Park Lane Healthcare (The Manor House) Limited

The Manor House

Inspection report

White Gap Road
Little Weighton
Humberside
HU20 3XE

Tel: 01482848250

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The Manor House is a care home that accommodates up to 38 older people, some of whom may be living with dementia. The home is situated in the village of Little Weighton, close to the town of Beverley, in East Yorkshire. Bedrooms are located on the ground and first floors and there is a passenger lift to reach the first floor. On the day of the inspection there were 32 people living at the home, including two people who were receiving respite care.

At the last inspection in June 2016 we were concerned that medicines records were not well maintained and that people had not received the right medicine at the right time. We issued a requirement in respect of Regulation 12 (2)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we saw that the management of medicines had improved and that the provider was no longer in breach of this regulation.

At the last inspection in June 2016 we were concerned that CQC had not been notified about DoLS applications that had been authorised as required by regulation. This was a breach of Regulation 18 of the Registration Regulations 2009. At this inspection we saw that notifications about DoLS and other issues had been submitted to CQC, meaning the provider was no longer in breach of this regulation.

At this inspection we identified concerns about the prevention and control of infection. The systems currently in place did not fully protect people from the risk of infection. We detected unpleasant odours in some areas of the home and found equipment and bedding that was dirty and stained.

This was a breach of Regulation 12 (2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment.

The manager and senior managers carried out audits to ensure people were receiving the care and support that they required, and to monitor that staff were following the policies, procedures and systems in place. However, these audits had not identified the shortfalls we found in respect of the cleanliness of the premises, indicating they were not always effective. We made a recommendation about this in the report.

There was a manager in post who was not registered with the Care Quality Commission. 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. The manager had commenced the registration process with CQC.

Although the provider was using a dependency tool to determine staffing levels required to support people who lived at the home, some people told us they thought more staff would be beneficial, especially during the evenings. We made a recommendation about this in the report.

Staff had been recruited following robust policies and procedures and people told us they felt safe living at the home.

People told us they were happy with the choice of meals provided at the home. People's nutritional needs had been assessed and food and fluid intake was been monitored when this was an area of concern.

Care planning described the person and the level of support they required. Staff knew people well and were able to meet their individual care and support needs.

Staff were kind, caring and patient. They encouraged people to be as independent as possible and respected their privacy and dignity.

People were supported to have choice and control over their lives and staff supported them to make decisions when this was something they found difficult.

Activities were provided and people reported that the availability and variety of activities had improved.

Risks to people were assessed and reduced where possible. Staff received training on safeguarding adults from abuse. They were able to describe different types of abuse they may become aware of and the action they would take to protect people from harm.

People understood how to express any concerns or complaints and were encouraged to feedback their views of the service provided.

Staff told us they were well supported through supervision and staff meetings.

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.

The premises had not been maintained in a clean and hygienic condition.

People told us more staff would be beneficial especially during the evenings.

Staff were recruited safely and were aware of their responsibilities to protect people from the risk of harm.

Is the service effective?

Good

The service was effective.

Staff understood their responsibilities under the MCA and people were supported with decision making.

People told us they enjoyed the meals at the home and people's nutritional needs were assessed and met.

People had access to health care professionals as needed.

Is the service caring?

Good

The service was caring.

Staff were kind and caring and there were positive relationships between people who lived at the home and staff.

People's privacy and dignity was respected by staff.

Is the service responsive?

Good

The service was responsive to people's needs.

People had care plans in place that described them and their support needs.

Activities were provided so people had social stimulation.

There were complaints policies and procedures in place that people were made aware of. People and their relatives had the opportunity to share feedback about the service provided.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Although regular audits to monitor the quality of the service were being carried out, these had not identified some areas that required improvement.

There was a manager in post who had commenced the registration process with CQC.

People told us that the manager was visible within the service and approachable.

The Manor House

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 checked 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 was a comprehensive inspection that took place on 31July 2017 and was unannounced. The inspection was carried out by two adult social care inspectors.

Before this inspection we reviewed the information we held about the home, such as information we had received from the local authority and notifications we had received from the provider. Notifications are documents that the provider submits to the Care Quality Commission (CQC) to inform us of important events that happen in the service. The provider was asked to submit a provider information return (PIR) before this inspection. The PIR 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. The PIR was submitted within the required timescale.

