of day one of our inspection we noticed that people did not have drinks easily available to them. One person told us, "They used to give us a cup of tea at 10 am and 3.30 pm. They've stopped that, I don't know why. It wouldn't cost an awful lot of money. I think you can have a cup of tea if you ask for one in the dining room but no one likes to ask". The same person spoke to us about drinks being provided in the summer saying, "They come around with drinks, usually orange or blackcurrant, on a hot day". They then said they were thirsty. We asked a staff member to provide them with a drink. The person later confirmed they had been given a drink. Staff said drinks were provided at meal times and if people asked for one. We noticed that many people had glasses of squash within reach in the afternoon. Some people using the service were not able to ask for drinks. The registered manager said people's fluid intake was monitored and we saw records were in place for this. However, this requires improvement to ensure people not able to ask for drinks have access to fluids when they want them.

People's care records showed relevant health and social care professionals were involved with people's care. Plans were in place to meet people's needs in these areas and were regularly reviewed. One visiting healthcare professional told us they felt the service met people needs.

Attempts had been made to provide an environment suited for people living with dementia. For example, toilet doors were painted red, bedroom doors yellow and wardrobe doors blue. The registered manager said they had sought advice and had further plans to provide a dementia friendly environment for people.

Requires Improvement

Is the service caring?

Our findings

People told us staff were caring. One person said, "Good, kind, and caring staff, that's the most important thing, all the staff are nice but that one over there she's my favourite, you feel she really cares, she's not just going through the motions". Another person said, "The staff are very nice, they're kind and caring". Relatives also said staff were caring. One told us, "(Person's name) is happy. It's obvious that they care". Care plans were regularly reviewed and attempts had been made to involve people and their families in the care planning process.

Staff said they felt the service provided was caring. A number of staff we spoke with said they would be happy for a relative of theirs to use the service. One care worker said that they were proud to get up every day and of the job they do. Another said, "The teamwork is great and that's what makes it caring here".

However, we saw that people were not always treated in a caring way. During lunch we saw one person frequently waving, smiling, and calling 'hello' to staff members who ignored them. The person's face fell and on one occasion, they turned to us, shrugged, and said, "I say 'hello' but I get no answer". Later in the day, we saw that a person was distressed, a staff member approached and gave them a hug and a kiss on the cheek before leaving them without having done anything to find out why the person was unhappy. We saw other examples of people calling out and asking for assistance and either being ignored or treated as though their request was not important.

Two people we spoke with said they weren't happy with the way they were helped to maintain their appearance. One person was concerned with the condition of her fingers nails and facial hair. She said, "I think I'm growing a beard". It was clear from the condition of her skin, which was sore with small cuts in places, that she had not received sufficient help to shave. Another person talked with us about appearances including, hair, clothes and earrings. These things were clearly of interest and importance to them. However, their long hair had been 'scraped back' into a ponytail held by an elastic band, their finger nails were long and dirty, their facial hair had been neglected and the cardigan they were wearing was too big for them and unravelling so much that it was coming apart.

We became concerned that staff were not caring for people who were sat in the lounge during lunchtime on day one of our inspection. One person was clearly distressed and uncomfortable. Another person walked in with the assistance of their walking frame and said she was worried about this person. She said, "It looks like she's falling out of the chair". She went to get a member of staff. Another person sat in the lounge then said, They won't do anything". After seeing this we found staff and prompted them to assist.

Staff did not always treat people with dignity and respect. Books recording when people had bathed and had used the toilet were left open in communal areas for anyone to view. These were removed and placed in the office when we pointed this out.

On one occasion a person sat in the lounge was distressed because the sun was in their eyes. They asked a member of staff to help them. The member of staff responded by saying, "I'm focussed on the task in hand".

At the time they were assisting another person to walk to the toilet. They then added, "We're going to the big toilet". This compromised the dignity of the person they were helping and added further distress to the person with the sun in their eyes. On another occasion we heard one staff member say to another, "(Person's name) needs taking". We asked what was meant by this afterwards and were told, "We were doing the toileting round". This lacked a person centred approach and appeared very task focused.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Dignity and Respect.

We did see some positive interactions with people, particularly from the registered manager and senior care worker who were clearly trying very hard to provide the care people required. We talked with the registered manager about staff not showing a caring approach. They said they felt the care staff were nervous because of the inspection and were not as relaxed and naturally friendly and caring as they usually were.

Staff had received training on equality and diversity. People's care records included an assessment of their needs in relation to equality and diversity. We saw the provider had planned to meet people's cultural and religious needs. Staff we spoke with understood their role in ensuring people's equality and diversity needs were met. One person explained they had specific dietary requirements and that these were met. Another person was assisted with keeping in contact with people from the church they had attended for many years.

Inadequate

Is the service responsive?

Our findings

The service was not responsive to people's individual needs. The overall impression of the service was that it was led by routines and tasks rather than being person centred.

Care plans were not sufficiently detailed or written in a person centred manner. Some people did not have any guidance in their care plans for areas important for them. For example, plans were not in place for how to manage pain. People assessed as being at risk of falling or of developing pressure sores did not always have a plan in place to reduce this risk. People's care plans did not detail their life histories interests and preferences. There was little information for staff to 'get to know' the person and talk with them about things that were important to them.

Daily recordings of people's care were kept. These were repetitive and did not give an individualised report of their care. This was particularly noticeable for recordings done at night. Many people had the same entry for night records, with just the person's name being different. For example, 'slept on hourly checks', 'incontinent of urine in the morning', 'personal care given', 'escorted/assisted down to the lounge'. The time these records were written was recorded and were often the same for each person. We saw some daily records being written at the end of shifts. This meant the records were not person centred, not detailed and were not written directly after care had been given.

