Shankar Leicester Limited

Marwood Residential Home

Inspection report

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Date of inspection visit:
30 June 2016

Date of publication:
02 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?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This was an unannounced comprehensive inspection that took place on 30 June 2016.

Marwood Residential Home is a care home registered to accommodate up to 24 people who are aged over 65. The home is set over two floors with lift access to both floors. The home has two lounges and a dining room where people can relax. At the time of the inspection 20 people were using the service.

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

People told us that they felt safe when staff supported them and that they enjoyed living at Marwood Residential Home.

Risk assessments were in place which described how to support people in a safe way. The service had safeguarding and whistleblowing procedures in place. Staff were aware of their responsibilities in these areas.

The provider carried out pre-employment checks before staff started to work to make sure that staff were suitable to work at the service. We found that one staff member had information of concern on their Disclosure and Barring service checks and this had not been reviewed to make sure that they did not present a risk to people who used the service.

People told us that there were not enough staff. We found that there were times when staff were not available in communal areas and people had to wait for support.

People received their medicine as it had been prescribed by their doctor. However, staff had not always signed to say that creams had been applied. Most staff were trained and assessed as competent to administer medicines. We found that one staff member was administering medicines without appropriate training.

Staff were supported through training and supervision to be able to meet the needs of the people they were supporting. They undertook an induction programme when they started to work at the service.

Staff sought people's consent before providing personal care. People's capacity to make specific decisions relating to their care had not been assessed. People had restrictions placed on them without the appropriate process being followed under the Mental Capacity Act.

People were supported to maintain a balanced diet. However, advice of a dietician had not always been

sought when it was required. People were usually supported to access healthcare services.

People told us that staff were caring. Staff we spoke with had a good understanding of how to promote people's dignity. Staff understood people's needs and preferences.

People were involved in decisions about their care. They told us that staff treated them with respect.

People were involved in the assessment of their needs. People and their relatives were involved in the review of their needs.

People were supported to take part in activities that they enjoyed.

People told us they knew how to make a complaint. The service had a complaints procedure in place.

The service was led by a registered manager who understood most of their responsibilities under the Care Quality Commission (Registration) Regulations 2009. The registered manager had not notified the Care Quality Commission of all incidents that they were required to. The registered manager had not completed a Provider Information Return when this had been requested.

People were asked for their feedback on the service that they received. The provider carried out monitoring of the quality of the service.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of 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 received their medicine as it had been prescribed by the doctor. However, staff had not always signed to say that they had administered creams; and a staff member was administering medicine without appropriate training.

People told us that they felt safe. Staff knew how to recognise and respond to abuse correctly. The provider had effective recruitment procedures. However, they had not always followed these.

Staff managed the risks related to people's care. Individual risks had been assessed and identified as part of the care planning process.

We found that there were times when staff were not available in communal areas and people had to wait for support.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff received training to develop their knowledge and skills to support people effectively.

People's capacity to make specific decisions relating to their care had not been assessed. People had restrictions placed on them without the correct process being followed in line with the Mental Capacity Act.

People's choices were respected and staff sought consent before providing personal care.

People were supported to maintain a balanced diet. However, advice of a dietician had not always been sought when it was required. People had access to the services of healthcare professionals in most cases.

Is the service caring?

Good

The service was caring.

Staff were kind and treated people with respect and dignity. Staff knew people's likes and dislikes.

People's privacy was respected and relatives and relatives were encouraged to visit regularly and made to feel welcome.

Is the service responsive?

Good

The service was responsive

People's care plans were developed around their needs, were kept up to date and reflected people's preferences and choices. People or their relatives were involved in reviewing their care plan.

People were able to participate in activities that they enjoyed.

People knew how to complain and felt confident to raise any concerns.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

People knew who the registered manager was and felt they were approachable.

The registered manager had not submitted notifications for all incidents they are required to report to the Care Quality Commission. The provider had not completed a Provider Information Return when this had been requested.

There were quality assurance procedures in place to monitor quality.

People had been asked for their opinion on the service that had been provided.

Marwood 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.

This inspection took place on 30 June 2016 and was unannounced. The inspection was carried out by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert had experience of caring for someone who used this type of service.

