Restful Homes Group Limited

Avon Court 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?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

This inspection took place on 16 February 2015 and was unannounced.

Avon Court is a purpose built residential and nursing home which provides care to older people including people who are living with dementia. Avon Court is registered to provide care for 64 people. At the time of our inspection there were 55 people living at the home.

A registered manager was not in post as the registered manager named in this report was no longer at the service. A new manager had been appointed and their application for registration was being assessed at the time of our visit. 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.

People told us they felt well cared for and safe living at Avon Court and staff knew how to keep people safe from the risk of abuse.

Staff received training in areas considered essential to meet people's needs safely and consistently. The manager told us they had identified staff required further training to make sure they continued to keep their skills and knowledge updated.

Summary of findings

Care plans and risk assessments contained relevant information for staff to help them provide the personalised care and treatment people required. However, we found occasions when delivery of care did not support people's needs and people did not always have the necessary treatment or equipment to protect them from associated risks.

People told us staff were respectful and kind towards them and we saw staff were caring to people during our visit. Staff protected people's privacy and dignity when they provided care and asked people for their consent before care was given.

Staff understood they needed to respect people's choices and decisions. Assessments had been made and reviewed to determine people's capacity to make certain decisions. Where people did not have capacity, decisions were taken in 'their best interest', although records of these meetings and decisions were not always kept to support the action taken.

The provider was meeting the requirements set out in the Deprivation of Liberty Safeguards (DoLS). At the time of this inspection, one application had been made under DoLS for people's freedoms and liberties to be restricted. The manager had contacted the local authority and was in the process of reviewing people's support in line with recent changes to DoLS to ensure people's freedom was not unnecessarily restricted.

People were given choices about how they wanted to spend their day so they were able to retain some independence in their everyday life. Family and friends were able to visit when they wished and staff encouraged relatives to maintain a role in providing care to their family members.

Some people we spoke with told us they were supported to be involved in pursing their own hobbies and interests. Activities were available for people living in the home, however it was recognised further improvements were required. The staff member responsible for providing activities was enthusiastic and we saw they spent some time with people and were engaged in one to one activities during our visit.

Regular checks were completed to identify and improve the quality of service people received, although some checks had not been completed for some time. The provider completed checks to assess the service people received which fed into an action plan to ensure improvements were made in the quality of service provided.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not consistently safe.

People told us they felt safe and staff understood their responsibility to report any observed or suspected abuse. Staff told us they were very busy at certain times of the day and night, so there were occasional delays in meeting people's needs. People's needs had been assessed and where risks had been identified, risk assessments advising staff how to manage these safely were not always up to date and followed. People received their medicines when prescribed from staff who were suitably trained and competent to administer their medicines.

Requires Improvement

Is the service effective?
The service was not consistently effective.

People and their relatives were involved in care planning decisions, although people did not always receive the support they required from staff. Where people did not have capacity to make decisions, support was sought from family members and healthcare professionals in line with the Mental Capacity Act 2005, although decisions reached were not always recorded. The provider was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). People were offered choices of meals and drinks that met their dietary needs and systems made sure people received timely support from appropriate health care professionals.

Requires Improvement

Is the service caring?
The service was caring.

People were treated as individuals and were supported with kindness, respect and dignity. People told us staff were patient, understanding and attentive to their needs. Staff had a good understanding of people's preferences and how they wanted to spend their time.

Good

Is the service responsive?
The service was not consistently responsive.

People's care records were reviewed but they did not always reflect the levels of care and support people required which meant staff were not always responsive to meet people's needs. The manager responded to people's written complaints, but if people raised informal concerns these were not always resolved to people's satisfaction.

Requires Improvement

Is the service well-led?
The service was not consistently well led.

Requires Improvement

Summary of findings

The home did not have a registered manager in post at the time of our visit. There was a lack of systems in place so people, relatives and staff could make sure their views and feedback was shared, so any improvements to the quality of service could be made. There were systems of checks and audits to identify improvements, however improvements to the care and support people required were not always acted upon in a timely way.

Avon Court 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 16 February 2015 and was unannounced.

The inspection team consisted of two inspectors and an expert by experience who had experience of caring for someone with dementia.

We reviewed the information we held about the service. We looked at information received from relatives and other agencies involved in people's care. We also looked at the statutory notifications the manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. We also spoke with the local authority but they did not share any information with us that we were not already aware of.