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

People said there were not enough activities at the service. Comments included; "Nothing much happens here, there's no activities here. When I first came here, they played bingo and skittles, I'd like to do anything where you make things. We had a nice priest who used to come in, about every three weeks for a little service. You could go if you wanted to, I haven't seen him recently but we had a nice little carol service before Christmas", "I mostly watch TV, just looking at it, not taking it in" and, "I live a very boring life really, and it's not good for you, I sometimes sit here doing nothing and wonder what on earth am I doing here". Relatives also said there were not enough activities. One relative said, "(Person's name) would like to play cards, every day the same people are in the same places".

An activities programme was on display, detailing activities due to take place that week. However, on the days of our inspection the scheduled activities did not happen. There was no activities coordinator at the service. We were shown an activities cupboard which was disorganised and looked as though if one thing was taken from it everything else would fall down. The registered manager was in the process of recruiting an activities organiser. This requires improvement to ensure people have the opportunity to participate in planned activities.

People's bedroom doors were marked with the name of the occupant but had no other distinguishing features. There were no photographs or other items to help the person recognise the room as theirs. Some people using the service were living with the early to mid-stages of dementia. Items linking them with their

past would give them a sense of security and help staff communicate meaningfully with them.

Meetings where people were encouraged to express their views and opinions were held. We looked at the records of these meetings and saw people had requested a large calendar to be placed in the dining area. The notes recorded people had explained this would help them recognise the date when they came to the room for breakfast. This had taken place in October 2015. This request had not been met and no calendar was on display. People we spoke with were unsure of how to complain but did say they could talk with the registered manager.

The provider had a policy on complaints and comments. A record of complaints was kept at the service. However, there were no complaints recorded. The registered manager told us no formal complaints had been received. They said comments and suggestions made were dealt with but not recorded.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Receiving and acting on complaints.

Requires Improvement

Is the service well-led?

Our findings

Throughout our inspection we found the atmosphere in the home to be institutional and led by routine. The registered manager and senior care worker staff spoke passionately about person centred care and support and their vision for the service. However this had not been translated into practice and staff did not have a clear understanding of the vision and values of the service.

The registered manager had not always notified CQC of events as required by law. Within the previous 12 months we identified two occasions were people had fallen resulting in injury and one safeguarding concern, each had been reported to other professionals but not to CQC. We spoke with the registered manager about this and underlined their responsibility to submit notifications as required by law.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. Notifications of other incidents.

People knew who the registered manager was and seemed to have a good relationship with them and be comfortable in their presence. Relatives spoke positively about the registered manager. One said, "She's lovely and positive and seems to care". A visiting healthcare professional said, "(Registered Manager's name) is fantastic, she's really on it and all for the patients". Staff spoke positively about the registered manager. Comments included; "Management is excellent, if there's a problem I'm told about it, which is how I like it", I think (Registered Manager's name) is brilliant, if I'm stuck I go to her" and, "She's great, really knowledgeable about the people and very supportive".

At the end of day two we gave feedback to the registered manager and deputy. The registered manager listened carefully to what we had said and clearly wanted to ensure the service to people improved. We spoke about the potential for them to become isolated and the need to find ways to seek additional support and keep up to date with best practice and legislative requirements. The registered manager said they would discuss this further with the provider.

An on call system for staff to access advice and support if the registered manager was not present was in place. This involved the registered manager, deputy manager and senior care worker taking turns to be the point of contact for staff. Staff confirmed they were able to contact a senior person when needed.

The policies and procedures we looked at were regularly reviewed. Staff we spoke with knew how to access these policies and procedures. This meant that guidance for staff was up to date and easy for them to use.

Regular staff meetings were held and records kept. Staff told us they found these meetings helpful. We saw from the notes of meetings that staff were encouraged to express their views and opinions.

Systems were in place to check on the standards within the service. These consisted of a schedule of audits. These audits looked at; health and safety, infection control, record keeping and the monthly completion of a care home audit tool. These audits were carried out as scheduled and corrective action had been taken

when identified. However, these audits had not identified shortfalls in record keeping.

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

Surveys to seek the views of relatives and visitors had not been carried out since 2013. The registered manager told us they intended to carry out these surveys and were aiming to develop an overall quality improvement plan for 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 18 Registration Regulations 2009 Notifications of other incidents The provider had not submitted notifications as required by law. Regulation 18 (2) (g) (i).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People who use services were not treated with dignity and respect or in a caring and compassionate manner. Regulation 10 (1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People who use services were not protected against the risks associated with receiving care and treatment without proper consent. Regulation 11 (1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who use services were not protected against the risks associated with their care or treatment. Regulation 12 (2) (a) (b). People who use services were not protected against the risks associated with medicines

management and did not always receive their medicines as prescribed. Regulation 12 (2) (f) (g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had not established and operated properly an accessible system for identifying, receiving, recording, handling and responding to complaints. Regulation 16 (2).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Accurate, complete and contemporaneous records of care and treatment provided were not kept. Regulation 17 (2) (c). The provider had not assessed, monitored and mitigated the risks relating the health, safety and welfare of people who used the service. Regulation 17 (2) (b). The provider had not ensured there was an effective system in place to assess, monitor and improve the quality of service provided. Regulation 17 (2) (a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured staff had received training to equip them to provide care and support for people living with dementia. Regulation 18 (2) (a).