Before the inspection, we asked the provider to complete 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. They did not return a PIR and we took this into account when we made the judgements in this report. We reviewed the information we held about the service and information we had received about the service from people who contacted us. We contacted the local authority that had funding responsibility for some of the people who used the service and the local Healthwatch.

We spoke with three people who used the service and five relatives of people who used the service who were visiting the home. We observed staff communicating with people who used the service and supporting them throughout the day. We 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 spoke with the deputy manager, two senior carers, two members of care staff and the cook.

We looked at the care records of four people who used the service and other documentation about how the home was managed. This included policies and procedures and records associated with quality assurance processes. We looked at four staff recruitment files to assess the recruitment process.

Requires Improvement

Is the service safe?

Our findings

People who used the service told us that they felt safe. Their relatives agreed with this. A relative said, "I am happy when I leave as it is safe."

Staff we spoke with had an understanding of how to protect people from the different types of harm and abuse. They understood their responsibilities to report any safeguarding concerns to a senior staff member or the registered manager. The management were aware of their responsibilities to report any safeguarding concerns to the local authority. Staff told us they were confident that any concerns they raised would be taken seriously by the registered manager. Staff had received appropriate safeguarding training and records confirmed this.

Staff managed the risks related to people's care. Each care plan had information about the risks associated with people's care and how staff should support the person to minimise risk. For example, one person had a risk assessment in place as they were at risk of falling. This had been completed to make sure that control measures were in place so that the person could be as safe as possible when they walked around. Risk assessments were reviewed monthly, or when someone's needs changed. This was important to make sure that information was current and was based on people's actual needs.

We found that where someone had behaviour that may be classed as challenging this had been identified in their care plan. However, we found that although things that might cause the person to present the behaviour had been identified, there was no guidance in place for staff to follow to support the person when they presented any challenges. We discussed this with the deputy manager. They told us that the care plans for one person were in the process of being rewritten as the person's needs had changed recently. The deputy manager told us that information about how to support the person if they presented any behaviour that may challenge was to be included in their new care plan.

People and their relatives told us that they felt there were not enough staff. One person told us, "They are often short staffed. They are so busy. We often have to open the front door." Another person said, "You can't complaint though as they do their best." One person commented, "I appreciate it if they get called away to someone who is more important." A relative told us, "They could do with more staff popping their head around the door. If someone needs the toilet and no one is here they can get agitated." Another relative said, "People often have to wait. They are short staffed." Staff told us that they felt that more staff were needed. One staff member said, "We have people with more needs. There is not always enough. Staff need looking at as people's needs change." Another staff member said, "There are not enough care staff." We saw that they staff appeared to be busy but when people requested help staff would assist them as soon as they could. However, we also found that there were periods of time when no staff were available in the communal areas as they were supporting people in other areas of the home. On one occasion an inspector had to find a member of staff and ask for assistance for someone who was becoming anxious. Staff did respond as soon as we asked them to. The deputy manager told us that the staffing levels had been agreed based on the needs and dependency levels of the people who lived in the home. The rota showed that the staffing levels that had been assessed as being appropriate were in place. We saw that as part of a team meeting staff had

been reminded of the importance of a member of staff being present in the communal areas. Throughout the day we saw that call bells were answered promptly.

Staff maintained records of all accidents and incidents. The registered manager had monitored these and actions that had been taken were recorded. We saw that accidents were audited each month and that changes were made to people's care to try and reduce the likelihood of reoccurrences. For example, one person had been referred to a health professional for further assessment when they had more than one fall.

Staff told us that fire drills and system tests were carried out regularly. We saw that regular testing of fire equipment and evacuation procedures had taken place. The registered manager advised, and records confirmed, that where people may need additional support in the event of an evacuation they had a personal emergency evacuation plan in place. Where someone had specialist equipment, for example a hoist, we saw that this had been regularly serviced. We found that other checks in relation to the premises were carried out in line with recommended guidance. However, we found that most risk assessments that related to the general environment had not been reviewed since 2013. The deputy manager told us that the risk assessments were in the process of being updated.