On the day of the inspection we also spoke with five people who lived at the home, five relatives, three members of staff, a visiting health care professional, the manager and three directors of the organisation. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked around communal areas of the home and some bedrooms, with people's permission. We also spent time looking at records, which included the care records for four people who lived at the home, the recruitment and induction records for two members of staff and other records relating to the management of the home, such as quality assurance, staff training, health and safety and medication.

Requires Improvement

Is the service safe?

Our findings

At the last inspection we were concerned about the management of medicines; this was a breach of Regulation 12 (2) (f) of the Health and Social Care Act (Regulated Activities) Regulations 2014. At this inspection we found there were thorough policies and procedures in place and staff were careful to adhere to administration practices. We saw that medicines were stored safely, obtained in a timely way so that the person did not run out of them, administered on time, recorded correctly and disposed of appropriately; this included the management of controlled drugs (CDs). CDs are medicines that require specific storage and recording arrangements. We saw that staff were patient with people when encouraging them to take their medicines, and did not sign the medicine administration records until they had seen the person swallow their medicines. We discussed the importance of having an audit trail to evidence that the medicine delivered by the pharmacy was the same as the medicine prescribed by the person's GP, and staff told us this would be actioned. This meant the provider was no longer in breach of this regulation.

Prior to the inspection we received information of concern about cleanliness of the premises and the people being cared for. We walked around the premises and looked at communal areas of the home, bedrooms, bathrooms and toilets. We observed that, although there was evidence of regular cleaning, some areas of improvement were required to ensure staff were consistently following best practice in relation to the prevention and control of infection. For example, we saw worn and stained bedding, dirty bed bumpers, dirty commodes and mobility equipment, stained floors and stained walls in bedrooms. The laundry facilities did not have distinct 'clean' and 'dirty' areas. The bath in one bathroom was used to store pillows and bedding. A toilet frame in the same bathroom was dirty and the paint flaked off when we touched it; it would not have been possible to keep this frame clean. Some bedrooms had an unpleasant odour. We toured the premises at the end of the afternoon and saw that those areas we found to be dirty earlier in the day remained dirty.

A member of domestic staff told us that they regularly cleaned bathrooms and toilets and vacuumed the home. They said that care staff were responsible for laundry and cleaning commodes. We saw there were cleaning schedules in place that recorded when areas of the home were cleaned routinely, weekly or 'deep' cleaned. However, our checks of the premises showed that these were not effective. Audits had also taken place on the prevention and control of infection. The bedroom audit dated 16 May 2017 recorded that in one bedroom the 'Carpet smells of urine and commode needs replacing' and an audit dated 15 February 2017 recorded 'Odour in entrance'. Other environmental and infection control audits also identified unpleasant odours in the home. There was no record on the documents we saw of the action that had been taken.

This was a breach of Regulation 12 (2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment.

Staff reported that there were ample supplies of personal protective equipment such as gloves and aprons, and we saw this to be the case on the day of the inspection.

One of the directors told us they were very disappointed with our findings, as they had carried out audits

themselves and had not identified these concerns, and they were following the prevention and control of infection code of practice. They arranged for a team of staff from another of their homes in the area to come to the home that evening / night to carry out a deep clean of all areas of the home.

The home had received a food hygiene score of five. The inspection had been carried out by the health and safety team of the local authority, and checked hygiene standards and food safety in the home's kitchen.

People told us they felt safe living at the home. One person said, "I'm quite happy. It's better than being on your own. There's lots of company. I couldn't be in a better place." A relative told us that their family member was reluctant to use the emergency call bell, but they felt their family member was safer since they had moved to a downstairs room. Another relative told us there had only been one occasion they had felt their family member was unsafe, and this was due to the actions of another person who lived at the home. They said that this was unsettling at the time, but the person had since moved out of the home. A health care professional told us, "People who live here can be challenging. We visit early and late and staff always seem to be 'on the ball'."

Care needs assessments had been carried out, and when risks had been identified, action was taken to minimise potential risks without undue restrictions being placed on people. We saw risk assessments in respect of people walking unaided and falls and noted that these had been reviewed monthly so they remained up to date and relevant to the person concerned. We saw staff assisting people to transfer from a chair to a wheelchair or to a standing position, and noted that appropriate equipment was used and the transfers were carried out safely. The manager was qualified to train staff on moving and handling techniques so this training could take place in-house. Care plans also recorded the specialised equipment people had been provided with to prevent the risk of pressure sores developing.

