Brownlow Enterprises Limited

Ernest Dene Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

This inspection took place on 18 December 2014 and was unannounced which meant that nobody at the home knew about the visit in advance.

Ernest Dene Residential Care Home is registered to provide accommodation and personal care for up to 33 older people. At the time of this inspection the home did not have a registered manager in place, however the acting manager was in the process of applying for 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.

Some risks to people's safety were not identified and managed effectively, and we found some examples of

Summary of findings

people's dignity not being protected at all times. There were also shortfalls in the standard of cleanliness within the home, and in the support provided to people with their meals.

People were involved in decisions about their care and how their needs would be met. Staff were available to meet people's health and social care needs. People's medicines were managed safely, and staff knew what to do if people could not make decisions about their care needs.

Staff understood people's preferences, likes and dislikes regarding their care and support needs.

People using the service, relatives and staff said the manager was approachable and supportive. Systems were in place to monitor the quality of the service, although there were some gaps in identifying areas for improvement. People and their relatives felt confident to express any concerns, so these could be addressed.

At this inspection there were four breaches of regulations relating to cleanliness, risk management, support with food, and dignity. 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 always safe. Some risks to people who use the service were not identified and managed appropriately.

Staff knew how to identify abuse and the correct procedures to follow if they suspected that abuse had occurred. Recruitment procedures were in place to determine the fitness of staff to work in the home, and there were sufficient staff available to meet people's needs.

Systems were in place to manage people's medicines safely.

Requires Improvement

Is the service effective?

The service was not always effective. Staff support to meet people's nutritional needs was not always sufficient.

Staff received training to provide them with the skills and knowledge to care for people effectively.

People's health care needs were monitored. People were referred to the GP and other health care professionals as required.

Staff understood people's rights to make choices about their care and the requirements of the Mental Capacity Act 2005.

Requires Improvement

Is the service caring?

The service was not always caring. Staff were caring and knowledgeable about the people they supported, but there were some practices in place that did not protect people's dignity. People's communication needs were not always met.

People and their representatives were supported to make informed decisions about their care and support.

Requires Improvement

Is the service responsive?

The service was not always responsive. Care plans were in place outlining people's care and support needs, however people did not always receive sufficient stimulation within the home.

Staff were knowledgeable about people's support needs, their interests and preferences in order to provide a personalised service.

People using the service and their relatives were encouraged to give feedback on the service and there was a complaints system in place.

Requires Improvement

Is the service well-led?

The service was not always well-led. There were some gaps in the systems in place to monitor the quality of the service people received.

Requires Improvement

Summary of findings

The manager promoted an open and transparent culture in which people were encouraged to provide feedback.	

Ernest Dene Residential Care Home

Detailed findings

Background to this inspection

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

The last inspection of the home took place in September 2014 looking at medicines, and the home was found to be compliant with this outcome.

This inspection took place on18 December 2014 and was unannounced. The inspection was carried out by two inspectors, a professional advisor who was a nurse with knowledge of older people's needs, 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.

Prior to the inspection we reviewed the information we had about the service. This included information sent to us by the provider, about the staff and the people who used the service. Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

There were 26 people living at the home on the day of our visit. During the visit, we spoke with eleven people who lived at the home, two relatives and one health care professional visiting the home, five care staff and the registered manager. We spent time observing care and support in communal areas.

Some people could not let us know what they thought about the home because they could not always communicate with us verbally. Because of this we spent time observing interactions between people and the staff who were supporting them. We used the Short Observational Framework for Inspection (SOFI), which is a specific way of observing care to help to understand the experience of people who could not talk with us. We wanted to check that the way staff spoke and interacted with people had a positive effect on their well-being.

We also looked at a sample of five care records of people who lived at the home, five staff records, and records related to the management of the service.

Following the inspection we spoke with three relatives of people living at the home and four health and social care professionals by telephone.

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Is the service safe?

Our findings

All but one person we spoke with told us that they felt safe in the home, they said "It's quite nice here. You get used to the crowd around you," and "I'm not in anyway uncomfortable being here." One person said they liked the unusual layout of the building saying the fact it was made up of three houses made it "like living at home." A relative told us, "My [relative] is safe at the home." However our observations of the day of the visit indicated that there were some unaddressed risks.