The provider had a recruitment and selection procedure in place to ensure that appropriate checks were carried out on staff before they started work. We saw that files contained a record of a Disclosure and Barring (DBS) check, and references. These checks help to make sure that staff are suitable to work at the service. We found that one staff member had information of concern that was recorded on their DBS check. The deputy manager told us that this had been discussed with the member of staff. However, the deputy manager told us that they had not recorded details of the conversation or completed a risk assessment to evidence that they had considered the potential implications of the concerns. The deputy manager said that they would discuss this with the individual staff member. We found that there was a recruitment policy in place and this had a procedure to be followed if a DBS check was returned with concerns identified. This had not been followed.

People received their medicines as prescribed by their doctor or pharmacist. We saw that there were policies and procedures in place to support medicine administration. Most staff had received training in medicines management and they had been assessed to ensure that they were competent to administer medicines. However, we found one staff member who had not received training through their employment with this home, or been assessed as being competent. This member of staff was administering medicine. We discussed this with the deputy manager who told us that they would stop the person administering medicine until the appropriate training and checks had been completed.

We looked at the records for medicine administration and found that these had been completed correctly for tablet and liquid medicines. However, where people had been prescribed creams these were stored in individuals rooms. We found that staff were not always signing when the cream had been administered. We saw that where people were prescribed medicines as PRN (as required), or variable doses, protocols were not always in place to advise staff when and why to administer the medicine. Staff who we spoke with could tell us when PRN medicines should be administered and what dose of medicine should be given. The deputy manager told us that the protocols would be put in place.

Requires Improvement

Is the service effective?

Our findings

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 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 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. We saw that where people may have been deprived of their liberty the registered manager had made applications to the 'supervisory body' for authority.

We found that people's capacity had been considered in their care plans in some areas. However, we found that capacity had not been considered in all specific decisions. For example, one person self-administered their medication. We saw that they had made an error that could have serious consequences. There was no record to identify if this individual's capacity had been considered in this area. We also saw that there were a number of restrictions in place such as alarm mats by people's beds. These mats are used to keep people safe, however if a person's capacity to agree to this being in place was in doubt an assessment of their capacity needs to be undertaken. This had not taken place. We discussed this with the deputy manager. They told us that no capacity assessments had been carried out, although there were a number of decisions that had been made in people's best interests. Under the MCA a decision cannot be made in person's best interests unless they do not have capacity to make the decision themselves, and a mental capacity assessment has been completed. We found that there were some very restrictive decisions that had been made in a person's best interests to keep them safe. However, the process under the MCA had not been followed and this meant that the person may have been deprived of their liberty unlawfully.

These matters are a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Need for Consent.

People told us that staff offered them choices throughout the day. One person said, "I have choices." Another person commented, "They always ask me what I want. They speak to me before they carry out personal care and they listen to my choice." Staff told us about their approach to supporting people and asking for consent. We observed that people were offered choices throughout the day of our visit. For example, people were asked what they wanted to eat and drink. Staff demonstrated a limited understanding of MCA and DoLS. Most of the staff we spoke with told us that they had received basic training in this area to help them understand what they needed to do. One staff member said, "It's to do with their rights. If it's restricting them we get DoLS involved." Another staff member told us, "We've had basic

training but I couldn't really describe it."

People and their relatives told us that they felt that they were trained. A relative commented, "Staff are competent at their job."

Staff told us that they had completed an induction process. Records we saw confirmed that staff had completed an induction process. The deputy manager told us that new staff were completing the Care Certificate. The Care Certificate was introduced in April 2015 and is a benchmark for staff induction. It provides staff with a set of skills and knowledge that prepares them for their role as a care worker. We spoke with staff who told us that they felt that they had done adequate training to do their job well. One staff member told us, "The training is very good. I am doing my NVQ level 3." Another staff member said, "The training is very good and interesting. It covers a lot of things." We looked at the records that were used to monitor the training needs of the staff team. These showed that some staff had completed training in a range of subjects; however, we found that there were a number of staff who had not completed training, or whose training was out of date. We discussed this with the deputy manager who told us that they were in the process of booking staff onto courses to make sure that all staff had received training and that this was in date.