Staff received training on safeguarding adults from abuse, although the training matrix showed three members of staff required refresher training. They were confident when describing different types of abuse they may become aware of and the action they would take to protect people from harm. Staff told us they would pass on any concerns to the manager and were confident their concerns would be dealt with immediately. We checked the folder where safeguarding information was stored. We saw the tool introduced by the local authority was being used to assess the risk level of each allegation to make a decision whether an alert needed to be submitted. The folder included information about a recent safeguarding incident that we had been made aware of.

The information supplied to us by the provider in the PIR indicated that staffing levels at the home were low compared to other services of the same size, and that they had higher staff vacancy rates. The provider showed us the formula they used to work out staffing levels based on people's dependency levels. The rota recorded there were four staff on duty during the day and three staff on duty during the night. These staffing levels were consistent over the three week's rotas we reviewed. Staff told us that they tried to cover any vacant shifts when other staff went off sick. Comments from relatives varied. They included, "I don't think there are ever enough staff. Some days here are tranquil, serene and quiet. Other days the atmosphere is different – service users are unsettled and staff are racing around", "I have visited at night and not seen any staff downstairs" and "I can always find a member of staff when I need one." A health care professional told us that staff were sometimes 'pushed for time' and that they felt more staff would be beneficial.

Domestic assistants were employed in addition to care staff. There was no cook at the home as the service provided pre-prepared meals from an outside company. This meant care staff were also responsible for the heating and serving of meals and laundry duties, which meant they had less time to spend with people who lived at the home.

We were concerned about staffing levels in the evenings. The night shift started at 7.00 pm and many people were not in bed by that time. This meant that the number of staff to serve supper and assist people to get ready for bed was reduced at a time of high activity. The provider told us they would look at staffing levels in the evenings.

We recommend that the provider reconsiders staffing levels, especially in the evenings, to ensure there is always a staff presence in the home.

We checked the recruitment records for two members of staff. These records evidenced that references and a Disclosure and Barring Service (DBS) check had been obtained. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults to help employers make safer recruitment decisions. We discussed with the provider how these records would be improved by references being dated when they were received in the home. New staff received a copy of their job description which gave them clear information about what was expected of them.

Accidents and incidents were recorded and analysed each month. This included a record of any action taken following the fall, such as contacting the emergency services or sensor mats being put in place. Body maps were used to record where on the body the injury occurred, and to assist staff to monitor the person's recovery.

There was a business continuity plan that provided advice for staff on how to deal with unexpected emergencies. In addition to this, people had a personal emergency evacuation plan (PEEP) in place that recorded the assistance they would need to leave the premises in an emergency. We discussed with the manager that a copy of each PEEP should ideally be placed with the contingency / fire evacuation plan and within each person's care plan.

We reviewed service certificates and these evidenced that equipment and systems had been appropriately maintained. This included the fire alarm system, emergency lighting, mobility and bath hoists, the passenger lift, the electrical installation, the emergency call system and gas appliances / systems. In-house maintenance was carried out; this included checks on wheelchairs, window opening restrictors, emergency lighting, hoists and slings and the emergency call system. There was also a fire risk assessment in place and evidence of weekly fire alarm checks and fire drills.

Good

Is the service effective?

Our findings

At the last inspection in June 2016 we recommended that people were offered more choice at mealtimes. We noticed that the home's newsletter was open and honest about the feedback they had received in respect of meals and informed people about the improvements they had made. People were invited to comment on these changes. At this inspection we saw that people were now offered ample choices and we received positive feedback about the meal experience. One person said, "I'm quite happy with the meals. It's better than doing it yourself. We get a choice" and another told us, "Yes, the food is nice. We get a choice." They also told us they had plenty to drink and pointed to the jug of juice next to them.

We observed that people's special dietary requirements and their likes and dislikes were recorded in their care plan and we saw people had appropriate nutritional assessments and risk assessments in place. When people were at risk of dehydration their fluid intake was being monitored, although we discussed with the manager that monitoring would be more effective if there was a record of target fluid intake and fluid intake was totalled at the end of each day. The home was following the Nutrition Mission, an NHS initiative to reduce the risk of malnutrition for people living in care homes. This included the provision of fortified food and drinks, and we saw people being given milk shakes on the day of the inspection.

