Bamford Care Homes Limited

Quinnell House

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**

Summary of findings

Overall summary

We inspected Quinnell House on 19th and 20th April 2016. This was an unannounced inspection. The service provides accommodation and support for up to 51 people living with dementia. The service no longer provides nursing care on site and uses district nurses to provide support when needed. At the time of inspection there were 48 people living at the service. The service provides en-suite rooms over two floors and has a lift. There is one large communal lounge, two smaller communal lounges, a sensory room, dining room, kitchen, treatment room for use of GP and district nurses, laundry, cinema room and a function room that is made available for private occasions.

There was a manager in post who was registered with the CQC. 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.

Staff were trained to protect people from abuse and harm. Staff could identify the signs of abuse and who to report to if they had any concerns. The provider had in place policies and procedures to record, investigate and track any safeguarding concerns. Staff were aware of these policies and procedures.

There were sufficient numbers of staff to keep people and safe and meet their needs. The provider had a system in place that allowed the register manager to recruit more staff when the numbers of people living at the home increased.

Medicines were stored and disposed of safely. Staff were trained in the safe administration of medicines. However, there were gaps in the application of creams. This could put people at risk, as there could have been applications that were missed. We have made a recommendation about this in our report.

The principles of the Mental Capacity Act (MCA) were not consistently applied in practice. Where people were unable to give consent to aspects of their care an assessment of their capacity had not always been completed. This put people at risk as staff could make assumptions about their ability to make their own decisions.

The CQC is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Appropriate application to restrict people's freedom had been submitted and the least restrictive options were considered as per the Mental Capacity Act 2005.

People were supported to maintain a balanced diet. People were provided meals that met their nutritional needs and choice preferences. The provider had carried out assessments of people to identify those at risk with their eating and drinking.

People were supported to maintain good health. People were being referred to appropriate health

professionals when needed. This included referrals to GPs, district nurses and dieticians.

The provider had not ensured that all information was provided in format to meet people's varied communicational needs. We have made a recommendation about this in our report.

People told us they were happy with the staff and felt supported with their care. Staff were seen to be communicating with people in a kind and caring way.

People and their relatives were not always involved with the reviews of care plans. Staff would carry out regular reviews of care plans and the registered manager sent out letters to relatives to inform them of reviews, however, some people told us they had not seen a care plan. People had pre-admission assessments that gave staff basic information. However, detailed care plans were not developed in time to give people full support during their first days at the service.

People's private information and personal documentation was not always respected and stored securely. Handover took place in a communal area with people living at the service in the same room. People's care plans were kept in a room that was, on occasions, left unlocked and unattended.

People and those important to them were encouraged to give feedback on their experiences of the service they received through meetings, surveys, suggestions and complaints. The provider had a system in place to ensure that all complaints received were fully investigated by the registered manager. All outcomes were effectively communicated to all interested parties.

People were supported to make their own choices at the service. People could choose what they would like eat and were encourage to decorate their rooms to their own tastes.

Staff are encouraged to contribute to the improvements of the service. Staff attended meetings where they could express their views and the provider carried out a staff survey. Staff told us they were happy that they could also express their views directly to the registered manager.

The registered manager had not ensured that all records were up to date. There were gaps in people's records when staff had to fill out paper records instead of putting them straight on the computer system. The registered manager had not ensured that audits had identified all shortfalls within the service.

People living at the service, staff and relatives spoke positively about the registered manager. The registered manager had an open door policy that was used by people, relatives and staff.

On inspection we found breaches in Regulations. 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 always safe.

Staff had the knowledge and confidence to identify safeguarding concerns and acted on these to keep people safe.

Risk assessments were centred on the needs of the individuals.

The provider had ensured that staff were safe to work with people at the service by carrying out necessary employment checks.

Medicines were not consistently managed in a safe way. Staff were not completing records to demonstrate administration of topical medicine.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received a training schedule that was appropriate for the people that live at the service.

The principles of the Mental Capacity Act (MCA) were not consistently applied in practice.

People were being provided food that was nutritious. People were being weighed on a regular basis to identify if there were any weight concerns that required further support.

People were referred to healthcare professionals promptly when needed.

Is the service caring?

Requires Improvement

The service was not always caring.

People spoke positively about staff and were happy with the service they received.

The service had not ensured that information was provided in a way for those with differing communicational needs.

Staff had good knowledge of the people they supported.

The provider had not ensured that people's confidential information was always kept private and secure.

Is the service responsive?