Staff told us that they had supervision meetings with the registered manager. Supervision meetings are an opportunity for staff to meet with a line manager to discuss their practice and any concerns. One staff member told us, "We have supervision quite frequently. They ask you're your feelings are." Another staff member said, "We do have regular supervisions. Mine are always positive." Records we saw confirmed that supervision meetings and appraisals had taken place with staff having had between two and four supervision meetings in 2016. Staff told us that they had team meetings and we saw minutes from the meetings. The most recent meeting had been held in June 2016. We found that the minutes of the team meetings demonstrated that issues were discussed with the staff. For example, we saw that good practice, dignity and respect and training had all been discussed with staff. This meant that the staff were being supported to meet the needs of the people who used the service.

People enjoyed the food offered and there were choices at mealtimes. One person told us, "I choose my lunch. There are options." Comments included, "That was really nice," "The food is okay," "I really enjoy the food, they give you a choice," and "It is very good. They let the relatives have Sunday lunch." A relative told us, "[Person's name] eats well." We saw that most people ate in the dining room or the lounges but people had choice over where they ate.

We observed lunch and saw that people were offered a drink when they sat down at the table. We saw that one person struggled to eat and staff did not offer them support until after everyone else had finished eating. The staff member asked if the meal was cold and the person replied, "Not to matter." The member of staff did not offer to get a fresh meal that was hot for the person. We found that when people requested an alternative before they had their meal this was brought for them. However, one person said they did not want the meal they had and they were not offered an alternative as they did not request this.

There was a menu available and this was on a noticeboard at the entrance to the dining room. However, the meals that were served were not what had been written on the menu. Staff had asked people what they wanted for lunch before the meal had been served. Staff did not remind people what they had requested when they brought them their meal. The cook told us that people were involved with developing the menus and had asked for certain meals to be added to the menu. Throughout the day people were offered drinks and snacks and water was available from a water machine in the dining room. People had care plans which included information on dietary needs and support that was required. The cook and staff we spoke with

were able to tell us about people's dietary needs and were knowledgeable about how to support people who needed additional support.

We saw that one person was on a liquidised diet. We asked the deputy manager about this and they told us that the decision to put the person on a liquidised diet had been made by the home. They said that the person had not been referred to a dietician to be reviewed to determine what sort of diet the person needed. The deputy manager agreed that they would discuss this with the doctor.

People's healthcare was monitored and where needed they were sometimes referred to the relevant healthcare professional. Records showed that people were supported to attend routine appointments to maintain their wellbeing, such as the opticians and chiropodist. We saw that staff monitored changes in people's needs, usually sought advice from health professionals and recorded what actions they had taken. However, we saw that there had been four incidents within the last three months where people had hit their head and staff had not sought advice from a GP or health professional in relation to this. We discussed this with the deputy manager who told us that they would discuss this with staff and make sure that medical advice was sought if people had bumped their heads.

Good

Is the service caring?

Our findings

People told us that they were happy with care provided. One person told us, "The carers are very good." Another person commented, "The carers are very good. I tell one all of my secrets." One person said, "They are very friendly." However, a relative told us, "They are very good although some are better than others. Some speak sharply to the residents." They went on to say that this had not happened to their relative and that they had not reported this to the staff or the registered manager.

Staff knew the people they cared for, they were able to tell us about what people liked, and disliked and how they used this information to support and care for people. One staff member told us, "I know people. It's when you are giving care. You get to know how they like to be spoken to." Another staff member said, "We can speak with people about what they like." All staff we spoke with said that information about people's likes and dislikes was recorded in the care plans. We saw that staff communicated with people effectively. They ensured that they were at eye level with the person they were talking to and altered the tone of their voice appropriately. This meant that communication was discreet and focused on the person. We saw that when someone asked for a staff member to help them, the staff supported the person as soon as they could.

People and their relatives told us that they had been involved in planning their own care. One person told us, "We go through the care plan and chat about it." Staff told us that people were involved in making their own decisions. One staff member told us, "We help people choose what they want to wear." We saw that people were asked information about how their routines and what they liked and disliked. We found that each care plan had a section about their personal preferences. This meant that people were asked about how they wanted the staff to meet their needs and were involved in planning their own care.

People told us that staff were respectful to them. Staff told us how they protected people's privacy and dignity, examples of this included knocking on doors, explaining what was happening and covering people when they were receiving personal care. We saw that staff provided reassurance and explanations to people when they supported them. The service had received the Dignity in Care Award in May 2016 and the Quality Assessment Framework at silver level from Leicestershire County Council in February 2016. This meant that they had been assessed as demonstrating an on-going commitment to promoting and delivering dignified care services. The deputy manager told us that five staff had been trained as dignity champions. This meant that staff were committed to promoting dignity and equality in the home.