The home was not always clean. Upon arrival at the home we noticed a strong smell of urine in the entrance hallway. It was not present later in the morning, but in one of the lounges the odour returned later in the afternoon. Three of the bedrooms we went into had an odour of urine. The manager told us there was a system in place to deep clean the carpets in the bedrooms. Records showed that some rooms were cleaned more than others. Some of the rooms had not had the carpet cleaned for more than two months, whilst others had had the carpets cleaned fortnightly. On the day of our visit one domestic staff member was observed cleaning the building.

Although there was a cleaning cupboard to store cleaning equipment we found mops and buckets were being stored in other inappropriate areas such as the laundry room and kitchen.

A nebuliser (a medicines delivery device) was stored in one of the lounges. We were told this was used by one person at the home. There was no recorded system in place for cleaning the box it was stored in, which was dirty at the time of the inspection. There was also no record in place for cleaning the nebuliser mask although we were told this was washed after every use, and it had not been serviced since December 2010. The storage of this equipment in a public area also presented an infection control risk. No recent infection control audit had been undertaken for the home.

The home was based in three former family houses knocked together to form one building. There were three lounges on the main floor all separated by steps. The décor showed signs of age with many of the carpets particularly worn. Throughout the home we noticed ultrasonic pest repellents in use. The provider was unable to tell us how long they had been in use for and they had not been electrical safety tested.

The above information was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, this corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risk assessments in people's care records enabled most risks to be managed effectively, and these were reviewed at least monthly. For example there were no people with pressure areas at the time of our visit and people going out of the home for medical appointments or leisure, did so by taxi and escorted by a staff member. However we found a number of unaddressed risks to people living at the home. One person whose care plan indicated that they should be given a soft mashed diet, was not provided with this at lunchtime on the day of our inspection, placing them at risk of harm. One person chose to wear latex gloves throughout the day, however although they were provided with a pair of gloves each day, the risk of them developing latex sensitivity had not been considered. Staff we spoke with were unaware of this risk and how to recognise and deal with an allergy should this arise.

We found that two first aid kits in the home contained bandages which were packed as sterile but out of date. Staff could demonstrate what to do in some emergencies such as choking or stopping breathing, but had not received training in addressing low blood sugar levels in people at the home who were diabetic. This placed people at risk of not receiving appropriate emergency care.

The above information was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, this corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person told us that another person living at the home upset them. They said that they were not sure if they felt safe in the home due to this person. Staff and the manager were aware of this issue and there was a plan in place to address these concerns. During our visit we observed one person exhibiting challenging behaviour, and a staff member addressing this calmly and without confrontation. Relatives and health professionals that we spoke with did

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Is the service safe?

not have any concerns over the safety of people living at the home from abuse. People living at the home and relatives told us that they could talk to staff if they were worried about anything.

Staff members we spoke with told us that they had received safeguarding training recently and we saw certificates to confirm this. Staff were able to describe the signs and symptoms of abuse. They were aware of the procedure for reporting concerns however some were not aware of the home's whistleblowing procedure.

Safe recruitment procedures were in place to ensure that staff were suitable to work with people. We looked at three staff files including those for two newly recruited staff members. We saw evidence of people being checked for fitness to work. There were copies of disclosure and barring checks, written references, identity checks, copies of employment histories and qualifications, application forms and national insurance numbers. However there were no interview notes maintained in the files. The manager advised that these were held at the provider's head office and they were not available for us to view.

Staff told us that there were enough staff available to ensure people were well cared for. We looked at the staffing rotas for the previous month. These indicated that there were at least four staff members on during the day including a senior support worker, and two staff at night. No agency staff were used in the home to ensure that people were supported by familiar staff. Staff said that sickness and absences were covered effectively, and if there was very short notice staff sickness, the laundry assistant, who had appropriate training, would step in to help out. The manager said that as part of people's assessment before they used the service an agreement was made as to the level of staff support they would need.

We looked at the Medicines Administration Records (MAR) and stocks of medicines for eight people living at the home. People had their allergy status recorded to prevent inappropriate prescribing. Medicines were stored appropriately, and we did not find any gaps in the records or inconsistencies between the stocks and records. Records indicated where people had refused medicines, as appropriate. One person was receiving covert medicines (with medicines disguised in food to prevent them being rejected). Although this had been agreed by the person's doctor and social worker, the pharmacy had not signed to confirm their agreement to this method.

Staff told us that medicines were only administered by senior staff, who had undertaken the appropriate training. We observed medicines being administered appropriately during our visit. Following the inspection we spoke with a pharmacist who provided medicines for the home. They told us that the home audited their medicines, prescriptions were ordered on time, and that they thought that the manager and senior staff were up to date with medicines management.