Requires Improvement

People had pre-admission assessments that did not provide enough information for people to be adequately supported when they arrived at the service.

Staff completed reviews of care plans and risk assessments. This ensured that people's information was up to date to provide appropriate care.

People had a range of activities to choose from and were involved in the planning of future activities. Activities were personalised to people's needs.

People's friends and relatives were made welcome by staff and could visit at any time.

The service sought feedback from people and their representatives about the overall quality of the service. People's views were listened to and acted upon.

People were encouraged to give feedback through meetings, surveys and comments box to assist to find ways to improve the service.

Is the service well-led?

Requires Improvement

The service was not always well-led.

People and staff spoke positively about the registered manager. Staff told us they felt supported by the registered manager and were happy to report any concerns.

The registered manager was open and transparent. The registered manager had an open door policy that allowed people, their friends and relatives and staff to approach with any concerns.

Accurate and complete records had not always been maintained to allow the registered provider to ensure people's needs were met.

The registered manager had not ensured that all audits were identifying shortfalls within the service.

Quinnell 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 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 the 19th and 20th April 2016 and was unannounced. The inspection team consisted of three inspectors. This is the first inspection since the service first registered with the CQC.

Prior to the inspection we gathered and reviewed information we held about the service. This included notifications from the service and information shared with us by the local authority. 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. A PIR was not available and we took this into account when we inspected the service and made the judgements in this report.

We focused the inspection on speaking with people who lived at Quinnell House, staff, friends and relatives. We spoke with fifteen people, ten members of care staff, maintenance staff, cook, five relatives, and the registered manager. We looked at people's bedrooms with permission and all facilities at the service.

We made observations of staff interactions and the general cleanliness and safety of the home. We looked at twelve care plans, three staff files, staff training records and quality assurance documentation. 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.

Requires Improvement

Is the service safe?

Our findings

People and their relatives spoke positively about the staff. One relative told us "There is always someone here. They are good at keeping an eye on what is happening." One person told us "The staff are lovely and help me when I need it." However, we found aspects of the service that was not safe.

The administration of medicine was not always safe. Some people had been prescribed medicine to take when they needed (PRN) for example pain relief. There was information on how the PRN medicines should be taken, the type, frequency and when it should be given to a person, for example, if a person has a headache. There was no guidance for staff to assess if people who were unable to express themselves verbally needed pain relief. However, this did not impact on people because staff knew them well. For example, a person reported to staff that they had a pain and wanted something for it. The member of staff recognised that the person was in a posture that may indicate they were in pain. The staff member reassured the person and said that they needed to check with the team leader who returned to talk the person and give them appropriate medicine. Body maps and records in people's rooms did not always inform staff where the cream should be applied and how much should be used. Staff told us they had applied the creams but had not always signed the forms to show this had been done. There was no clear evidence that staff had applied the creams as prescribed. We recommend the provider seek advice with regard to the administration and management of medicines in line with guidance from the Royal Pharmaceutical Society.

The provider had reduced the risk of people receiving the wrong medicine. Each person had a medicine file with a picture of the person for identification purposes, date of birth and any known allergies. Medicines were labelled with directions for use and contained both expiry date and the date of opening. Medicines Administration records (MAR) were checked daily to ensure they were given as prescribed and any omissions accounted for. Staff received regular medicine training they told us they attended training and only team leaders gave out medicines. This practice was seen throughout the inspection. Medicines were stored in a medicine trolley that was locked when not in use. Medicines were safely stored in cupboards in a lockable, dedicated room. Medicines requiring refrigeration were stored in a fridge, which was not used for any other purpose. The temperature of the fridge was monitored daily to ensure the safety of medicines. No one at the care home managed their own medicine and no one received medicine covertly, that is, without their knowledge or permission. Medicines were given in a way people choose to take them. For example, some people chose to have their medication in yoghurt.

People were protected against potential abuse by staff who had received appropriate training. Staff could identify abuse and how they should act. One member of staff told us, "Safeguarding protects people that live here. If I had a concern I would go to management." Another member of staff told us, "Safeguarding protects people from abuse. If I needed to report anything I could go to my manager or the local authority." We saw recent reports of safeguarding at the service. We saw evidence of a full investigation and outcomes were communicated to relevant people. A person told us "I feel safe here, of course I do". One relative told us "We feel that our mum is safe here".