People were encouraged to be as independent as possible. Staff told us that they prompted people to do things for themselves when they could. One staff member told us, "I think we try to maintain people's independence for as long as we can." We saw that people were encouraged to do what they could for themselves. This meant that staff were encouraging people to continue to use the skills they already had and not deskill people by doing things for them.

People told us that their family visited them and they could come when they wanted to. One person told us, "They can come in and visit whenever they want." A relative told us, "We can come whenever we want." We

saw that relatives and friends visited throughout the day of our visit.

People could be confident that their personal details were stored securely and protected. We saw that confidential information was kept securely. This ensured that people could only access this when they were authorised to do so.

People were encouraged to personalise their own private space to make them feel at home. One person told us, "I have lots of pictures in my room. It is very homely." We were invited to see three bedrooms and people had brought their own items with them to decorate their rooms.

Good

Is the service responsive?

Our findings

People told us that they received care in ways that were important to them. One person said, "I don't like to go to bed early so a few of us sit up and watch TV. We have a chat and then go to bed." Staff confirmed that information about people's routines and preferences had been included in their care plan. We saw that the care plans detailed information about people's preferences. For example, we saw that it was recorded if people preferred a bath or shower and when they preferred this. We also saw that people's preferences around taking medication had been recorded. For example, we saw that a person preferred to be given their tablets one at a time followed by a drink of water.

People and their relatives told us that they had been involved in planning their care. One relative told us, "We were asked about [person's name] before they came. The move has been very smooth and [person's name] is very comfortable." The deputy manager told us that people's needs were assessed before they moved into the home and that this involved the person and their family. We saw that an assessment had been completed that included key information about the person, their needs, what was important to the person and what they were interested in. Care plans contained information about what each person liked and things that were important to them. Staff were able to tell us about people's care plans. The care plans had been updated monthly to help ensure the information was accurate. Relatives told us that they had been involved in the reviews. One relative said, "We have been involved." We found that care plans identified people's needs and how to meet these needs. However, we found that some information was not updated in individual care plans. For example, we saw that one person had an increase in their medication. The information on the medication record was correct, and staff could tell us the correct dose of the medicine. We found that the care plan recorded the previous dose even though it had been reviewed three times since the change. We discussed this with the deputy manager who told us that all care plans were audited and reviewed by a manager and this would be rectified.

Information about people was shared effectively between staff. A staff handover was held between staff and the information was recorded. We saw that staff shared information about any changes to care needs, or if something had happened. This meant that staff received up to date information before the beginning of their shift about changes to a person's needs.

People were supported to maintain relationships that were important to them. One person told us, "I have friends here I knew before I moved in. we keep each other company." Another person said, "It is not isolating which I thought it would be. I have lots of good friends here. They pop into my room for a chat." One person commented, "I still see two friends and my son." A relative told us, "When I visit we go and sit outside and my son comes and does the plants." We saw that one person was concerned about one of their friends who were not well on the day of our visit. The staff told the person that they would let them know when the person was awake so that they could visit. We were told that this person had visited their friend the day before. This meant that people were enabled to maintain friendships and family relationships.

People told us that they took part in activities that they were interested in and enjoyed. One person said, "We have lots to do. I enjoy the sing song and I go on as many trips as possible." A relative said, "There is

plenty to do especially in the afternoon." Another relative commented, "The activities co-ordinator does a good job. They won't please everyone." We saw that there was a list of planned activities which included singers visiting the home, day trips and church services. On the day of our visit a local singing group visited. People enjoyed the singing group and joined in with all of the songs. An activity co-ordinator had been employed who visited the home each day to carry out activities such as arts, crafts, bingo and nail painting. On the day of our visit the activity co-ordinator was on holiday. One person said, "I am bored," during the morning. A member of staff replied, "There is nothing to do until the activity lady comes back. She is off all week." The staff told us that alternative activities had not been planned to cover. Staff told us that people enjoyed the activities they participated in.

