Runwood Homes Limited

St Michaels Court

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 and 6 July 2016 and was unannounced. The service provided accommodation for persons who require nursing or personal care, including some people living with dementia. The home consisted of three units, one for nursing care, a residential unit and a unit for people living with dementia.

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.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The management of medicines was not consistently safe. People did not always receive their medicines as the prescriber intended. The service had failed to maintain accurate and full records in relation to medicines administration.

People received enough to eat and drink and told us the food was good. People's nutritional needs were met, although at times they were not positioned in a way that was ideal for eating. People's hydration needs were not always met, as people were not always supported to drink.

Systems were in place, including staff training, to protect people from the risk of abuse. There were risk assessments that staff followed to help mitigate risks to individuals and their environment.

The CQC is required to monitor the Mental Capacity Act (MCA) 2005 Deprivation of Liberty Safeguards (DoLS) and report on what we find. Although staff did not always have a good understanding of these areas, we found that assessments for people's mental capacity were thorough and least restrictive methods were used in people's best interests if they were to be deprived of their liberty.

People's social needs and personal preferences were not consistently met. There was little time for meaningful interaction with staff and very little provision of activities.

People told us staff were kind and caring. However, there were several occasions during our inspection where people were distressed and staff did not provide timely reassurance and comfort. We saw that staff did not always interact with understanding of people living with dementia. At times staff interactions were purely task-led.

People's health needs had been identified, assessed and reviewed on a regular basis. Their care plans were individual to them and accurate, however lacked details of people's personal interests and history. Staff did

not always adhere to care plans.

There were some effective systems for monitoring and improving the service in place, and the registered manager had taken appropriate action in response to any complaints.

There were several areas where audits or observations had not picked up issues with regard to person-centred care and staff competency.

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.

The management, administration and recording of medicines was not always safe.

Risk assessments were in place for individuals and their environment , however staff did not always follow them.

People were supported by a sufficient number of staff. Staff had a good awareness of how to keep people safe.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had some effective training but there were some areas where improvements were needed. Staff did not always seek consent, and people living with dementia were not always supported to make their own choices.

People had access to a choice of nutritious food, however people were not always supported to drink enough. Fluids were not always recorded when people were at risk of not drinking enough.

People had timely access to healthcare services and staff followed advice given from healthcare professionals.

Is the service caring?

Requires Improvement

The service was not always caring.

Some interactions with people were solely task-led, and there were some practices in the home that did not promote privacy and dignity. Interaction between people and staff was lacking.

People living at the home, visitors and health professionals felt that staff were kind and caring.

People and their relatives were involved in making some decisions about their care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There was not enough time dedicated to activities, therefore people were not always stimulated and supported to follow their interests.

Staff reported any changes or issues promptly, however the service was not always responsive to people's changing health needs.

People knew how to raise concerns and complaints, and these were acted upon.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There were areas where the competency of staff had not been assessed and checked thoroughly.

The provider had some effective quality assurance processes which helped improve the service, however there had been some concerns which were not picked up.

The culture of the staff in the home was positive and the registered manager was well-supported.

St Michaels Court

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.

The inspection took place on 5 and 6 July 2016 and was unannounced. The inspection was carried out by three inspectors 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.
Before the inspection, we reviewed the information available to us about the home, such as the notifications that they had sent us. A notification is information about important events which the provider is required to send us by law. 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. This was received from the provider. We reviewed this information when planning our visit.

During our inspection, we observed the care and support provided to the people who used the service in the communal areas. We spoke with nine people who used the service, seven relatives, and three visiting healthcare professionals. We spoke with fifteen members of staff. These included a nurse, two senior care workers, seven care assistants, a catering assistant, the cook, an activities coordinator, the deputy manager and the registered manager.

We viewed the care records for ten people and checked how five of these people were supported at each stage of their care and treatment. We also inspected a large sample of medicines records for people who used the service. We looked at other records showing the way the quality and safety of the service was assessed and managed .We reviewed all staff training records and reviewed information on how the quality of the service was monitored and managed.

Requires Improvement

Is the service safe?

Our findings

We found some inconsistency in the way in which medicines were handled, recorded and administered. We found that on the nursing unit, medicines were recorded accurately and stored safely. We found on the residential and dementia units that there were several missed signatures during the week before, and one extra signature where the medicine had been signed for but not given. This was a risk of staff not knowing whether people had taken their medicine as well as a concern for staff competency. Where someone had not taken their medicine, this could pose a serious risk to their health. We noticed on the day of inspection that the medicine round on one floor lasted until mid-morning, only three hours before the lunchtime medicines would be administered. The senior on shift told us that the next round would be between 1pm and 130pm. This could pose a risk of people having some medicines too close together.