The provider had ensured that there were effective systems in place to keep people safe whilst at the service. There were arrangements in place to keep people safe in an emergency. Staff understood the procedures and knew where the information was kept in the event of an emergency. People at the service had an appropriate personal evacuation plan that was designed to keep them safe. For example, one personal evacuation plan told us that a person required the support of two staff. There were regular maintenance and health and safety checks in place. This included water temperatures, electrical and gas safety. An environmental and fire risk assessment was in place and no concerns identified. All equipment was serviced and maintained to ensure that it was safe for use.

All accidents and incidents were being recorded so the registered manager could identify trends to keep people safe and improve the service. Where falls had occurred staff had completed the necessary accident and incident form. It showed what staff had done to make the person comfortable and any action that occurred, for example, a call to the emergency services. Further referrals to a GP or falls risk assessment and outcomes of the referrals were documented. For example, people would be referred to for a falls risk assessment and this would identify any further support or equipment to reduce the risk of further falls, for example, the use of a hoist or standing aids. These were documented as being reviewed by staff on a regular basis to identify if there had been any improvement or if there was further support required. Each person had risk assessments that were appropriate for their individual needs. Each person had a falls risk assessment, mobility assessment and assessments to identify risks of developing pressure wounds or poor nutrition.

The staffing levels were sufficient to meet the needs of people living at the service and there were processes in place to cover staff during times of unexpected absence or leave. The registered manager told us "There are a total of ten staff available during the morning, seven during the afternoon and six overnight, This includes carers and shift leader". The registered manager had a system in place to employ more staff if required, this included when more people moved into the service. The provider had taken appropriate steps to recruit people who were suitable to work within a care setting. The information included completed application forms, two references, photo identification and Disclosure and Barring Systems (DBS) checks.

Requires Improvement

Is the service effective?

Our findings

The service did not always take into account the principles of The Mental capacity Act 2005 (MCA). 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. The registered manager completed a general mental capacity assessment but these were not decision specific. This could result in people not being correctly assessed for every day decisions. There was no evidence to show that mental capacity assessments were being carried out for specific decisions. We reported this to the registered manager who told us "We will be using a new process for mental capacity assessments." People at the service did not have direct access to their rooms. Doors would lock to restrict outside entry when they were closed. People were not locked into bedrooms but were restricted from going in. People were seen to be accepting this practice and waiting by their rooms for a member of staff to let them in. We did not see any evidence that people had been assessed to have the capacity to use a key. We reported this to the registered manager who said, "All staff have keys and they let people in when asked. We have a history of problems with people gaining access to other people's rooms. However, we will review our process immediately." During the inspection, we saw that a new person was being welcomed to the service and this person was given a key to their room.

Failure to carry out mental capacity assessments when a person is deemed not to have capacity to give consent is a breach of the Health and Social Care Act 2008 Regulation 11 (Regulated Activities) Regulations 2014.

Deprivation of Liberty Safeguards (DoLS) were being applied for when appropriate. People can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards. Care plans had DoLS applications when people were being restricted from leaving the service when it was decided that it was in their best interest. We observed that in most cases the registered manager agreed decisions from the next of kin and we did see evidence that where a person did have capacity they were signing consent forms to receive personal care. We saw staff asking people for consent before carrying out daily activities such as assisting with moving. When asked people gave consent when staff offered assistance and when people did not want assistance this was respected. For example one member of staff asked a person if they wanted to assistance to go and join in a group activity. This was declined by the person and the member of staff positively acknowledged this.

There were inconsistencies in staff knowledge of MCA and DoLS and this could put people at risk when they may not have capacity to make a decision. We asked staff their understanding of the principles of MCA and DoLS. One member of staff told us "The main reason for doing a mental capacity assessment is to do a DoLS" and another member of staff admitted, "I have forgotten the training." One member of staff told us "I would tell the person that they could not leave the premises." This action can cause distress if people were trying to leave the service. We reported this to the registered manager who organised external training for all

staff on MCA and DoLS during inspection.

The provider ensured that the staff were competent to carry out care tasks for people living at the service. One member of staff told us "The induction was in depth. I had to go through training and shadow for a few weeks. When I was ok to start on my own I was observed to make sure I was doing things correctly. "Another member of staff told us "We get put on probation for six months and are assessed at three months and six months." The training schedule showed that all staff was receiving training, this included specific courses on dementia and challenging behaviour. Staff do not assist people to move or transfer until they have completed moving and handling training. Moving and handling at the service was seen to be appropriate to meet people's needs. People were assisted to stand up with staff supporting people by putting their hand on the person's back or using a stand aid. Staff were seen to be walking with people who needed to be accompanied and assisted those that required prompting. Staff received regular supervision and a yearly appraisal. The manager undertook spot checks of staff during both the day and night. The manager had recently undertaken an unannounced night visit to check staff were providing appropriate care to people. The night visit identified no problems, concerns or issues.