A medicines audit had been undertaken by the local Clinical Commissioning Group in September 2014, with a number of recommendations for improvement. We saw evidence that these recommendations were being put in place including countersigning handwritten medicines records. We found delivery checklists, including descriptions of medicines provided in mixed dose boxes.

We looked at records of three people's personal monies kept for safekeeping in the home, and found that these were recorded appropriately to protect people from financial abuse in line with the home's policy.

Requires Improvement

Is the service effective?

Our findings

People spoke positively about the support provided by staff. People told us, "You get to see the doctor when you want to," and "the staff and everything are good here." They were also very complimentary about the food at the home, although this was not always reflected in our observations on the day of the visit. They told us "I enjoy the food. You get a good variety," "The food's exceptionally good," "If we don't like something we can get something else," and "We have a good choice." One person told us that the food was a "highlight" for them.

We carried out observations during lunchtime to see the care and support people received in the dining room and lounge areas. In the dining area people we spoke with were not aware of what the lunch options were before the meal was served. Staff did inform them of the meal options when they were seated and people were given a choice of two different drinks and meal options. We saw the food was served efficiently and appeared hot and well presented. We also noticed some people asked for a second helping and this was provided. Staff asked a person who did not want the food available what they wanted to eat, and arranged to get this made for them.

However food for ten people eating upstairs in the lounges was loaded onto a trolley without a hotplate. This was served to people approximately 25 minutes later with only covering plates to keep the food warm. The food served to these people did not appear to be warm, as the plates were cold. We also found that people in the lounges were not told what was on the plates served to them, and were not given a choice of food or drinks. There were no menus on display anywhere in the building.

We asked the cook about preparing meals for people with special dietary requirements and people's likes and dislikes. The cook told us they had been working in the home for two days and were unaware of people with special diets; however we noticed on the wall in the kitchen there was a laminated poster stating one person needed to be provided with a soft diet. During our observation at lunchtime we noticed this person was not provided with a soft lunch. The cook and staff we spoke with were also not clear about which people had diabetic dietary needs. We also observed a lack of staff encouragement for one person who did not want the meal provided, and left their food untouched. This meant people's nutritional needs were not always catered for.

The above information was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, this corresponds to Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's nutritional needs were assessed and when they had particular preferences regarding their diet these were recorded in their care plan. Drinks and snacks were available at set times throughout the day. At the time of the inspection staff told us that there was nobody whose dietary intake was of particular concern and needed close monitoring or a fortified diet. People's weight was being recorded in their care plans at least monthly and more often if there were concerns. We observed that one person who had been admitted to the home underweight was gaining weight effectively. We were told that the main cook for the home was the home's nutrition champion and senior staff also had training in nutrition and this was confirmed by training records.

People were supported to access the health care they needed. People told us that they were able to see their GP when they wanted. Relatives said that when they asked staff to contact the GP, this was done quickly, and they were kept up to date with their relative's medical situation. Care records showed that the service consulted relevant health professionals including community nurses, community psychiatric nurses, dentists, opticians and chiropodists about people's needs. One health professional told us "they are very pro-active," and sought advice promptly when needed. Risk assessments were in place describing preventative measures to protect people from identified health risks such as developing pressure sores. At the time of the inspection no one living in the home was at high risk of pressure sores.

People said they were able to make choices about some aspects of their care. There were assessments available regarding their capacity to make decisions and consent to their care and treatment. Care records made it clear as to whether people had capacity to make decisions about their care and treatment. Staff had received training on the Mental Capacity Act 2005 (MCA). They could explain the process to be followed if they believed that people were

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Is the service effective?

not able to consent and make decisions about their care and treatment. One person had a Deprivation of Liberty Safeguard (DoLS) in place, and was escorted on trips out of the home twice weekly as stipulated in the conditions of this safeguard. The manager was aware of the duty to ensure that further applications were made for DoLS in the light of the most recent Supreme Court Judgement.

People were supported by staff who had the necessary training to meet their needs. One person told us, "If I'm not well, they have trained staff to help me." Staff who had recently started to work at the home had completed induction training. Training records showed that most staff had completed all areas of mandatory training in line with the provider's policy, and those who had not had been identified and were due to complete this training. Staff also had specific training on mouth care, falls prevention, dementia, mental health, and managing challenging behaviour . Most of the care staff had attained a national vocational qualification in care. A training matrix chart was used to identify when staff needed training updated. Diabetes training was not included on this chart, and this was brought to the attention of the manager in view of the needs of some people living at the home.

