Linden Care Homes Limited

Linden Lodge Residential Home

Inspection report

Browns Lane
Dordon
Tamworth
Staffordshire
B78 1TR

Tel: 01827899911

Date of inspection visit:
18 August 2016

Date of publication:
28 September 2016

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	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 18 August 2016 and it was unannounced.

Linden Lodge is one of three homes provided by the Linden Care Homes Limited and provides accommodation and personal care for up to 34 older people; over three floors. At the time of the inspection 32 people lived at the home. Linden Lodge was last inspected by us in May 2013 and we found the regulations were met.

The home is required to have 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 and associated Regulations about how the service is run. At the time of this inspection the home had a registered manager in post. Since our last inspection, there has been a change of manager, with the new manager registering with us in December 2014.

People felt safe living at the home because staff were there to support them when needed. Staff were trained to know what abuse was and how to report any concerns to the registered manager. People were supported to take their prescribed medicines by trained staff, however guidance was not always available for staff to ensure people received their medicines in a safe way.

Some risks were assessed but actions were not always put into place to reduce the risk of harm or injury to people. Staff did not have the information available to refer to, if needed, to know how to keep people safe from identified risks.

Staff worked within the principles of the Mental Capacity Act 2005 when supporting people with personal care but did not always act in accordance with the requirements of the Act when supporting people with their medicines. People had choices offered to them about what they wanted to eat and drink and were supported to maintain their health and, when needed, were referred to health professionals.

Staff had received some training but did not always feel this gave them the skills and knowledge they needed to effectively meet people's needs.

People said staff were kind to them and involved them in making decisions about their day to day care and how they spent their time. There were planned group activities for people to take part in if they wished to do so.

Staff promoted people's dignity where they were able to, but the registered manager and provider had not given consideration to promoting people's privacy and dignity in shared bedrooms.

Systems were in place to assess the quality of the service provided but audits were not always effective.

Risks of cross infection had not been identified by checks undertaken and care plan reviews had not identified where improvement was needed. Feedback was sought from relatives, however people living at the home were not always given the opportunity to give their feedback on the service they received.

We found a breach in the regulation relating to the governance of the home. 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 consistently safe.

People felt safe living at the home because staff were there to support them. Staff were trained to know what abuse was and how to report any concerns to the registered manager. People were supported to take their prescribed medicines by trained staff, but guidance was not always available for staff to ensure people received their medicines in a safe way. Some risks associated with people's care were assessed, however, actions were not always put into place to reduce the risk of harm.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had undertaken some training to deliver care and support to people, but did not always feel they had the skills they needed. Staff worked within the principles of the Mental Capacity Act 2005 when supporting people with personal care but did not always follow the requirements of the Act when supporting people with their medicines. The requirements of the Deprivation of Liberty Safeguards were followed. People were offered choices and given the support they needed to eat and drink. People were supported to maintain their health and were referred to health professionals when needed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People and their relatives told us that staff were kind and caring towards them or their family member. People were involved in decisions about their day to day care. People's privacy and dignity was not always promoted.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People felt that overall their care needs were met by staff, but people sometimes experienced delays in staff responding to

their requests. There were planned group activities for people to take part in if they wished to do so. People's feedback was not always sought.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The provider had some systems in place to monitor the quality of the service provided but had not ensured these were effective. This meant opportunities to identify where action was required to implement improvement were missed. Staff told us they felt supported by the registered manager.

Linden Lodge Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 18 August 2016 and was unannounced. The inspection team consisted of two inspectors and an 'expert by experience.' An expert by experience is a person who has personal experiences of using or caring for someone who uses this type of care service.

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 held about the service. This included information shared with us by the local authority commissioners. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority. We reviewed statutory notifications sent to us from the provider. A statutory notification is information about important events which the provider is required to send us by law.

We spoke with nine people who lived at the home and 12 relatives who told us about their experiences of using the service. We spoke with staff on duty including five care staff, two care supervisors, the cook, the activities staff member, the dementia care champion for Linden Care Homes, the deputy manager for care for Linden Care Homes and the registered provider. We spent time with and observed care staff offering care and support in communal areas of the home.

The registered manager was on planned annual leave on the day of our inspection visit, so we offered the opportunity to the provider for the registered manager to have a telephone conversation with us on 22

August 2016 so they could contribute to the inspection, which they did.