We observed the serving of lunch in both dining rooms; the meal looked appetising and we saw that people were offered a choice of meals and hot or cold drinks. Tables were set with cloths, placemats, napkins and cutlery. In the small dining room some people were seated at the table for quite a while before the meal was served and became agitated. When a staff member arrived, they were able to diffuse the situation. The atmosphere in the large dining room was calm; there was music playing and people were chatting and laughing together. A health care professional told us there was always a lovely atmosphere in this dining room.

We saw there was a menu on display and staff also explained the meal choices to people, and showed some people the different meals to try to help them make a decision. Each table was served in turn so people were eating at the same time as each other.

We felt that some meal portions were small, especially for the males who lived at the home. We fed this back to the directors at the end of the inspection and they told us people should have been offered a second helping, and they would ensure this happened.

Members of staff had been nominated to take the lead on dignity and dementia, medicines, nutrition, infection control and safeguarding. This 'committee' met every six weeks to look at good practice guidance and how this could be shared with the wider staff team. We saw evidence of these meetings in quality assurance records.

Staff received induction training when they were new in post, and this included shadowing experienced staff; these 'shadow' shifts were recorded but not dated. When staff were new in post they were required to bring in evidence of any previous training; this helped the manager determine their level of competence and

any immediate training needs. Training records showed staff (including ancillary staff) had completed training on the topics considered essential by the home, including MCA, safeguarding adults from abuse, health and safety, fire safety, moving and handling, dignity and respect, first aid, dementia awareness and infection control. Records showed that six staff had completed a National Vocational Qualification (NVQ) or equivalent at either level 2, 3 or 4. Senior staff had completed training on the administration of medicines.

Staff told us they felt well supported via staff meetings, annual appraisals and supervision meetings. Supervision meetings give staff the opportunity to meet with a manager to discuss people's care needs, identify any training or development opportunities and address any concerns or issues regarding practice.

We observed that people who could mobilise independently walked around the home without restriction and had no problem with finding their way around. Bedroom doors were painted in different colours and had room numbers to help people to locate their room. A director told us they planned to replace some patterned carpets with plain carpets later in the year. Research shows that people who are living with dementia find it easier to walk on plain carpets as there are fewer distractions. One relative told us they had made curtains and blinds for their family member's bedroom that were the same as those they had at home to help them feel 'at home'.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA , and whether any conditions on authorisations to deprive a person of their liberty were being met.

Although training records showed most staff had completed training on the MCA, we found that staff had only a basic understanding of the principles. However, we saw that staff asked people for consent before they carried out day to day tasks. One person told us, "I have no grumbles at all. I have my own room and I go there when I want to watch my own TV."

When people lacked the capacity to consent their care, care plans recorded this. Relatives were only asked to consent on behalf of their family member if they had power of attorney (POA). This is when a person has been legally authorised to make decisions on another person's behalf. One relative told us they had POA for their family member and were consulted about all aspects of their care. We saw evidence that best interest meetings had been held to assist people who lacked capacity to make important decisions.

We saw that mental capacity assessments had been carried out in respect of decisions people needed to make, such as permanency at the home, consent to having photographs taken and restraint by the use of bed rails and lap belts on wheelchairs.

Staff told us that they asked people what they would like to do and offered them choices, and that people were able to make day to day decisions for themselves. One member of staff said, "We have a list for baths and showers but it's flexible. People can choose a bath or a shower – the list just serves as a reminder." A person who lived at the home confirmed, "I can have a bath or shower when I want."

People were supported by GPs, community nurses and other health care professionals. The contact with health care professionals was recorded and any advice given had been incorporated into care plans. A health care professional told us they had no concerns about the care people received from staff. They said, "Staff always seek advice and act on it." One person's care plan recorded, "I have been discharged from my physio. They feel I am progressing with my mobility using my frame."

Good

Is the service caring?

Our findings

We observed staff were kind, caring and patient. We saw positive interactions between people who lived at the home and staff, and between relatives and staff. People told us that staff genuinely cared about them. One person pointed to a member of staff and said, "I like her" and another person told us they would recommend the home to others. Staff told us they believed all staff genuinely cared. Comments included, "The quality of care is good. There are always things we can improve on, but staff do care." A health care professional told us, "You can just tell [staff care] – it's the way they talk with people." Relatives told us they believed staff genuinely cared; one relative said, "Staff are great – very helpful. Nothing is too much trouble."