We spent time observing care in the lounge and communal areas. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us.

We spoke with four people who lived at Avon Court and four visiting relatives. We spoke with seven care staff, the manager, the deputy manager and the operations manager. We looked at five people's care records and other documentation related to people's care including quality assurance checks, management of medicines, complaints and incident and accident records.

Requires Improvement

Is the service safe?

Our findings

People told us they felt well cared for and safe. Comments included, "I feel quite safe here, I would talk to the nursing staff or my [family member] but I've never felt not safe" and "Never felt unsafe. If I did, I would speak to the nurse to begin with, then the manager." Relatives we spoke with also felt their family members were safe. One relative told us, "[Family member] has always been safe" and, "Yes I do. The night staff are excellent."

Speaking with staff showed us they understood what to look out for if they suspected people were at risk of harm or abuse. Comments staff made were, "There are all sorts of abuse. We have to keep an eye out for any kind of abuse" and "The way people are treated, the way they look and if the resident doesn't look quite right it makes you wonder why." Staff told us they recorded bruises or marks on people's bodies and these were reported to nursing staff to make sure people were protected from harm.

Staff told us they had received training on how to protect people from abuse or harm and were aware of their role and responsibilities in relation to protecting people. Staff training records confirmed staff had received relevant training to support people safely. The provider had a policy and procedure about safeguarding and this linked in with the local authority's protection of adults. From the information we looked at prior to the visit, we were aware that the provider had reported safeguarding concerns to the local authority and the CQC appropriately.

We looked at whether staffing levels were sufficient to meet people's needs. Prior to this inspection we received some concerns from relatives that staffing levels did not always meet people's needs. We spoke with people and relatives to get their views on whether staff provided support when they needed it. Most of the people and relatives said they felt staffing levels met their needs. Comments people made were, "More than enough staff here", "Generally speaking yes, there are enough staff. There are occasions when they are short, usually in an emergency or when a new person arrives" and, "As far as I'm aware the staff change a lot here, but there seem enough of them". Relatives we spoke with told us, "There's always enough staff, I think so. They are usually there when I want them" and, "They are always busy, but they have been popping in all the time."

Nursing and care staff spoken with said they could meet people's needs, but found it became difficult at certain times of the day. Staff told us a high number of people required two staff to help mobilise and transfer, so on occasions people had to wait longer for assistance, particularly when staff went on breaks because it left reduced numbers of staff on the floor. When this happened, we were told staff from other floors had to assist. One nurse said, "Nursing levels are terrible. We have agency nurses but the quality is variable and they only do the basics. I am the only nurse really for 40 people. It is full on. "Some staff told us that because they were so busy, there was little time to spend quality time with people.

The manager told us staffing levels were not based on people's dependencies, but on a ratio. We spoke with the deputy manager who completed staff rotas. They told us they were satisfied with the staffing levels for care staff, but did agree with nursing staff that three nurses would be better than two nurses. They said, "It gives you more time to spend with people, without having to fire fight because we have a high turnover."

During our observations we saw staff supported people and responded to people's requests, however some staff appeared rushed and on occasions it was difficult to find staff to talk with without affecting the delivery of the service. We discussed this with the operations manager and the manager and asked them to have a look at staffing levels to satisfy themselves that staff were deployed to meet people's needs safely. The operations manager told us they thought there was sufficient staff to meet people's needs and if any additional staff were required, then levels would be increased.

The manager and operations manager told us they were recruiting for nursing and care staff and because of this they relied heavily on agency staff. The manager told us they used the same agency and the same staff where possible. This was confirmed by a relative who said, "You see the same agency staff coming back time and time again so it does give you some semblance of continuity." The manager recognised they required additional staff and were recruiting for more permanent staff so they could reduce their reliance on agency staff.

Risk assessments were in place to identify and manage risks. Staff had information to manage and minimise those risks to people and used assessment tools to help keep people safe. Most assessment tools were reviewed

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Is the service safe?

regularly to identify whether there had been any increase in risks. However, we did identify some records where the risk assessment tool had not been updated. We also found that risk management plans were not always being carried out in practice. For example, one person was at risk of their skin breaking down and their care records indicated the risk assessment tool should be reviewed monthly. The risk assessment tool had been completed in September 2014 and was not reviewed again until February 2015. The person had developed a breakdown in their skin in January 2015. To minimise further risks to the person, they were required to sit on an airflow cushion for a maximum of two hours daily. We observed this person was sat in the communal lounge from 11.15am to 4.45pm. They were not sitting on an airflow cushion during this time which posed a risk to the person as they were not receiving the care and support they required to manage the risks to their skin appropriately.