People were supported to maintain a healthy diet. Each person had a malnutrition universal screening tool (MUST). A MUST is a tool to identify adults who are at risk of malnutrition (undernutrition) or obesity. These assessments allow the staff to manage people's nutrition correctly and identify any other risk. One care plan told us that a person had a low score and that this person should be monitored. During this process the person was seen to be losing weight and was referred to the GP and dietician. The registered manager told us "People are weighed weekly and these are logged on the sheet and this is transferred to the care plans each month." This was to ensure that people maintained a healthy weight and the staff could act appropriately to change. People were seen to be offered drinks on a regular basis and could choose what drink they could have. People were seen to be asking for drinks throughout the day and staff acted on these requests promptly. Records showed us that people were being referred to health services when people's needs change. For example, one person required continued support from a district nurse to manage a wound. Every time the district nurse came to see the person this was documented and included advice that staff may need to be aware of and guidance

People had choice over what they would like to eat. The registered manager told us "There is a four week rolling menu that changes seasonally. There is a choice of two hot meals a day with a vegetarian option." One person told us "The food is good, today it was beautiful." Another person told us "They keep cheeses for me in the kitchen." We saw that staff were approaching people to give them their food options in the morning. Staff would sit with people and go through the options available speaking in a way that was understood by the person.

Requires Improvement

Is the service caring?

Our findings

Confidentiality of people's private information was not always respected. Handover took place in the communal lounge while two people who lived at the service remained in the room. This meant that they could hear confidential information about other people living at the service. Staff told us they "Usually sit in the lounge and did not see it as a problem if people were there as well." The handover included personal information about people for example medicines taken and health related concerns.

The failure to ensure that private discussions about care treatment and support only take place where they cannot be overheard is a breach of the Health and Social Care Act 2008 Regulation 10 (Regulated activities) Regulations 2014.

The registered manager had not ensured that all personal records were kept securely at the service. There was an office where care plans and a computer for staff to update the daily logs were stored. The office was located in a public area where visitors were free to walk past. We saw the door was wedged open and on one occasion, a member of staff had not logged out of the computer correctly. We reported this to the registered manager who closed the door and turned off the computer. On the second day of inspection we saw that the door was wedged open throughout the day by staff.

The failure to keep personal records secure is a breach of the Health and Social Care Act 2008 Regulation 17 (Regulated activities) Regulations 2014.

People at the service were not always involved with the reviews of care plans. People who used the service might not have their views and preferences considered. The care plans had staff input and signatures and we saw evidence that the registered manager had written to relatives of residents, to ask them to attend care plan reviews. Some of the care plans did not involve any other person, other than staff, for up eight months. We spoke to the registered manager who told us "We are trying to find ways to involve others in the care plan reviews but we are finding this difficult." One relative told us "We asked to be involved in the care plan but we have never seen it."

Despite these concerns, most of the care people received respected their privacy and dignity. Care staff used a private screen when assisting people with certain types of medication that required removal of clothing. Prior to this the person was asked if they wanted to go somewhere more private, which was declined. We saw the privacy screen being used when people were being hoisted in communal areas. One member of staff told us "We always respect people's privacy and use a screen when hoisting in communal rooms." Staff told us we spoke discretely if someone wants to go to the toilet." This is what we observed during inspection. Another member of staff told us "I treat people how I would want my family to be treated."

People and relatives told us they were happy with the staff and felt supported. One person told us "The staff are good and nice," and one relative told us "The staff do a good job and we have no concerns." We saw staff using a hoist and they explained what was happening at every step during the transfer. This reassured the person during and helped them to remain calm.

People received care and support from care staff that had got to know them well. One member of staff told us that a person "Likes to get ready in a certain way each morning. She likes to have orange juice before putting on her make-up and she does not like clothes that are a bit tight, so we make sure we go through them every so often to see if anything does not fit anymore." Another member of staff told us "One person shows behaviours that may challenge themselves and others, and the best way to manage this is to make sure the person is ok and leave the person alone as the person is self-calming." This action was documented in the care plan. One person had a unique way of communicating to staff they would like to return to their room. We asked a member of staff who told us this was because the person could not remember the right words. We saw this during inspection and staff reacted in a timely manner to the persons calls.