We saw people who lived at the home looked well cared for, were clean shaven (when this was their choice) and wore clothing that was in keeping with their own preferences. People's bedrooms were personalised to make them feel 'at home'.

People told us that staff respected their privacy and dignity and the training matrix recorded that staff received training on dignity and respect. People confirmed that staff knocked on doors before entering the room. Staff were able to describe how they promoted people's privacy and dignity, such as offering assistance discreetly and escorting people to their bedrooms. One relative told us, "They couldn't do it any better. Any accidents are dealt with discreetly." However, another relative told us their family member's incontinence pad was sometimes "Soaked", which did not respect their dignity. We fed this back to the manager who assured us they would address this with staff.

We saw that people were taken to their bedrooms so they could be treated by health care professionals in private, and this was confirmed by a health care professional who we spoke with. They also told us, "People are spoken with politely."

We observed that people were supported by staff to be as independent as possible. If they were able to carry out tasks themselves, staff encouraged them to do so.

Our SOFI observation showed that, when people were showing signs of anxiety or distress, staff were skilled in providing distraction to calm and reassure them.

Relatives told us they were happy with the way staff communicated with them and kept them informed of important events, such as visits from GPs and other health care professionals.

We saw that written and electronic information about people who lived at the home and staff was stored securely. This protected people's confidentiality.

Good

Is the service responsive?

Our findings

The manager completed an initial assessment of people's needs before they moved into the home; this included the use of recognised assessment tools for tissue viability and nutrition. A care plan was developed from these assessments. Care plans contained information for staff about how to meet people's needs in a variety of areas, such as social activity, medicines, mobility, continence, communication, personal hygiene and daily routines. This included their hobbies and interests, their likes and dislikes and family relationships. When risks had been identified as part of the assessment process, there were risk assessments in place to help minimise the risk.

Relatives told us they had been involved in developing care plans for their family members, and one relative said, "They are always updating the care plan."

We saw that care plans contained sufficient information to ensure staff were aware of people's specific care and support needs and to enable staff to provide care that was centred on the individual. For example, one person's care plan recorded they needed to have their legs elevated when sitting in a chair in their bedroom. We checked this and found the person was sitting in their bedroom with their legs elevated. A health care professional told us, "Staff are not task orientated. They do what people want and need."

Care plans were reviewed each month to ensure that information was reflective of people's current care and support needs. We saw that reviews included information about any falls, visits to hospital, visits from health care professionals and any safeguarding alerts submitted to the local authority.

Daily handover meetings provided staff with up to date information, and a communication book was also used to pass information from one shift to the next. Records showed staff discussed any concerns about each person who lived at the home. A newsletter was produced. We saw the newsletter for June and noted that it included interesting facts about the month of June, information about re-decoration of the home, birthday celebrations, and the outcome of the bi-annual survey conducted with people who lived at the home and relatives. This helped to keep people informed about events at the home and in the local community.

People were supported to keep in touch with family and friends and visitors were made welcome at the home; we observed this on the day of the inspection. One person told us, "My family can visit at any time and they are made welcome." Staff told us they supported people to have telephone contact with family and friends, and also read letters and postcards to people.

The manager told us they had forged a very close partnership and working relationship with a registered dementia charity. This ensured, through partnership working, that staff had access to up to date training and resources which helped them to support and work with people who were living with dementia. In addition to this, one of the activities coordinators had completed training on how to provide activities specifically designed for people with dementia. One of the directors told us they were working closely with this organisation to introduce activities that would encourage people to use the local community. Based on

life histories, two people were going to a boxing club and there were plans for local children to be invited to the home at the same time as an ice-cream van. The children were going to be invited to buy an ice-cream for themselves and for a person who lived at the home. Staff told us there were also plans in place to have more tactile items available to engage people who were living with dementia.

We received positive feedback about the activities on offer at the home. There were two activities coordinators; one worked mornings and the other worked afternoons, Monday to Friday. The activities board displayed the planned activities for each day of the week, and showed that activities were varied to try to meet people's interests and capabilities. Care staff felt that activities had improved and that more people were spending time out of the home or in the garden; an enclosed garden area was being completed on the day of the inspection. One person said to us, "I like the garden and I like the activities."