Systems were in place to make sure people received their medicines safely from staff who were suitably trained. People told us care staff supported them to take their prescribed medicines when required. One person said, "I take medicine morning and night, it's usually on time." Medicine records contained photographs and known allergies and staff said this helped make sure people received the right medicines and any risks were identified. Medicines were stored at the correct temperatures and were disposed of safely and appropriately at the end of each medicine cycle.

Medicine administration records (MAR) confirmed each medicine had been administered and signed for at the appropriate time. We checked four people's medicines and found one person's medication was required to be taken once or twice a day. The records did not accurately reflect what dosage was to be given which made it difficult to check stocks of this medicine. The manager agreed to discuss this with the nursing staff to ensure medicines were recorded correctly to reduce the potential of errors being carried over to the next medicines cycle. PRN medicines or 'as and when' medicines had protocols in place; however these did not always record the reasons why PRN medicines were to be given. The manager gave us assurance this would be addressed promptly so staff knew when and why people required these medicines.

Records showed incidents and accidents had been recorded and where appropriate, people received the support they needed. The manager told us they analysed these incidents for any emerging patterns. The operations manager told us they also reviewed these on a monthly basis to ensure appropriate measures had been taken to keep people safe.

Requires Improvement

Is the service effective?

Our findings

People told us the service they received was good and they usually received care and support from staff who had the skills and experience to care for them. One person told us, "Care can be inconsistent when they bring in agency staff who are not fully trained to use the hoist, but they always involve a more experienced carer." Other comments included, "They appear to be kind and well trained, they look after me. You see so many, they change frequently, you don't know their names" and, "I think they look after her, there's no reason to think not."

Staff spoken with told us they received an induction when they started work at the home. A new staff member told us they completed essential training, shadowed an experienced member of staff and then worked with a senior staff member before they worked on their own. They told us there was no pressure for them to work on their own until they felt confident to do so.

Staff told us they received training to meet people's health and safety needs, however the manager told us they had identified all staff required further training updates to make sure their skills and knowledge continued to support people effectively. The manager told us they were in the process of arranging the training. Speaking with staff we found some staff had not received training to provide them with further knowledge about managing and supporting the specific needs of people who lived in the home. For example, dementia, catheter care or diabetes. One staff member told us, "I think we could do with more training." Another told us, "Maybe you need more training. I had dementia training in my previous place but haven't had it here, or catheter training."

We found further training would support staff in understanding people's needs so they could respond in a more informed way and provide more effective care. For example, one person could be resistant to receiving personal care. Their care plan provided staff with information and guidance if care had to be delivered in the person's best interests. Care records stated staff should use the least restrictive way of managing the person's needs and adhere to the provider's policy on restriction. From speaking with staff, we found most staff had not received training in managing behaviours that were difficult to manage, so we could not be sure staff had the skills and knowledge to effectively support people whose behaviours challenged others.

We saw staff gained people's consent before supporting them with care tasks and staff prompted people to make their own decisions, whether they wanted assistance or not. One person said, "They always ask first." Staff gave us examples of how they sought consent and how they made sure people had consented before any care was provided. One staff member said, "I will talk and explain what I am doing. If they are not happy we will leave them to calm down and go back and try again."

We found staff had limited knowledge of the key requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and what this meant for people. This was because the provider had not trained care staff in understanding the requirements of the Mental Capacity Act. The manager told us they would arrange mental capacity training for all staff. The MCA and DoLS require providers to submit applications to a Supervisory Body for authority to deprive a person of their liberty. The manager confirmed that one application had recently been submitted to the Supervisory Body although this had not yet been approved.

The manager and deputy manager told us mental capacity assessments had been completed as a priority for people on the second floor because they had a diagnosis of dementia. We looked at one completed capacity assessment. The person's assessment indicated they did not have capacity to make decisions in respect of some aspects of their care. There was no information to show which healthcare professionals or those closest to them, had been involved in decisions that were made in the person's best interests.