Staff told us that they received regular supervision in their work with people. The five staff records we looked at showed that staff had received supervision sessions approximately two-monthly and annual appraisals in line with the provider's policy. Records showed that some supervision sessions involved staff being asked to complete a question and answer sheet which was reviewed with the manager. Observations of some staff members' work with people took place as part of their supervision. However not all staff had been observed whilst doing their work, in the past year. The manager advised that this was an area she was addressing. Staff also said that senior staff checked on their work and provided them with feedback on a day to day basis.

Requires Improvement

Is the service caring?

Our findings

Most people told us that they or their relatives were treated with kindness and respect and staff responded to their views regarding how they wished their needs to be met. They said, “The staff have the right level of attention. They don’t fuss but they ask if they think there’s something wrong,” “Generally it’s very pleasant, much nicer than I thought living in a home would be,” and

“I think I’m lucky, I’ve landed on my feet.” A relative told us, “My [relative] is looked after well.”

However we found that one person with complex needs who did not speak English did not receive the care and support they needed. Their relative told us “My [relative] is left in bed all day to watch TV. It isn’t good. No one speaks to [them] or comes to see [them].” We were told that one staff member could speak to this person in their language, but the relative said, “She stays here by herself. Nobody talks to her.” She said, “The people here are good people but she doesn’t understand them.” We noted that the TV provided did not have programmes in this person’s language. Staff had some basic words in this person’s language available to them, but it was clearly difficult for them to provide company and reassurance to this person.

We observed one staff member showing little understanding of the needs of people with dementia or interacting beyond basic task based activities. This staff member frequently stood surveying people in the lounge in silence, not interacting with them at all. Although not seen to be unkind, when supporting people with their mobility they told them what they were going to do and gave instructions (such as to move a leg or to lean forward) but did not asked them if this was alright or say please or thank you.

Throughout the day we observed hot and cold drinks also being served in plastic mugs. We asked the manager why these were used instead of china mugs (china plates were being used). We were told this was due to the china mugs being thrown and subsequently broken by some people who used the service. This meant the provider had implemented a blanket policy without taking into consideration people’s individual needs and abilities.

The above information was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, this corresponds to Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We also observed a notice in the entrance hall informing visitors that they were requested to come at specific, limited times. These were 10 -12 pm, 2 - 4.30pm and 6 - 7.30pm. The notice stated “we operate a protected mealtime for our residents and only the staff are allowed in the dining and lounge areas at this time.” This gave the appearance of a hospital type setting rather than people’s own home.

In other cases staff demonstrated a good knowledge of people, their likes and dislikes. They spoke to them with compassion and kindness. The relationships appeared warm and people spoke positively about care workers. During the afternoon, a former resident who had lived at the home for five months came for a visit. They told us, “I give it a ten out of ten” and, “When I get older, I want to come and live here.” Asked what they felt made it so good they replied, "They look after you so well. There’s plenty of love.” They and the friend who had accompanied them were made to feel welcome with cups of tea and biscuits.

All rooms were single occupancy except for one which was shared by two people. We spoke to the people sharing the room and they confirmed that this was their choice. Bedrooms had en suite toilets but bathrooms were shared. Given the lack of en suite bathrooms,

we asked people if they were able to have a shower when they wished. This did not appear to be a problem. One person noted “Oh we get plenty of showers, you can have a shower whenever you want, you don’t have to ask.”

We observed staff assisting one person with eating at lunchtime. This was done gently, explaining what they were going to do and telling the person what food they had on the fork as is was offered. Another staff member supported a person to go to their room speaking with them respectfully and gently. We also observed one care worker painting a person’s fingernails according to their wishes.

Throughout the day we observed staff knocking on bedroom doors prior to entering to ensure people had privacy. Staff told us they had enough time to talk to people and recognise their needs. They demonstrated that they respected people’s dignity by telling us how they managed

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Is the service caring?

personal care. One staff member told us, “The residents are the best thing about working here.” They went on to give examples of how they cared for people and how they helped them to maintain their dignity and independence. For example one person was encouraged to bring down their own laundry. People were encouraged to feedback about their experience of care in the home at resident meetings held on a regular basis.

We spoke with three health and social care professionals who told us that staff were very friendly and helpful, supportive of people’s likes and dislikes and spiritual needs. They told us that the staff in the home had a very welcoming approach.