We reviewed a range of records, these included care records and medicine administration records for ten people. We looked at quality assurance audits and feedback from people.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at the home. One person said, "I feel safe with staff supporting me here, such as when I have a shower." Relatives told us they felt their family members were safe living at the home and protected by staff from the risks of abuse. Staff told us they had received training on how to protect people from abuse and how to recognise concerns. One staff member told us, "I'd report any concerns of abuse straightaway to the manager." Another staff member said, "There is a poster displayed to tell us what to do if we have any concerns about abuse."

Some assessments were in place to identify where people were at risk but these did not record actions to be taken, by staff, to minimise the identified risks. For example, some people were identified as being at high risk of falls but no information was available to tell staff how to minimise the risk of harm or injury.

Staff informed us some people, who were living with dementia, could on occasions present behaviour that challenged. One staff member told us, "Sometimes we may need to support someone who is soiled to wash, but they might lash out at us. I don't feel the risk assessment or training tells us what to do in these situations." Some people's assessments identified they may become anxious and challenging but we found no information to tell staff about potential trigger factors that may lead to those behaviours and how to effectively manage them safely.

We identified some potential risks to people had not been assessed, which meant people's safety could not always be assured. For example, each floor had an accessible kitchenette with hot water urns used for hot drinks. One staff member told us, "Mostly staff and relatives use it to make drinks if they wish to, but on this floor there are two people that live here that go in there sometimes." The registered manager confirmed to us that no risk assessment had been completed for this. Following our inspection visit, they told us one would be completed and code locks would be installed on the kitchenette doors because people would need the support of staff to use the facilities such as the hot water urn.

We found bottles of alcohol, belonging to one person living at the home, were stored in the kitchenette. One staff member explained to us why it was not in the person's own bedroom and said, "It is always stored in here." We identified this to the deputy manager for care and they said, "I would have expected alcohol to be locked away for safety." During our inspection visit, the bottles were moved, several hours later, to a secure area. The registered manager told us, "I will ensure all alcohol is stored safely, and staff will access this when this person wants their alcoholic drink."

Potential risks to people's health and wellbeing, posed from health conditions, had not always been assessed. For example, one staff member showed us a care plan which recorded a person had diabetes but did not give any key information about the condition. The staff member told us, "I've never had any diabetes training, but the previous manager once showed me how to do blood sugar testing. We do this about once a month for [Person's Name], I'm not really sure what the reading should be." Another staff member said, "I did diabetes training at the previous care home I worked at, I know the symptoms to look out for and I'd do the person's blood sugar test if I was concerned. I do the blood sugar tests here on people but I'm not sure

what their result should be." We found the lack of guidance for staff to refer to presented a potential risk because staff did not know when to seek professional support.

Some people had Malnutrition Universal Screening Tool (MUST) assessments. (MUST) is a management plan for people who are malnourished or at risk of malnutrition. We spoke with the cook and they told us they added extra calories to all meals, such as butter and cream to mashed potato, and high calorie snacks were made available to people. Staff recorded details about people's food and fluid when needed, so that their intake could be monitored and checks were made on people's weight where concerns had been identified.

Most people told us there were enough staff on shift to keep them safe. However, a few people said more staff were needed at night to help them with tasks they could not safely undertake themselves. One person told us, "There is only one staff member on each floor at night, it isn't enough really." Some relatives felt staff were a 'bit stretched' in the morning times and 'struggled' to meet people's needs.

Staff told us that most of the time they felt there were enough staff on shift. However, staff did not always feel the skill mix was suitable to safely meet the needs of people. We were told that people's needs on the first and second floors were higher and not all staff have the skill set needed to meet their needs. One staff member told us, "I have mentioned this to the manager but the same issue happened again." We discussed this with the registered manager who told us they felt sufficient consideration to staff skills and knowledge was given when planning the rota, but were aware that staff allocations was an 'issue' for some of the staff team and were monitoring this.

We asked staff how they would deal with emergencies, such as a fire or accidents requiring first aid that might arise from time to time. One staff member said, "If the fire alarm went off, I have to go to the fire panel and then care supervisors or managers will tell me what to do. If someone has a fall, I'll call for help." Staff appointed as fire officer on the rota knew what action to take and how to move people to a safe area of the home. Staff that had completed first aid training could tell us what they would do if a person had a fall. One staff member told us, "We'd always check the person for any injury, if we suspected an injury we'd call 999. The manager makes sure there is a first aider every shift." People had personal emergency evacuation plans (PEEPS) to tell staff the level of support they needed in to keep them safe the event of a fire. However, we saw these did not refer to emergency evacuation mats that were available and staff told us they had not been trained to use these.