We looked at a second assessment for a person who had a diagnosis of dementia and confusion. Bed rails were in place but there was no mental capacity assessment and no evidence of a best interests meeting to assess whether this was the least restrictive way of keeping this person safe.

People told us they enjoyed the food and we saw they were offered a variety of drinks during our visit. Comments people made were, "The food is lovely. You get a choice of

Requires Improvement

Is the service effective?

three", "It satisfies me, they come round with the menu the day before" and, "They come round with tea at elevenish and in the afternoon. You always have a jug on the table; they fill it up every morning."

Staff told us if people did not want any choices on the menu, alternatives would be provided and this was confirmed by what people told us. One person we spoke with said, "Last week I didn't want what was on offer, they made me a nice salad instead."

People who had risks associated with poor fluid and food intake were monitored. Staff completed food and fluid charts and people were weighed regularly to make sure their health and wellbeing was supported. Staff told us they knew people's individual requirements and made sure people received their food, drink and support in a way that continued to meet their needs.

People told us they saw other healthcare professionals when required. One person said, "I have a chiropodist, they come weekly. I also have a reflexologist. I go out to my dentist; it's only round the corner." Records showed healthcare professionals were contacted when people required specialist support or advice. For example, people were seen by the dietician, occupational therapists, district nurses and the GP visited the home on a daily basis to monitor people's health and wellbeing.

Good

Is the service caring?

Our findings

People were very complimentary about the staff who they described as 'kind' and 'caring'. We spoke with one person who told us staff were caring. This person told us they preferred to stay in their room, but said, "Sometimes they are straight round when I ring. If they are free, they look after me especially if it's urgent" and, "They are very caring. I had one carer who was lazy, but [staff member] has mended their ways." All of the people and relatives we spoke with said the staff worked hard to make sure people were cared for.

People and relatives told us they were involved in care planning decisions and reviews which meant people's care needs continued to be met. Some relatives said they had not been reviewed for some time, although they said their family member's needs continued to be met. Comments people made were, "They did an assessment after three months. I have a copy. No reviews since, I think its twelve monthly", "When they discharged me from the hospital they did a care plan with me and my son. There's a review going on at the moment, my son is looking after that." There was a system of review in place and people were involved in making decisions about the care they received.

We spoke with two relatives and asked them whether their family members were well cared for. We also asked how the manager and staff supported them at difficult times, particularly when their family member's received end of life care. Both relatives gave examples to us of the support and comfort they had received. One relative told us staff had helped their relative with personal care and then put some lipstick on for them. They explained, "It was a lovely little touch that made my day." This relative also told us staff arranged for a local priest to visit as their family member was Catholic. The other relative said because they lived a distance away, staff found them a room to stay overnight so they could be near to their loved one. This relative said, "I think they thought outside the box." All the people we spoke with said family members and visitors could visit whenever they wanted and there were no restrictions visiting times or the length of stay.

One staff member described to us the qualities and attitudes that made a good carer. They said, "You have got to build a bond, a relationship with people. You have to be there for them, look after them and do what you would do for your family." Staff we spoke with told us they cared for people living at Avon Court, although all staff said they would prefer to spend more time with people.

We saw staff knew how to respond to people to minimise distress. For example, we saw staff spent time with a person, they comforted them and the person responded by smiling and appeared more relaxed. However, our observations during the day made it difficult to find other examples that supported what people and relatives had told us about the kind and caring attitude of staff. We saw staff only interacted with people in communal areas when carrying out tasks such as giving people drinks and snacks. We saw very little other engagement between staff and people which supported what staff had told us about a shortage of quality time to spend with people. This was because staff were busy providing support to people in the privacy of their own rooms.

People told us staff respected their independence and supported people to maintain their own relationships with others. One person said, "They understand that to be independent is a necessary requirement of mine." Another person told us, "I'm quite independent, they encourage that". We spoke with one person who had their own telephone in their room so they were able to maintain friendships and relationships in privacy. This person's room contained personal items, such as furniture and ornaments. They said, "She [manager] said bring a few things in to make it like home. This is my choice." We asked this person if staff protected their privacy and dignity. They responded, "I feel I am being well protected. It is like a family."

People we spoke with said staff respected their privacy and dignity when care was provided. Comments people made were, "Yes, they do, very respectful. They always close the door when they wash me and pull the curtains and when the doctor comes" and, "If I need to be hoisted, they close the door and the curtains. I can have the door closed if I want to be more private, it's my choice".