People's religious preferences were respected and supported. One member of staff told us they had decorated the room to reflect the person's religious preferences. This allowed the person lived in an environment they enjoyed and were accustomed to. Staff told us "We can arrange a priest or vicar on request." One care plan told us that person was not religious and did not want to attend church services. It was seen in one person's activity log that they were attending a monthly church service.

People had access to independent advocates and information was available in the entrance lobby to the service. An advocate is an independent person who represents the interests of another. The registered manager told us "One person under Deprivation of Liberty Safeguards (DoLS) has an independent mental capacity advocate." This was seen in the persons care plan. There was a range of information available for people entrance lobby. This information included a statement of purpose and information on dementia support services.

Requires Improvement

Is the service responsive?

Our findings

The provider had not ensured that there were effective systems in place to provide people with full support that they needed. Pre-admission assessments did take place at the service and included basic information on breathing, cognitive assessment and behaviour. One person had recently moved to the service and the only information available to staff was the pre-admission assessment. The pre-admission assessment told us that appropriate risk assessments had taken place but these were not available in the care plan. Staff did not have sufficient information to support the person appropriately. We saw that this person was disorientated throughout the day with little interaction from the staff. We reported this to the manager who said, "We are going to write up the care plan now that the person had moved in." We also saw a person who was upset and said they were in pain. Staff spoke to the person quietly and were very respectful asking what the problem was. The person became more distressed, staff remained with the person comforting and saying they would get something to help. The member of staff went to a senior member of the team to report the problem. After this, it took 45 minutes for the person to receive pain relief. The persons care plan stated the person 'Was able to tell staff they were in pain and they had ongoing problems with back and neck pain.' This action shows that there was unnecessary delay that could cause discomfort to people. The culture of the service was not always focussed on people. At times the service was task led rather than person centred. For example, staff said they had been very busy because not enough people had been "Got up by the night staff". There was a list of people who required two people to assist to put on nightclothes and staff were seen to start this at 5pm. Staff told us "The people do not mind."

The provider had not ensured that people who use the service receive person-centred care and treatment that is appropriate to meet their needs and reflect their preferences. This is a breach of the Health and Social Care Act 2008 Regulation 9 (Regulated activities) Regulations 2014.

The provider had not ensured that all information provided in a format that was suitable for a person living with dementia. For example, the complaints policy and procedure was available in the entrance lobby but was not presented in a clear way that is easy to understand. We recommend that the registered provider review the complaints procedure to ensure it is produced in a format that meets people's varied communication needs.

People were encouraged to make their own choices at the service. People's rooms were decorated to their own choosing and included their choice of furniture and personal items. People also had choice over what they would like to eat and could decide if they wanted to take part in activities during the day. Staff were seen to be asking people in the small communal lounge if they wanted to join the group for live music entertainment and giving support that those that wanted to join in.

People had access to a range of activities and friends and family could visit at any time. One relative told us "I can visit whenever I like." Relatives were seen to be visiting throughout the day and were welcomed to be involved in activities taking place. People at the service were involved with the planning and development of activities. A resident meeting took place October 2015 and identified that more outings should take place. The activity coordinators also sent out monthly updates to friends and relatives about what had been going

on at the service and what will be happening the next month. A member of staff told us "That we are arranging more activities outside of the service in the summer months." The service also provided activities to those that want it who have to stay in their beds. A member of staff told us "We provide support to those who are in their beds. For example there is one person who likes a certain type of music in their room so we make sure we spend time with them listening to this." During inspection a group of people went out for the day with the activity coordinators." Activities were personalised to people's needs. People were seen to be using Twiddlemuffs. Twiddlemuffs are knitted woollen muffs with small items attached such as ribbons and buttons that people with dementia can twiddle in their hands and provide a source of visual, tactile and sensory stimulation. A cinema room was used for social screenings of films picked by people. People could also use a sensory room that provided gentle stimulation of sight, sound and touch. Sensory can enhance feelings of comfort as well as relieve stress and pain that can assist people living with dementia to improve communication and memory. The provider had installed memory boxes on the walls outside each person room, this practice is recommended for people who have dementia. Each person had the option to fill the box with items that they could identify with. This gave people the opportunity to show what is important to them. For example, one had a popular retailer sign in it and a name badge of where the person worked. In the persons care plan it said that the person enjoyed shopping at this retailer and that they spent their life as a beautician, a job of which was 'thoroughly enjoyed'. Another memory box had a national flag in it and another some small bottles of whiskey and a statement about the person and their love for their family. These boxes showed what was important to people and it also assisted them to identify their room. Staff were developing a 'My life story' for people. The registered manager told us "It is a new system to show what makes them a person." The people were developing these with relatives and friends with the activity coordinators. The 'My life story' books included information about people that made them unique. For example, one told us when and where a person got married and other special memories of that person. The books included a person's likes and dislikes such as what films they enjoyed or shops they like to visit. One book identified that one person loved to visit Italy, what school they went to and that they enjoyed Maths. The activity coordinator told us "We hope that these would help them to develop the current activity plans."