Staff showed an understanding of people's needs with regards to their disabilities, race, sexual orientation and gender. However staff told us that they had not yet undertaken equality and diversity training. Care records showed that staff supported people to practice their religion, attend places of worship or have services within the home.

Requires Improvement

Is the service responsive?

Our findings

Although people did not complain about activities provided, we observed a lack of sufficient stimulation for most people living in the home.

Four people were observed throughout the morning sitting in their chairs in a lounge, they did not move for lunch or throughout the afternoon. One person spent their time leaning forward with their head resting on a small table in front. They remained in this position until approximately 4pm when they said they wanted to go to bed. Most people spent their time in the lounges for all or part of the day. The televisions were on in each lounge with a range of programmes throughout the day, however nobody was observed watching them. One person told us, "I don't like to watch TV. I like the radio."

There were some exceptions for example one person told us they liked to read and had selected a book from the shelves in one of the lounges. Another person told us "I sit in my room and listen to the radio." This person was also observed chatting with other residents and walking in the garden. Another person was observed during the morning and afternoon doing puzzles and a crossword. They said, "there's plenty to keep me occupied. I don't get bored," noting that they sometimes went out and had been to the cinema. They also said, "I have a TV in my room. If I get fed up I can go and watch it."

However the majority of people were observed throughout the day unoccupied and being offered little in the way of stimulation. The activities coordinator was not present and it was unclear how many of the activities listed on the noticeboard took place on a regular basis. For example, the noticeboard indicated there would be musical exercises in the morning. There was a short session before lunch (for about 20 minutes) in one of the lounges where six people joined in throwing a ball and a bean-bag with two staff members but no music. The staff did not invite people to join in or discuss what they were doing. Other than that, we observed little activity or non-task based interaction involving care workers.

This contributed to a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, this corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were told that one person living at the home played the piano, and a professional musical entertainer was booked for the home on a twice monthly basis. The activities coordinator was scheduled to provide a one hour activity on five days weekly, and we were told that staff stayed later than their scheduled shifts in order to take people out. The library and hairdresser visited quarterly. Some escorted external activities were provided to a small number of people, including trips to places of worship, local shops, the cinema, pub and cafes. Group activities recorded for people within the home included bingo, films, music movie, and quizzes.

Staff said that most people did not like set activities, but some liked to read newspapers, flower arranging and parties within the home. Hobbies and interests were recorded in people's care plans, but staff advised that many people did not wish to pursue these within the home.

Care plans were in place to address people's identified needs, and were reviewed monthly or more frequently such as when a person's condition changed, to keep them up to date. People living at the home and their relatives confirmed that they were consulted about their care when they moved into the home and their needs changed. This was recorded in people's care records. The home used a system known as 'service user of the day' devoting each day to a different person, reviewing their needs, and spring cleaning their room. The manager took responsibility for updating all the care plans. Monitoring records were in place for people who were at risk of pressure sores, with Waterlow assessments and turning recorded as appropriate. There were also behavioural monitoring records for people who had behaviour that challenged the service..

People's preferences were included in care plans for example their breakfast choices and, preferred snacks. The service used a recording tool know as an 'independence measurement decision tree' with guidance available for staff on its usage. Care records included a clear personal history, keeping active preferences, and clear evidence of health care provision. However we observed that some of the language used in care plans was judgemental such as the use of the word 'spinster,' and descriptions of people as 'pleasant,' or 'difficult and demanding.'

Care plans showed that people and their relatives had been consulted about how they wished to be supported. The Alzheimer's society tool 'This is Me' was used to record

Requires Improvement

Is the service responsive?

personal information about people and encourage a holistic understanding of them as a person. Relatives had been involved in decisions and received feedback about changes to people's care.

Health and social care professionals told us that they found the home's care plans to be comprehensive and up to date, describing care needs well. One professional said, "The care plans are always up to date. The staff and management are helpful."

People were confident that if they made a complaint this would be listen to. Copies of the complaints procedure were available in the service. Staff told us that if anyone wished to make a complaint they would advise them to speak with the manager and inform the manager about this, so the situation could be addressed promptly. Records showed that when issues had been raised these had been investigated and feedback was given to the people concerned. Complaints were used as part of ongoing learning by the service so that improvements could be made to the care people received.

People living at the home and relatives we spoke with said that they knew how to make a complaint. One person said, "I'd tell the manager if I had any issues." Complaints were dealt with promptly, in an effort to bring about improvements in the service. When one person complained about the food provided, the cook changed the menu for that person. Another person complained about challenging behaviour by another person living on the home on the day of the visit and advised that this had been addressed by both staff and the manager.