Recent weekly medicines audits had not highlighted that there were some missed signatures and no action had been taken to address this. This meant that they did not pick up some errors, and that some medicines remained unaccounted for. The stock counts of medicines we looked at showed the expected balance of medicines on the dementia and nursing units, despite missed signatures. We saw that medicines were counted more regularly following a recent audit by the registered manager which had highlighted that more accuracy was needed in medicines stock recording.

The registered manager told us that thickening powder kept in people's rooms should be put away when not in use. We observed that, on both the nursing and residential units, staff had not put away thickening powder for people's drinks which was kept in people's rooms. This posed a risk to people's health due to the possibility of ingestion.

Percutaneous endoscopic gastrostomy (PEG) is a medical procedure in which a tube is passed into a person's stomach, most commonly to provide a means of feeding. We observed that one member of staff administered medicines to a person via PEG, without first ensuring that they were sitting at the recommended angle. We saw other instances throughout the day when people could help themselves to a drink but not get themselves in a safe position to avoid choking. We noticed that in one person's room, they had a different amount of thickener administered in their two drinks that were there. The person was lying down throughout the day of our visit, and not in an appropriate position to drink safely.

Where people had their meals in their rooms, staff did not always support people to position themselves sitting up in a way that was conducive to eating safely. Where several people were not sitting up properly and therefore at risk of choking, we observed that staff did not regularly check them.

These concerns meant the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did see some good practice concerning medicines management. Medicines that people took 'as required' were kept safely and monitored regularly. Staff recorded on the administration records when they had been given. The care and administration records contained information about what these medicines

were for and when they should be given. The registered manager told us that there had been a recent occasion when staff had administered an 'as required' medicine more frequently than expected. They discussed the medicine with the staff member, advising them when it should be administered, and reviewed the person's medicines with the GP. The monitoring of 'as required medicines' helped to ensure that people were not receiving unnecessary medicines and that they were given as prescribed. Medicines which held a higher risk and required two people to sign for their administration were stored securely and administered correctly.

The front sheet of the medicines administration charts included details of people's preferences in how they liked to take their medicines, allergies and a photograph. This minimised the risks of medicines being given to the wrong person or someone being given something they were allergic to.

One person said, "I feel secure and safe here which is important to me." Another person said, "I feel safe here in every way." Staff had an understanding about safeguarding people from harm. They were able to tell us what potential signs of abuse could look like and give examples. They told us who they would report any concerns to. They received training in this area, which helped contribute to people's safety in being protected from abuse.

People's care records contained detailed risk assessments including manual handling, falls, choking and medical conditions. The care records gave guidance to staff on how best to mitigate the associated risks. However, with regards to administering medicines and choking, staff did not always adhere to the risk assessments in place. Staff were able to tell us about other risks to individuals and how they worked with them. Where people had falls, risk assessments were updated and reviewed accordingly. The manager analysed information about falls and audited the risks assessments for falls monthly. This meant that any trends or patterns in falls could be seen and therefore acted upon, and the registered manager ensured that risk assessments were current and relevant.

People were regularly checked for pressure areas and repositioning charts were in place where needed. Where people had sustained a pressure area, these had been responded to promptly and the appropriate treatment and equipment had been provided. Staff knew how to look for pressure areas and risks were reviewed regularly. We saw that charts confirming repositioning were completed in order to protect people from pressure related wounds.

We found that the building and environment had been maintained and risk assessments had been carried out for fire and other emergencies. We saw that equipment was available for assisting in evacuation of people using the stairs. Fire equipment and alarms had been recently checked and tested. We saw that other checks including the safety of electricity and electrical devices, water and lifting equipment had been completed.

One person told us, "When I ring the bell I know it won't be long before someone comes." Other people who lived in the home confirmed this. Another person said, "There is always someone around to help me." We noted during the inspection that staff answered bells promptly. People and healthcare professionals said that there were not always staff evident passing by their rooms and checking on them. One visitor said, "I would say there are times when there is no one about." This was echoed by another visitor we spoke with, and we observed this to be the case when we visited.