The top of one stairway, identified as a fire exit, was partially blocked by two hoists. We discussed this with the deputy manager for care and they told us, "Storage is a bit of a problem here. The hoists would usually be in the bedroom or ensuite of the person who uses them." Throughout our inspection visit, the two hoists were not moved and we saw staff used the stairs for access, which meant the hoists also presented a trip hazard.

Staff told us they completed training before supporting people with their prescribed medicines. One staff member told us, "We do medicines training and the manager also does checks to observe we are doing it right." People had their prescribed medicines available to them and these were stored safely. We looked at ten people's medicine administration records (MARs) and saw some people had medicines 'when required'. Guidance was available to tell staff when these medicines should be given to ensure consistency. We observed one staff member giving people their medicine and providing the support they needed.

One staff member told us, "Four people living here have their medicines given 'covertly'. Staff disguise their medicines in their food or drink because these people will not always take them and it's important they have them." All staff we spoke with, that administered medicines to people, confirmed they gave medicines to

these people in this way. One staff member said, "I might try to give their tablets on a spoon first and on occasions they have taken them, but most times I crush them and mix them in with a cup of tea or their porridge." We asked staff to show us guidance which told them how to safely administer these medicines in a covert way, however staff told us they were not aware of any guidance. We found no guidance had been sought by the registered manager, from the supplying pharmacy, to tell staff how to safely administer people's medicines in a safe way.

We looked at one person's MAR, who had their medicines given to them 'covertly' and saw some medicines had a pharmacist's printed instruction which stated, 'do not chew or crush'. We discussed this with staff and one staff member told us, "I spoke with the manager about us crushing [Person's Name] tablets and asked if there were alternative forms of medicine, such as liquid or dispersible tablets, that they could ask this person's doctor to consider. I know it says on their medicine sheet, 'do not crush,' but nothing has changed yet." We asked the registered manager about this but they could not recall staff raising this with them but said they would seek advise from the GP and pharmacist following our feedback about this.

People had prescribed topical items such as creams and ointments and these were stored in people's bedrooms. One staff member told us, "I've signed that the creams have been applied to people as needed, but this is based on assumption rather than knowing. This is because the night staff have helped some people up, so it is not possible to check. Generally, the staff doing personal care should put creams on people. But, sometimes we don't know where or how a certain cream should be applied." We found there was no information available for staff to tell them where people's creams and ointments needed to be applied. Records of application may not always have been accurate because the staff member signing was not always able to check people's prescribed topical applications had been applied to their skin as needed.

We found one person had some prescribed creams and other items including tubes of toothpaste stored in an unsealed container in the sluice room. One staff member told us, "I think these are in the sluice room because we didn't want this person to mess around with them in their bedroom." This storage presented a risk of cross infection and during our inspection visit, the deputy manager of care disposed of the items and told us, "Any items still required by this person will be replaced. They should not have been stored in the sluice room."

Relatives told us they felt the home was clean. However, we identified there was a strong odour of urine and faeces in parts of the home on the first floor. During the morning we looked in the sluice room, there was a strong offensive odour. This odour became worse in the afternoon, and may in part have been made worse from a pair of soiled pants we found had been discarded, by staff, on the floor of the locked sluice room. When we pointed this out to the deputy manager for care, they said, "Staff should know better than to do that. There is strong odour all along here. I'll speak with staff."

Staff informed us that a wheeled mobile dignity curtain we saw in the sluice room was stored there. We saw this was dirty and may have been splashed from items being sluiced, we asked staff if the curtain was used. One staff member said, "I know we used it once when someone had a funny turn in the lounge and we put the curtain around them." We discussed the risk of cross infection from the dirty curtain with the deputy manager for care and they said, "It should not be stored there and I can see it is dirty, it is not fit for purpose. I'll get it sorted out."

Requires Improvement

Is the service effective?

Our findings

People felt staff had the skills they needed to effectively support them. One person told us, "I can't fault the staff, they are very good. They know me well and know what they are doing."