All of the people we spoke with told us they would raise any concerns if they had needed to. One person told us, "I have no complaints. If I have any issues I would speak to them and it gets sorted. I am happy with how it is done." A relative said, "I have been given all of the information regarding complaints and I have read it. I would speak to them. I have not seen anything that concerns me." Another relative commented, "I would happily raise issues if they arise." We saw a complaints procedure was in place and was displayed in the main entrance to the home. This included timescales for when a complaint would be responded to. The deputy manager told us that they had not received any complaints. However, we saw that relatives had raised concerns in relation to two issues during a relatives meeting and these issues had been raised previously. This meant that people's concerns may not have been recognised as complaints and investigated appropriately.

Requires Improvement

Is the service well-led?

Our findings

People and their relatives spoke highly of the service. One person said, "I like it. It is so much better than I thought." A relative told us, "It is very good in this home. I have told them to put my name down for when I need a place"

People and their relatives told us that they knew who the manager was and that they usually felt listened to. A relative said, "They do listen, but are sometimes slow in action." Another relative told us how they had asked for the Christmas decorations to be taken down as they were still up in May. They said, "It was something little but it is important to us." The registered manager told us that the decorations were not still up. However, there were still bits of tinsel and decorations in places where they had been stuck to the walls. Staff told us that they felt they could approach the manager. One staff member told us, "You can talk to the managers." Another staff member said, "The managers are around during the day. If we ask for things we get them." However, staff told us that they felt that the management team did not always listen or understand their role. One staff member said, "They don't always see how things are on the floor. They don't appreciate how hard it is lately." Another staff member commented, "I'm not sure they would always listen. There are lots of managers but not enough care staff." The deputy manager told us that they liked to make sure that they spent time in the home to see what was happening and to develop relationships with people who used the service. We saw on the day of the inspection that the deputy manager spent time walking around the home and talking to people who used the service. This meant that people knew who they were.

People and their relatives had a meeting that gave them an opportunity to share their views about the service. We saw that two meetings had been held in the last 12 months. The minutes showed that concerns about the service had been raised as part of this meeting. We saw that answers had been given in relation to the concerns although some relatives felt that their concerns were not addressed adequately. For example, one relative had raised a concern about a time when the lift did not work. They said this had a big impact on their relative's health. They asked about a stair lift which had been mentioned by the provider. The minutes of the meeting show that the stair lift was still being considered as an alternative option to the lift in case of breakdown, but that no final decision had been made on this as a new lift had been installed. The deputy manager told us that the lift had been fixed and there were plans in place in case of this breaking again.

People and their relatives had been asked for feedback through a questionnaire to ask them about the quality of the service that had been provided. We saw that the last questionnaire had been sent out in October 2015. The results from this were mainly positive with people identifying that the care was good. The feedback identified that people felt that more staff were required in the communal areas and that the lift being out of service was a concern. The deputy manager told us that feedback from this was given to people at the residents and relatives meeting. This meant that people were encouraged to provide feedback and their views had been sought.

We saw that the registered manager carried out monitoring to review the quality of the service that had been provided. This included checks on the environment, documentation, falls and medication. We saw that actions were identified as part of the audit. However, it was not always recorded that these actions had been

completed. We discussed this with the deputy manager who told us that the actions had been completed and they would update the records to reflect this. We found that although the audits did identify some areas for improvement and actions not all of the concerns we found during our visit had been identified as part of the audit process.

We found that information in policies and procedures, as well as environmental risk assessments was out of date and had not been reviewed. The deputy manager told us that they were working with the registered manager to update all of the policies and risk assessments.

Before the inspection, we asked the provider to complete 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. They did not return a PIR and we took this into account when we made the judgements in this report.

The registered manager was not notifying the Care Quality Commission of all incidents they were required to report. For example one person had developed a pressure sore that was a grade three sore. This had not been reported. These notifications are an important safeguard for people using services and failure to notify the Commission denies people and important level of oversight and protection. These notifications are also a requirement of the Care Quality Commission Regulations. We found that they had notified us that two person had applications for DoLS approved. We discussed this with the deputy manager who agreed to look at all notifications that are required and to submit them. Since our visit we have received two notifications.

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 11 HSCA RA Regulations 2014 Need for consent Where a person lacked capacity to make an informed decision, or give consent, the Mental Capacity Act and associated code of practice had not been followed.