Requires Improvement

Is the service responsive?

Our findings

People we spoke with told us they were pleased with the quality of care they received. Comments people made were, "The nursing care is their forte" and "The support from the staff at the home, I think this is their strength."

People needs were assessed before moving to the home. These assessments provided staff with the necessary information and knowledge before people moved to the home to ensure it was suitable to meet their needs.

People and relatives of people who used the service told us they were involved in the care planning decisions and felt able to discuss any care and support needs. A relative we spoke with had been involved in a care plan review. This relative said, "They have asked me and they did do a review about three months ago." This relative told us when their family member's health declined, they, "Had a meeting with two nurses to discuss what the plan of action was." We saw records that showed family involvement was an essential part of people's care planning.

People spoken with told us staff knew their likes and dislikes and how they wanted to spend their time. One person we spoke with said, "They know what I prefer. My interests are sport, I have books to read and I watch TV." Another person enjoyed plants and said staff helped them to replant an orchid which they enjoyed.

We asked staff how they got to know people's needs. Responses included: "If I'm not sure I can ask" and, "I can always read their care plans if I have five minutes. There is not much time to read care plans but they have told me what most of the resident's needs are." We saw examples where care plan records and staff knowledge supported each other to make sure people received the right levels of support. For example, we saw information in one person's care plan whose mobility varied. Staff told us they had to assess the person's mood, understanding and co-operation before each attempt to mobilise this person. Staff told us this helped support this person to maintain as much independence as possible and encouraged them to mobilise themselves when they were able.

Most of the nursing staff told us they had a shortage of time which meant care records were not always changed or reviewed when required. Nurses told us this had impacted on the quality and consistency of care some people received. This was supported by some care records we saw. For example, one person's care plan for 'physical intervention' identified them as being resistive to personal care and records stated three to four staff were required to deliver care. This person's care plan was last reviewed August 2014. We were aware this person's health had declined so we could not be sure it supported their changing needs.

We looked at the care records for one person who had a pressure area which affected their skin integrity. The management plan to promote healing of the skin was that this person's dressing was to be changed every three to five days or as required. At the time of our visit the dressing had not been changed for seven days. Staff spoken with were unable to provide an explanation as to why.

We also looked at care records for a person who had a catheter fitted. The manager confirmed the catheter should be changed every 12 weeks. Records indicated the catheter had been changed in February 2015 having been in place since May 2014. The nurse told us this person had suffered numerous urinary tract infections during this period. The nurse on duty confirmed that the catheter change had been grossly overdue. The nurse said, "We suddenly thought it hadn't been changed for months. It was disgusting. There was never a protocol in place but there is now." The nurse confirmed to us that other people who had catheters fitted, had been checked and catheters were replaced as required.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people we spoke with told us they felt there were not enough activities or hobbies provided to meet their individual needs. One person we spoke with said, "There isn't much to do here." A relative told us, "[Person] goes into the day room and does quizzes, that's about it" and "

"It's only been a few weeks so it's hard to know if they know what [person] likes."

Some people told us they did group activities such as quizzes which they enjoyed although not everyone was able to participate, for example people who remained in their rooms because of their health. Most of the staff we spoke with felt more could be achieved to involve people in hobbies and interests. One staff member told us, "We are the classic four walls and a television." We spoke with the manager about this and they recognised improvements

Requires Improvement

Is the service responsive?

were required in this area. The manager agreed to discuss hobbies, activities and interests with people and staff and any suggestions that could be made, would be put into practice.

Most people spoken with told us they had no complaints about the service they received. People said if they were unhappy about anything they would let the staff know or talk to the manager. One person said, "I would let the carers or manager know." Another person said, "I would let my son sort it out." One relative we spoke with told us they had not made a complaint, but had raised concerns with staff and management however they told us they were disappointed actions were not taken quickly enough. This relative told us they wanted their family member to have more time with staff, so they felt less isolated and had some stimulation. They told us the delay in reaching a decision, meant it was too late to provide additional support because the person's health and wellbeing had decreased to a level they could no longer benefit from this support.