Staff told us they received an induction when they started work at the home. One staff member told us, "I transferred here from one of the provider's other homes, but I still had an induction here. I worked alongside another staff member and this was really helpful in getting to know people." All staff spoken with identified that further training would be beneficial in giving them the skills they needed to effectively support people. One staff member told us, "I feel I have the right training, but a challenging behaviour course would be useful." Another staff member told us, "Sometimes we have training or a discussion about something but I don't really feel it gives the answers or information needed."

Other staff told us they had worked at the home for several years but had not yet completed key training such as supporting people with dementia or food hygiene. We discussed this with the provider and they told us, "Staff are trained, but don't always recall when asked. For example, some training might be in-house and staff might not always class this as training when you ask them." The registered manager explained that they trained care supervisors in specific topics and care supervisors then passed this knowledge onto other staff. We discussed gaps in staff training records with the registered manager and they told us, "Staff have not yet completed all of the training needed, but more training is planned for Autumn 2016."

Staff understood the importance of gaining people's consent before undertaking personal care tasks. One staff member told us, "I'd always explain to someone what I was doing. We can't force people to do things, such as have a shower." Some staff told us they had completed training on the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act 2005 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. However, we found this training had not always been effective. For example, one person's care record had been amended, during August 2016, by a staff member to say this person now had their medicines 'covertly'. A staff member told us, "It can be hard to get this person to take their medicines so sometimes we hide them in their pudding." We found no steps had been taken by staff to bring this to the attention of the deputy manager for care's attention whilst the registered manager was on leave; to ensure the requirements of the Act were being followed, and no 'best interests' meeting had been requested.

Another person's care records contained details of a generic mental capacity assessment and 'best interest' meeting involving their GP and family member in deciding they have their medicines 'covertly.' This was dated April 2014 and we found no review had taken place of this person's capacity or the 'best interests' decision.

On the registered manager's return from their leave, we discussed these issues with them and they told us

they had been unaware of staff administering one person's medicines 'covertly' and would ensure action was taken to comply with the MCA. The registered manager confirmed that no review had been undertaken for the other person we identified to them.

The deputy manager for care told us they understood their responsibilities under the Act when people had restrictions on their liberty and worked with the registered manager to ensure referrals were made when needed to restrict people's liberty. They informed us that five people were deprived of their liberty and they had submitted referrals for a further 18 people whose mental capacity was to be assessed for a DOLs. 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. Most staff could not recall which people had a DOLs in place, but told us they would check with the registered manager.

People told us they enjoyed their meals. One person said, "We have choices and the food is always hot when served. I enjoy it." One relative told us, "My family member finds the food lovely here and the mealtimes are an enjoyable experience. My family member is never hungry or thirsty and they have put on weight since living here." Another relative said, "The food always looks good." We observed mealtimes were unrushed and staff supported people when needed.

People could not recall if they had been visited by healthcare professionals but said they would tell staff if they felt poorly. One relative said, "Staff have told me my family member has been visited by the doctor." Other relatives commented to us that family members had been visited by healthcare professionals such as chiropodists, opticians and district nurses. Staff told us they would inform the manager or person in charge of the shift if someone was unwell and a GP visit was needed. People's care records confirmed visits were made to them when needed.

Requires Improvement

Is the service caring?

Our findings

People told us they felt staff were kind and caring toward them and had a caring approach. One person said, "Staff definitely look after me well." Another person said, "I think the staff are generally kind and caring." Relatives told us they felt their family member was well cared for and that staff were friendly and kind.

During our inspection visit, we observed that staff were cheerful and provided a caring approach, for example, when people needed reassurance. Staff spoke with people in a polite way and listened to them.

People told us staff involved them in making day to day decisions about their care. One person told us, "Staff will ask me if I want a shower, then they will pick out clothes for me to choose from for the day." Another person said, "I can choose what time I want to go to bed, the staff ask me if I'm ready for bed or not. They never say it's time for bed now."

People could not recall being involved in their care plan or in contributing to reviews about the support they received. One person told us, "I don't remember anything about a care plan." However, some relatives told us they had been involved on their family member's behalf and some records confirmed this to us. One relative said, "I am happy with the staff in how they care for my family member and have been involved in their care plan." Another relative said, "I feel the caring side is brilliant and if I needed to discuss anything, I'd go the manager."