Relatives and friends were also encouraged to give feedback. A relative and resident survey took place March 2015 and identified that more staff were needed. The management have put in place more staff since this survey. There was a compliments and suggestion box in the entrance lobby for people to fill out if they wanted. The service had information available on how to complain. The complaints file contained all recent complaints and management carried out full investigations. Written responses were provided were provided to people to acknowledge the complaint and people were provided with a letter of the outcome. People were also informed of what they can do if they are not happy with the outcome.

Requires Improvement

Is the service well-led?

Our findings

The registered provider had not ensured that all records were up to date. There were inconsistencies with the record reporting specifically around daily logs that were handwritten in care files but not on the system. We reported this to the registered manager who told us "We only use paper forms if the system is down and when agency staff did not have access, which they do now." The records that were hand written had not been transferred to the computer system and the service did not have in place a contingency plan in the event that the computer system was not working or during electrical failure. Important information about people living at the service could get lost during times when the computer system was not available. The recording of peoples care plans was not always consistent. For example, some of the care plans were lacking information of people's likes and dislikes on the main front sheet. As staff had got to know people well this limited the risk to people. We reported this to the registered manager who told us "These should all be completed and I will make sure that they are." During inspection staff were seen to be updating the care plans to reflect the likes and dislikes from the information within the care plan. The service had introduced a digital system to log all records and daily logs. The system had clear labels for each type of activity that included GP visits, one to one interaction, other health professional involvement such as district nurses and dentists, night and day logs. It was easy to track what involvement a person had and identify any areas of concern.

The provider was carrying out audits to try to identify any areas for improvement. However, there was evidence to show that the audits were not identifying all shortfalls within the service. A care plan audit took place April 2016 that did not identify that there was a lack of people's involvement in the reviews of their care plans. The provider had recently undergone an external quality assurance audit that highlighted that the service should carry out a resident turning and air mattress audit. The two audits had taken place during March and April 2016 and identified improvements to people's care that was acted on.

Staff were empowered to contribute to improve the service. One member of staff told us "The staff meetings are very good and things change because of them. For example, we now have a staff room and lockers. Shift leader meeting took place November 2015. It identified that that the service would be taking on new staff and the importance of telling relatives if there had been an accident. We saw that staff were informing people's relatives if there had been an incident. Staff surveys do take place, the registered manager told us "The staff questionnaire was sent out in March 2016." People and those important to them had opportunities to feedback their views about the home and quality of the service they received.

People and staff had confidence the registered manager would listen to their concerns and these would be received openly and dealt with appropriately. One member of staff told us "I feel supported in my role and I am confident the manager will support with me any concern." Another member of staff told us "The manager is brilliant and always has time for us." One relative told us "The manager is very approachable." One person told us "The manager is lovely." The registered manager had good knowledge of people that lived at the service and all staff. The manager had an open door policy and was happy to assist anyone who came to the office. We saw a family come to speak to manager for advice around a personal concern and this was taken up immediately. The provider ensured that all policies were up to date and staff saw these.

The registered manager ensured that there were good links with the local community. They encouraged activities provided from the local community such as school choir's youth and church groups and currently arranging a fete on site that is hoped will be open to the local public. Some staff attended a regular dementia awareness group, which assists them to gain a better understanding of dementia that can help to improve the service. The registered manager had notified the CQC about significant events as required in the regulations. We use this information to monitor the service and ensure they responded appropriately to keep people safe.

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 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 The Provider had not done everything reasonably practicable to make sure that people who use the service receive person-centred care and treatment that is appropriate and meets their needs. Regulation 9(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had not ensured that discussions about care treatment and support only take place where it cannot be overheard. Regulation 10(2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured that staff were acting in accordance with the requirements of the Mental Capacity Act 2005 where a person was deemed to lack capacity to give consent. Regulation 11(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 17 HSCA RA Regulations 2014 Good

personal care

governance

The provider had not ensured that personal records were kept secure at all times.

Regulation 17(2)(d)