During the afternoon, we observed a planned meeting to which all residents were invited. These meetings were held every three months. Fifteen people attended including some people who previously had spent most of the day in their rooms. The meeting was led by the manager supported by two care workers who explained items patiently to people who may not have understood them. The meeting covered issues raised at the last meeting to check if these had improved. For example people had complained about the vegetables being overcooked previously, but felt that this had since improved. Throughout the meeting people were encouraged to ask questions and say if they were not happy about anything including services delivered by external providers such as hairdressing.

People's requests were noted for example one person requested provision of curry on the menu more frequently. The process was observed to be consultative and inclusive. It moved at a pace suitable for people who might struggle to understand and every effort was made to include those with communication difficulties.

Requires Improvement

Is the service well-led?

Our findings

People spoke positively about the management of the home. One person said "I'm quite happy with the home." People, speaking about the manager told us, "you're always aware when she's on duty, she's always popping in and out and around the place," and "she has a kind heart."

We found that people and their relatives felt involved in decisions about the care provided in the home. Regular meetings were held for people living at the home at which they were able to participate in decision-making regarding activities and menu planning. The manager advised that there had been a lack of interest from relatives in having a relatives forum meeting for the home.

The manager told us that since the previous inspection the chairs in the home had been replaced, and a new boiler was installed. We asked staff the procedure for reporting items which needed to be repaired. We were told the manager was to be informed and items were documented in a maintenance book and the manager then arranged for head office to undertake the work. However on the day of our visit, we found that there was a broken tap and extractor fan in toilets on the ground floor, which had not been documented in the maintenance book for repair. The provider undertook to get this work completed.

Staff told us there were regular fire drills and records confirmed that there were also regular fire alarm checks and servicing of alarms and fire fighting equipment as appropriate. A fire risk assessment and evacuation plan were in place. We were provided with details of equipment which had an electrical safety test. However we noticed some items within the home such as an electrical fan heater in the lounge were not documented as being tested.

We asked the manager how they reviewed the quality of the service. She described audits undertaken and we were provided with records of audits of medicines records, water quality and the time taken for call bells to be answered. We were also shown cleaning charts detailing the daily cleaning carried out, however the provider did not have evidence of undertaking an infection control or health and safety audit.

At the time of the inspection the home's policies had been sent to head office for annual review, and staff needing these had to request them electronically. Quality assurance checks were carried out by head office staff including some placement reviews. A quarterly quality assurance report was recorded including a review of staffing , financial audits, cleaning, fire safety and accidents and incidents. Areas for improvement from the last report included senior staff involvement in care planning, keeping a vulnerable residents list and the need for more domestic staff. However issues identified in this report had not been identified by the provider's quality assurance procedures.

Incident and accidents were recorded with details about any action taken and learning for the service. Staff said that learning from incidents was discussed at staff meetings and in their training.

The provider had a system to monitor and ascertain people's views of the quality of the care and support they received. Suggestions and feedback from eleven relatives was primarily positive. With comments including "very friendly staff," "impressed with the new manager," "efficiently managed," and "staff have been brilliant." One person noted that the "building is a bit tired." Minutes of recent residents meetings included discussion of privacy and dignity, activity choices, food served, cleanliness, manager availability, the need for redecoration and feeling secure.

It was evident that the manager operated an open door policy to enable communication to be easily managed. Staff told us that the manager was open to suggestions they made and ensured they were meeting people's needs. The layout of care plans and daily logs enabled staff to document clearly and in the same way. Staff were clear about their roles and responsibilities and attended regular team meetings. Minutes of recent meetings included discussion of team work, record keeping, key working, maintenance, cleaning, the staff rota, and deprivation of liberty safeguards.

Health and social care professionals we spoke with told us they did not have concerns about this home. They said that the home was working well with other agencies to make sure people received their care in a joined up way.

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 People were not protected against the risks associated with receiving care that was inappropriate or unsafe because of insufficiently rigorous assessment, care planning and emergency procedures. Regulation 9(1)(a)(b)(3)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People were not protected against the risks associated with insufficiently rigorous standards of cleanliness within the home. Regulation 12(2)(h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs People were not protected against the risks of inadequate nutrition and dehydration, by provision of sufficient choice and support. Regulation 14(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect People's dignity was not always protected and support did not always have due regard to their linguistic background. Regulation 10(1)