One person told us, "I am treated with dignity here, staff close doors when needed and talk to me when they help me have a shower." Another person told us, "Staff treat me with respect, such as when I have a shower." However, this person added, "At night, staff have told me I can only have one incontinence pad and have to make it last." We found this did not reflect a caring or respectful approach to this person.

During our inspection visit, we observed staff practices that promoted people's privacy and dignity. For example, one person had been incontinent and staff discreetly offered to support this person to the bathroom to freshen up. Staff gave us examples of how they would promote people's dignity such as ensuring bedroom doors were closed. We saw staff knock before entering people's bedrooms showing people were respected.

We found no consideration had been given by the registered manager or provider, as to how the privacy and dignity of people, who were unrelated and sharing bedrooms should be promoted by staff. One staff member told us, "People in shared bedrooms are sometimes washed and dressed on their beds or might have personal care during the night time." There was no privacy curtain in shared bedrooms for staff to use to promote these people's privacy or dignity. We discussed this with the provider and they told us, "People have signed a contract to live here and know it is a shared bedroom."

Relatives told us they were able to visit people at any time and there were no restrictions placed on them. One relative said, "We can visit whenever we wish to, there are no set visiting times here."

Requires Improvement

Is the service responsive?

Our findings

Overall, people felt their needs were responded to and care was personalised to them. People told us they were happy living at the home and gave us some positive feedback about staff. One person said, "The staff are very good and friendly and help me when needed." Another person said, "The staff are kind and helpful to me." However, a few people told us they had to wait for staff, for example when they pressed their call bell or were told to wait for day staff to meet their needs. One person said, "Staff can be a bit slow in answering the buzzer when I press it at night time." Another person said, "I've asked night staff for something and been told to wait for the day staff to arrive."

During our inspection, we saw most people's needs were met in a timely way by staff. However, we observed one person waited seven minutes before staff responded to their call bell. No reason was given to this person for the delay. We informed the deputy manager for care and provider of this, the deputy manager for care said, "I haven't noticed call bells ringing for long."

Relatives felt staff met their family member's needs. One relative said, "Staff look after my family member well and meet their needs." Another relative said, "I'm happy with my family member's care needs being met, I've no concerns."

People's care needs were assessed and their relatives had been involved in initial assessments to plan care. One relative told us, "We completed a 'life history' form when my family member moved here." Staff felt they knew how to respond to people's day to day needs. One staff member told us, "One person only likes to be supported by female staff so we make sure this happens as otherwise they would be upset."

The Linden Care staff member who was the dementia care champion informed us they had completed a dementia care mapping course. They had used these skills to create a reference tool for staff to refer to, which informed them what had a positive impact on individuals living with dementia at the home. For example, spending quiet time alone or being involved in group activities. The information was personalised and could be used to guide staff as to how a 'good day' was achieved for people. However, staff we spoke with told us they did not use the information or refer to this tool, which may have been beneficial to them when supporting some people, whose behaviour could, on occasions, be challenging.

We looked at how people spent their time in the home and saw some people independently pursued interests and hobbies. One person told us, "I like knitting," this person was showing one staff member how to knit and we observed this staff member interacted in a way that valued this person. The activities staff member and care staff took opportunities to engage people in group activities such as indoor skittles, art and crafts and chatting to people. Some people were enjoying watching the Olympics on the television and one staff member gave a person a flag to wave, which they enjoyed doing in support of the British teams competing.

People told us they felt there were enough activities offered to meet their needs, however some relatives felt improvement could be made in staff offering more activities to those people who wished to take part.

One staff member told us, "We have a local Church offer a service on the ground floor and people on the other floors are asked if they wish to attend." One person told us, "I think I went to the service, and I know we have special events at Easter and Christmas which are really nice."

People living at the home told us they were not aware of any 'resident meetings' and the registered manager said they had not yet commenced these or relative meetings. The registered manager said, "I know some meetings took place before I started here two years ago, but I don't think they were very successful so I haven't done any yet, but the first one is planned for this month; August 2016. Relatives know they can always come to see me if there is any concern they need to discuss." Relatives confirmed they would raise any concern or complaint with the registered manager if needed. We found that people living at the home were not routinely supported or encouraged to express their views about their care or support.