The home was made up of a residential unit, a dementia unit and a nursing unit and staff worked across all units. One staff member said, "At times we do struggle." They explained how staff were allocated to duties on each floor to ensure everything was done. If needed, due to last minute sickness or absence, staff would

be redeployed around the home. We saw on the staff rota that where there had not been enough staff to meet the assessed expectation, agency staff were called in. Other shortfalls were covered by agency staff as the service had several staff vacancies. We saw that the service used a dependency tool to assess how many staff were needed, and staff felt that although at times they felt under pressure, there were enough staff. We concluded that there were enough staff to keep people safe and respond to people's health needs, however they lacked extra time to spend with people.

There were systems in place to ensure that the home only employed staff who were deemed suitable to work in their roles. Staff confirmed that the registered manager had made the appropriate checks before employing them. These included references, proof of identity and criminal record checks, and we saw records confirming this to be the case. The management team obtained profiles from agencies detailing worker's identities, training and criminal records checks, and also carried out these checks with any volunteers who worked in the home. When we inspected, there was one volunteer working with the activities coordinator.

Requires Improvement

Is the service effective?

Our findings

We found that there was a lack of consistency in the effectiveness of the care, treatment and support people received across the different units of the home. Staff told us that the dementia training they received was currently via e-learning, which they felt was not enough. On observing staff on the dementia unit, we saw that there was some lack of understanding of working with people. We saw some staff use distraction and effective communication with people when they were distressed. However, some staff did not always engage effectively with people who were living with dementia. An example of this was in dealing with arising conflict between people, when we observed a member of the staff team ignore this and continue with the activity rather than distract or engage the people involved directly. Staff we spoke with were not always able to demonstrate to us that they understood this condition well.

There was a volunteer taking the lead on an activity with people living with dementia; however, there was no provision evident to check their competency. Where people had behaviour that could challenge others, the staff team, including the volunteer, had not received training or competency checks around this. We observed during the inspection that they did not always behave appropriately in response to people living with dementia. We concluded that although the staff were skilful in their roles in some areas of the home, some staff lacked the appropriate skills in caring for people living with dementia. The registered manager informed us that the volunteer had not received training in dementia, but that more face-to-face training in this area was organised and would include the volunteer.

Staff told us that they felt they had lots of training, but would like to have more training in specialist conditions, such as Parkinson's disease as well as dementia. Staff received training in areas such as manual handling, first aid and fire. The training they had received was a mixture of face to face and e-learning. People living on the residential unit told us that they had no concerns about the competence of staff, one person telling us, "I am well looked after by staff who know what they are doing." A visitor who said, "It seems they have had the appropriate training", reiterated this.

Staff confirmed that they received an induction when starting work in the home, and that this consisted of training and shadowing until they were deemed competent. Staff told us that they received supervisions, and although they were not always regular according to the provider's expectations, they felt supported in their roles. Supervisions provide an opportunity for staff to discuss their role, including any training needs, or areas where they may not be confident, with a senior member of staff.

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 interest 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 interest and legally authorised under the MCA. The application procedures for this in care homes are called

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. Some people living in the home were awaiting DoLS applications and we could see that whilst they were awaiting authorisation, that the least restrictive methods within their best interests were employed to keep them safe.

People's mental capacity assessments were detailed and thorough in explaining the extent to which people could make decisions, however we found that some staff lacked full understanding of the MCA. Staff were not always clear on what the MCA or DoLS were when we spoke with them, and we observed that some staff did not assume people had capacity when working with people living with dementia. An example of this included when somebody said they wanted to leave the room and a member of the staff team told them that they did not want to. This not only removed choice, but exacerbated the person's distress and staff did not intervene. This meant that staff did not always provide opportunities for people to make choices. We could see that at other times, staff acknowledged people's capacity, for example at mealtimes. Staff used various methods including physical examples to encourage people to make choices of what they wanted to eat. Staff told us that they had received specific instructions in this and that it was working well.

It was not evident within the home whether or not the service was meeting people's hydration needs from the fluid charts filled in by staff. The service did not always sufficiently monitor, manage and encourage people at risk of dehydration . We saw that drinks were in people's rooms throughout the day, however we saw that the previous drink was not replaced by the new one and was often still full. We saw other people, requiring assistance, who went for long periods without staff offering their drink. We concluded that although there were systems in place to aid people with drinking enough, they were not always effective. Staff did not always support people to drink throughout the day and document it. The charts used for fluid monitoring were not always totalled at the end of the day, and action had not been taken following people repeatedly drinking significantly less than the GP's recommended amount.