We looked at how the provider managed complaints and saw they had received seven complaints in nine months. The manager told us these complaints had been investigated and responded to in line with the provider's own policies and procedures and to the satisfaction of the complainants. We saw one person who made a complaint was not happy with their response and further investigation of the complaint was being completed by the operations manager. The operations manager told us they took complaints very seriously and ensured lessons learnt could be made to prevent similar complaints from reoccurring.

Requires Improvement

Is the service well-led?

Our findings

People and relatives were complimentary about the service provided. Comments people made were, "I would give the home 10/10, there's nothing to improve" and, "We saw the manager when she first came in three weeks ago. We see her around the home. It's too early to give any views yet, it looks fine to me. I would say 9/10, it's all fine."

The service was required to have a registered manager in post however the registered manager left this service in August 2014. At the time of our visit a manager had been appointed and the process for registering them with us was underway. The new manager was open with us about challenges they faced at the home. For example, they acknowledged improvements were needed to the provision of training within the home as most staff required refresher training to ensure their knowledge and skills were up to date and continued to support people safely. The manager also told us they had not completed staff supervisions in line with the provider's expectations because they had focussed their efforts on restructuring the care within the home. We were told plans were in place for other senior staff to complete supervisions with all staff to ensure they had an opportunity to discuss any issues or concerns.

People and relatives told us they had not been asked to share their views on how the service could be improved. One person we spoke with told us, "I honestly don't know if they do have any meetings. I've never been taken to any, never had a questionnaire, not since I've been here." A relative told us, "I think they used to have relation meetings. A carer [staff member] told me they were hoping to start them again. I have never been asked to fill out a questionnaire." The manager told us they had not held any group meetings with people or relatives since they started at the home in July 2014.

Minutes of the last resident and relatives' meeting showed it was May 2014. Before we left the home the manager planned a series of meetings in 2015 and told us these dates would be displayed in communal areas so people and relatives knew when to attend.

Staff told us they had not had staff meetings for some time and the manager confirmed this. Following our feedback, the manager planned staff meetings for all staff during 2015 and gave us assurance these meetings would be held. Staff we spoke with said if they had any concerns they could speak with the manager and most staff we spoke with said the manager was approachable. Comments staff made to us were, "I think we are a good home. The staff work hard and it shows we work hard" and, "[Manager] knows where to find the carers [staff]. For me [manager] is nice, approachable and she will listen to you."

The manager told us they carried out various quality checks and audits of the service. Some of these checks included the safety of the environment, equipment and health and safety. We found that whilst checks were completed, sometimes concerns were missed or the frequency of checks had not been completed as required. For example, fire safety checks had not been completed from October 2014 to January 2015 and daily fire tests were only completed once a week which had potential to place people at risk in the event of an emergency.

Medicine audits showed actions had been taken when issues had been identified. For example, a medication error was identified and the process for administering a specific medicine was changed so only nursing staff administered that particular medicine. This helped reduce the potential of further medication errors.

Care plans were reviewed and checked by the manager, however we found the system in place to audit care reviews required improvements. The manager had recognised the audit process was less effective on two floors, yet only checked a small number of care plans. During this inspection we found three care plans out of five required further improvements to make sure they met people's changing needs.

The manager told us they were responsible for completing all of the pre assessments of care for people who moved to the home. The manager told us they had a deputy manager who supported them to make sure managerial tasks and day to day running of the home was maintained in their absence. The manager said the deputy manager had six hours protected time to carry out their managerial responsibilities. However, the deputy manager told us they did not get protected time and as a result, this impacted on their ability to complete certain managerial tasks and quality checks.

We found there were some arrangements in place to assess and monitor the quality of the service. These included provider quality monitoring visits which the operations

Requires Improvement

Is the service well-led?

manager completed. The results of these visits were shared with the manager to identify any actions that were required. The operations manager completed further checks to ensure the action plans had been completed and the improvements made.

The manager understood their legal responsibility for submitting statutory notifications to us, such as incidents that affected the service or people who used the service. During our inspection we did not find any incidents that had not already been notified to us by the manager following their appointment.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 9 HSCA (RA) Regulations 2014 Person-centred care We found that the registered person had not protected people against the risk of receiving care and support which had been delivered in a way that ensured their welfare and safety, or in a way that met people's individual needs. This was in breach of Regulation 9 (1)(b)(i)(ii) of the Health and Social Care Act 2008 (Regulated Activities) 2010, which corresponds to Regulation 9 (1)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) 2014.