A notice on display in the home invited people to comment on the care they were receiving, including making a complaint. We checked the complaints register and saw that four formal complaints had been made to the home during the previous 12 months. The records evidenced that these had been investigated appropriately and feedback given to the complainants. In addition to this, there was a record of any safeguarding investigations that had been carried out by the local authority and any investigations that CQC had asked the provider to undertake.

Staff told us they would support people to make a complaint if they were reluctant to complain or did not understand the complaints procedure. Relatives told us who they would speak to if they had any concerns, and that they felt their concerns were listened to.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in June 2016 we were concerned that CQC had not been notified about DoLS applications that had been authorised as required by regulation. This was a breach of Regulation 18 of the Registration Regulations 2009. At this inspection we saw that notifications about DoLS and other issues had been submitted to CQC, meaning the provider was no longer in breach of this regulation. The submission of notifications allows us to check that the correct action has been taken by the registered persons following accidents or incidents.

The provider is required to display their inspection rating following a CQC inspection. The rating for the inspection conducted in June 2016 was clearly displayed within the service and on the home's website.

There was a manager in post who was not registered with the Care Quality Commission as required by a condition of the provider's registration. 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. The manager told us they were in the process of applying for registration and our records evidenced this.

We asked for a variety of records and documents during our inspection, including people's care plans and other documents relating to people's care and support. We found that these were well kept and easily accessible. Those that were not available on the day of the inspection were forwarded to us promptly.

The provider had a quality assurance system that was based on the CQC regulations. Topics audited included premises and equipment, consent and MCA, safe care and treatment, staffing, training, safeguarding, dignity, complaints, personal care and nutrition. The outcome of all audits and checks were recorded on a central action plan for the organisation. Although the manager or one of the directors could tell us when any identified shortfalls had been actioned, and on some occasions this had been recorded, this was not always the case. The directors told us they would ensure this always happened in future. Additionally, the audits of the prevention and control of infection had not identified the shortfalls we found during this inspection. This indicated to us that some audits were not effective in identifying areas that required improvement.

We recommend that the provider ensures quality audits are fully effective in identifying shortfalls and poor practice.

Just prior to our inspection staff from the local authority had visited the home to investigate a safeguarding allegation. Their investigations were on-going but in the interim period it had been agreed that one of the directors would visit the home each day to carry out 'walk-arounds' and ensure that daily logs, care plan reviews, monitoring tools and audits were being carried out as required. There was a director present at the home when we arrived to carry out this inspection.

A healthcare professional said, "The manager and deputy are great" and staff told us that the manager and senior management were approachable. One member of staff told us, "All bosses who come in are really friendly and speak to you." Another member of staff said when asked about staff morale, "Mine is ok. We get on well as a rule." A member of staff described the culture of the service as, "We all get on really well. I feel I could tell someone if I made a mistake." Comments from relatives included, "I like the atmosphere at the home" and "It's friendly." Two relatives also spoke highly of the deputy manager.

Staff told us they were certain information would remain confidential if they used the home's whistle blowing policy.

Staff meetings were held and minutes of these meetings showed that topics discussed included documentation and teamwork. When concerns had been identified, group supervision meetings were held with staff to discuss these concerns and any remedial action or changes to staff practices that were required.

Satisfaction surveys had been distributed to people who lived at the home. We saw a food and activities survey that had been conducted in April 2017 and noted the survey asked people for suggestions about the variety of meals and the range of activities. Previous surveys had been carried out about staffing, laundry and management of the service. In addition to this, people had been asked to sample some new dishes and say whether they would like them to be included on the menu.

Meetings were held for people who lived at the home and their relatives. The minutes of the most recent meeting showed activities, trips out, the mobile shop, meals, laundry and the home's newsletter were discussed. Relatives confirmed that meetings were held and their views were sought. One relative said, "I have been to a few meetings. They produced a report about the refurbishment. I think our suggestions are listened to." This showed that people were given the opportunity to comment on the service provided at the home.

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 12 HSCA RA Regulations 2014 Safe care and treatment How the regulation was not being met: Care and treatment was not provided in a safe way by assessing the risk of, and preventing, detecting and controlling the spread of infections. Regulation 12 (2)(h)