Care plans were clear about people's nutritional support. People were supported to have a balanced diet and people we spoke with said that the food was good. A person living in the home told us, "The food is tasty. We get a good mix of vegetables, salad, meat and fish. If I don't like it I can ask for something else." Staff, visitors and other people reflected this. We saw that staff supported people to eat in a timely way. We observed that people living with dementia were offered choice which was helped by showing them small servings of each choice, and they were able to have whichever they chose. We spoke with kitchen staff who were able to tell us how they knew who was on a special diet and how they provided this. Where people ate soft diets, components of the meals were mixed separately and included a choice.

People had timely access to healthcare services. If there were changes in people's health, the service referred them to the GP or dietician, or speech therapist when they needed. We saw in people's care plans that the mental health team had been involved with their care when needed. Three visiting healthcare professionals that we spoke with confirmed that staff followed their recommendations. They said that staff referred people to them appropriately. One also stated that they thought staff were more alert to people's changing needs and this had improved.

We recommend that the provider seek current guidance and good practice around providing care for people living with dementia.

Requires Improvement

Is the service caring?

Our findings

We found that there was inconsistency in the approaches of staff concerning their interactions with people.

In two units of the home, we noticed that people were shouting out and in obvious distress, but staff did not attempt to interact with them. There was an acceptance of this being the way that some people behaved, we saw no attempt made to reassure these people. One person living in the home said they heard other people crying out a lot. A member of staff told us it was necessary to ignore one person who became distressed, saying, "[Person] always does that."

Some people confirmed that they contributed to the planning of their care and signed their care plans, others were not sure what their care plan was. Relatives we spoke with confirmed that where appropriate, they had been involved in decisions about their relative's care and kept informed of any changes.

We looked at a person's care plan which stated that they required staff to introduce themselves and talk the person through what they were doing throughout all care. We observed that a staff member entered the person's room, administered medicine to the person, and left, without any interaction with the person. This resulted in them being more distressed and shouting not to be left alone. Not only did this not follow the care plan, it was not conducive to a caring interaction, and negatively affected their wellbeing.

We found that there were instances where people's dignity was compromised. We saw that one person who was unable to ask for assistance, had not been supported to change clothes from the night before, to the daytime. They were in bed when we arrived for our inspection, and wearing a t-shirt and underwear. This was visible to us as they had been left uncovered in bed for several hours. The staff supported them to be washed, dressed, and sit in a wheelchair during the course of the morning. However, we saw that the person was wearing the same t-shirt as they had been wearing before the staff supported them to dress and get up. The staff leaving the person uncovered and not supporting them to change did not protect their dignity.

We observed staff administering eye drops in a communal area without discretion. The person receiving the eye drops was in the bathroom at the time they were administering medicines. The staff member requested that the person come to the dining room to receive their medicines, instead of give them in the bathroom. This showed that the staff member did not take the opportunity to give these in private, compromising the person's privacy by requesting they come to a communal area.

Other staff told us how they promoted people's dignity and privacy by ensuring they supported people to cover themselves up during personal care, and knocked on people's doors. They also used a sign to out on the door to ensure nobody would walk in during personal care. We saw that not all staff knocked and announced themselves before entering people's rooms.

Staff appeared busy at all times during our inspection and some interactions were purely task led, rather than focused on the individual. One member of staff told us that staff were not always caring towards people if their behaviour was viewed as challenging. They told us staff would tell them to sit down and stay

where they were, rather than distract them or reassure them. Although we observed some kind interactions between staff and people, we also saw that people's choices were not always respected when they were living with dementia. In one instance, we saw that someone was asking to leave the room when doing an activity and that staff ignored the request. We also saw staff place a person's feet on their footrests of the wheelchair without explanation.

All of the people we spoke with in the residential unit said that staff were caring and thoughtful towards them, one person saying, "I have settled because of these kind people", and another saying, "I like to have a laugh and a joke with [staff]." This was supported by all of the relatives we spoke with who referred to carers being kind. Some staff members showed a caring approach, one staff member told us, "I often come in on my day off and sit and talk to people who don't often have visitors. It also helps me to get to know people." Another staff member said, "It is a job for life. As long as residents are happy that is what matters." We observed some people receiving support to move around using equipment, and staff spoke to them reassuringly and respectfully throughout their care.

We saw that staff gave choices of food at mealtimes by giving visual aids to people. They showed them mini-meals of what was on offer, and that this was effective. We saw that staff respectfully asked people if they needed assistance to clean their hands before they ate. People were able to choose which they wanted, or have a mixture of options if they wished. Staff told us how they supported people, one saying, "I offer choice whenever I can. When helping someone up I offer them a choice of clothes. If they can't get to their wardrobe then I take the choices to them."