Relatives told us they had no current complaints about the overall care their family member received. One relative said, "Staff do their best and I've no complaints about them. I've raised issues about the laundry before, overall if I had something to complain about, I'd speak to the manager."

Requires Improvement

Is the service well-led?

Our findings

There was a management structure in place to support the registered manager. The registered manager told us the provider visited the home on a regular basis and was always contactable by telephone. The registered manager explained that the deputy manager for care for Linden Care Homes Limited visited the home and undertook audits as a part of their role. The registered manager said, "I feel supported in my role by the senior management and also by the care supervisors here in the home."

Staff told us they felt supported and that the registered manager was approachable. However, a few staff said that where they had identified an issue to the registered manager, they had not been informed as to whether action had been taken. For example, one staff member had suggested one person's medicines should be reviewed but had not been informed about whether anything was being acted upon. Care supervisors and team leaders informed us they were supported though team meetings, however care staff said they did not have team meetings and felt these would be beneficial to them. Most staff told us they had one to one supervision meetings with the registered manager or a care supervisor.

The deputy manager for care gave us a copy of a staff notice dated June 2016. We identified this related to an incident that we should have been informed about, but had not been. We discussed this with the registered manager and they told us, "I didn't know I needed to send a notification to you." We found that whilst the provider had dealt with the incident and followed their disciplinary policy, we had not been sent a statutory notification as required.

The deputy manager for care told us feedback had been sought from people's relatives during June 2016. We looked at copies of feedback questionnaires and saw that overall, comments were positive. However, we found no overall analysis had been completed and there was no action plan to outline how improvement, where needed, would be implemented. For example, one comment stated, 'sometimes not enough staff especially at weekend'. The registered manager had noted this had been discussed but there was no record of the discussion or how improvement, if required, was planned for.

Visiting professionals, such as social workers, had made positive comments on feedback questionnaires. These included the comments, 'lovely décor' and 'friendly atmosphere.'

The registered manager confirmed to us that feedback questionnaires had not been given to people living at the home. However, the registered manager said, "When relatives complete their questionnaire, they do this with their relation." We acknowledged this may take place, but found people were not offered a separate opportunity to give their feedback and where some people did not have visiting relatives, may not have had opportunities to share their feedback to the registered manager or provider.

Some systems were in place to audit the quality of services. The deputy manager for care informed us they completed a medicine audit every six months and other checks by the registered manager were completed informally on a monthly basis. The deputy manager for care told us, "I've just completed a medicines audit and found no major issues." The audit completed just three days prior to our inspection visit had identified

some of the issues we found such as missing signatures on some medicines administration records. However, the audit had failed to identify other issues we found. For example, bottles of homely remedies were undated on opening and one bottle of simple linctus cough syrup had passed the expiry date of May 2016. Checks had not identified where staff were not following pharmacy instructions on medicine administration records.

We asked to look at infection control audits and were told these formed part of the housekeeping checks. These checks had not been effective in identifying risks of cross infection, such as with items stored in the sluice room, incontinence pads removed from their packaging and towels left in communal shower rooms.

Care plan audits were not always effective because they had not identified issues we found. For example, where people had a specific health care condition this was stated but no information was available about the person's health care condition for staff to refer to when needed. Care plan information ensures staff take a consistent approach to meeting people's needs and audits of care records had not identified any need to include further information.

Accidents and incidents were recorded and analysis took place. However, we found the registered manager's analysis had not given consideration as to how to prevent a reoccurrence of accidents. For example, we saw 15 accidents had been recorded for July 2016 but no action plan for the 8 accidents where injuries had occurred. We discussed this with the registered manager and they told us, "There is no overall action plan, but on an individual basis I would review care plans and update risk assessments when needed."

The registered manager informed us they completed informal checks on staff and the environment as a part of their walk around the home whenever they were on shift. We asked how they checked the timely responses of staff meeting people's needs and they told us, "When I am here in the office I can hear if the call bells are ringing for a long time and would check if they were. I don't complete any audit on how staff respond to call bells." The informal checks had not always identified issues we found.

This was a breach of Regulation 17 (1) (2) (a) (b) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the registered manager on their return from leave and they informed us improvements would be made in areas we had identified to them and given feedback to the provider and deputy manager for care on the day of our inspection visit. These included planning a review for people receiving their medicines 'covertly'.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place to monitor the quality of the service provided were not always effective.