Some people were unsure whether they had been directly involved in planning their care, but confirmed that staff knew what they required. One visitor said, "[Relative] has a care plan which I've been involved with."

Staff told us how they promoted independence, one saying, "I encourage people to still be independent. I always encourage people to do what they can for themselves." Another member of staff told us how they had supported someone to improve their independence with their mobility through practising walking. This had had a positive impact on the person's life as they were now able to mobilise around the home independently.

Visitors that we spoke with confirmed that they were able to visit whenever they wished and were always made to feel welcome by the staff. However, one visitor had said that it had been difficult to speak with their relative on the phone when staff were busy. This was resolved and times were agrees to call back when staff were less busy. One person living in the home told us how staff were very understanding towards them following a good friend passing away.

Requires Improvement

Is the service responsive?

Our findings

We found that the service was not always responsive to people's needs and preferences.

One person confirmed that staff were responsive to their needs, saying, "They all know me so when they come to help me out they know what I need." Another person told us, "[Staff] do understand what support and help I need." Some staff were able to tell us about people's preferences and what support they needed. Care records did not show in detail people's preferences and interests. Staff were not able get a sense of who the person was from their plan of support. Where care records contained preferences, we saw that staff did not always adhere to them in practice. We concluded that, where people were able to converse with staff, staff understood their needs well.

Where people were not able to ask for themselves, some aspects of their care was incomplete. A visitor stated that their relative had not always received support to wear their hearing aids. This visitor said, "The basic health needs are met." Care plans did not always include details of people's sensory support requirements, for example hearing aids and glasses, and we saw that these had not always been considered by staff. We saw that people's basic health care needs were assessed on admission to the home. The registered manager told us that they placed a summary of information about people inside their rooms so that staff could easily be reminded of what care people needed.

People's preferences, where they had been identified and recorded in care plans, were not always respected. Where someone was not engaging in an activity and wanted to go, the volunteer told them they couldn't go. Where people wanted to walk about the home, staff did not always support them to do so. There was a person who was receiving one to one support during the day, from a male care assistant. Their care records stated that they reacted better to a female. Other staff on shift and the registered manager confirmed that this was the case. We observed that they were becoming agitated towards the male member of staff at times. The registered manager informed us, and we could see from the rota, that this member of staff was not usually allocated to support the person, and that this staff member had wanted to work with them. This was not responsive to the person's specified preferences.

All of the people that we spoke with felt that there were not enough activities and trips provided for them. One person said, "It would be nice if there were more things put on for us to do." A visitor said, "For a home this size, I'd expect a bit more going on to keep people occupied." At the time of the inspection, the service employed a staff member for 40 hours a week for activities and had a new volunteer for two days a week. The registered manager told us that the volunteer would be doing more one to one work and finding out what people wanted to do. There were activities organised such as a quiz and some games, a gardening club, keep fit and the service had visiting entertainment occasionally. One person we observed had been left sitting in their chair alone in the dining room with minimal interaction from staff for over two hours. We did not see staff sitting with people talking. When staff were sitting in the lounge, they were sitting away from people and were completing their notes.

We saw that there was no stimulation or activities available for the majority of people in the home during

our visit. Most people had stayed in the same place and position throughout the day. One person we spoke with told us how they liked to do jigsaw puzzles and playing draughts, and as they were in bed all day. They said, "I'm a bit bored." The person said they had not been consulted about what channel they wanted their television on, and had not been given their glasses. The care plan did not have any information regarding the fact that the person wore glasses. On entering their room on their request, we located the glasses in the person's room and found that they were very dirty. This person had recently had changing health needs leading to them being more dependent and less mobile. We felt that there were unnecessary restrictions on the person due to the service not providing the resources to support them to get up, therefore limiting their lifestyle.

We found during our visit that staff did not always provide support with mouth care. A visiting healthcare professional and another visitor we spoke with, confirmed that this was an area which could be improved upon. Mouth care had not been documented on people's daily records, and we saw that it had been a concern previously noted by another agency visiting the home. Omissions with people's personal care had not been picked up by team leaders or managers.

These concerns constituted a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although some raised concerns about oral care, some other healthcare professionals we spoke with told us that the service responded to people's changing health needs and followed recommendations. One told us, "The staff are receptive to advice. They follow turning guidance. They document information as required." We saw that people were supported to reposition as recommended by healthcare professionals.

Many people living in the home required support from a family member if they had any problems with the care they received. People and their relatives had confidence their complaints would be addressed. The visitors that we spoke with all said that, when they had raised any concerns with the registered manager, that they had been resolved and dealt with appropriately. They felt that the registered manager was approachable and took action to solve problems.

Requires Improvement

Is the service well-led?

Our findings

There was not an audit in place for the regular monitoring of the use of fluid charts, so that staff could decide when to take action if someone was persistently not drinking enough. Some fluid charts were not filled in accurately. Where this may have been due to people having their own drinks alone or with visitors, systems were not in place to check their records. We saw that many people drank significantly less than the target shown in their records. Where fluids were not being totalled, this was not regularly picked up on, or where staff had made omissions. An action plan had pointed out that the completion of fluid and diet charts was lacking prior to our visit.

Actions from individual audits of care records had led to requested action such as increasing input in fluid and diet charts, as the auditor could not recognise whether or not people were drinking and eating enough. There was an action plan which we saw in place for these to be improved, however it did not lead to an audit of all fluid charts. There were no actions that the registered manager had taken to audit these on a day to day basis. We found that they were not being filled in correctly, and where people were not drinking enough, this was not acted upon.

Previous manager's audits of medicines records had highlighted that there had been some missing signatures, however, following this, action had not been taken to solve these. Although we could see that staff had audited medicines weekly, several errors were overlooked. We were therefore concerned that people's safety in receiving medicines as prescribed may be at risk. There was no action taken in on-going assessment of staff competency with regards to medicines administration or staff following best practice.

The management team undertook audits of care plans and these had led to actions being taken forward. We saw that these had recently pointed out that 'person-centred care' needed to be more evident in people's records. We saw that although care plans were regularly reviewed in terms of people's health support needs, the action to be more person-centred had not been checked. There was no action plan and timescale in place for this to be completed. In practice, care was not always person-centred and there was not a process for checking staff competencies regularly.

We found that in allocating staff to work with the person who required one to one support, the registered manager had not consulted with the senior on shift to further discuss it. This contributed to one person not receiving the individualised care outlined for them.

Although there were meetings for the people who lived in the home to discuss concerns and ideas, if they could not attend the meetings, their views were not always sought. We saw evidence that a catering survey had taken place and that this had led to actions following people's requests for more snacks and condiments. We saw some surveys which the activities coordinator had completed with people living in the home, however the uptake of these was very low. The service had not been proactive in engaging people to seek their views and increase input into the surveys. There was no evidence that the views of visiting relatives had been sought.

These concerns constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff carried out weight audits and checked that people were receiving the support they needed if they were losing weight. This meant that people's risks of not eating enough or weight loss was picked up and acted upon.

There were monthly audits in place for monitoring and analysing falls and accidents and records showed that actions were taken following these audits. Risk assessments were updated and completed where necessary as a result of these audits.

There were several meetings in place for the different staff groups, however some care staff told us that they could not regularly attend them because they were not at work that day, or had to be on shift.

A visitor told us that the current registered manager had improved the home and that it was more organised. A staff member who said, "We have more routine now and more of a team effort." All the care staff we spoke with said that they worked well as a team. Staff told us that they found the management team supportive, saying, "We have great managers; they are there for us about anything." Staff also told us that they could go to the registered manager at any time and that they were approachable.

The registered manager told us they felt well supported by the representatives of the provider, and they received regular compliance visits from them. We saw that these visits had led to improvements being made, for example updating risk assessments in people's care plans to keep them current and relevant.

Appropriate disciplinary action was taken when the manager had picked up poor practice. Staff confirmed that the management team carried out spot checks on them and addressed any issues with them. However, we could not see that the concerns we found regarding staff competencies around dementia care had been found or addressed. There was not a system in place to ensure that staff were deemed competent in giving appropriate care to people.

The management team had notified safeguarding and referred any concerns to the relevant authorities. Where serious injuries had occurred, the registered manager had notified CQC as required.

There was a comprehensive and accessible complaints procedure in place. We could see that the management team investigated and responded appropriately to any complaints that they had received.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not always receive care that took into account their individual needs and preferences and how these could be met. Regulation 9(1) and 9(3)(h) and (i)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service had failed to protect people against risks by doing all that is practicable to mitigate any such risks. Regulation 12 (2) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems for monitoring and improving the quality and safety of the service, having regard to the accuracy of records and for seeking the views of others, were not operating effectively. Regulation 17(1)(2)(a), (c) (e) and (f)