

Mr & Mrs Murphy C Hampton and Ms C Hampton

Lakenham Residential Care Home

Inspection report

Lakenham Hill
Northam
Bideford
Devon
EX39 1JJ

Tel: 01237473847
Website: www.lakenham-devon.com

Date of inspection visit:
05 July 2016
12 July 2016
19 July 2016

Date of publication:
06 September 2016

Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Good 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Good 

Summary of findings

Overall summary

The unannounced inspection took place on 5, 12 and 19 July 2016.

Lakenham Residential Care Home is a care home which provides care and support to older people some of whom have been diagnosed with a form of dementia. The home does not provide nursing care. The home can accommodate up to 28 people. There were 22 people using the service at the time of the inspection.

The service is required to have 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. Lakenham Residential Home had a registered manager.

Our previous scheduled inspection of Lakenham Residential Home, in September 2015, found the provider had failed to protect people who used the service. This related to ensuring a safe premises, the handling of medicines, consent to care and treatment, deprivation of liberty without authorisation, not notifying the Commission of incidents, assessment of risk and insufficient oversight of the service to maintain safety and promote welfare. Following the last inspection, the provider sent us an action plan. Following this a focused inspection in March 2016, to look at medicine management, found that there was significant improvement but not all risk had been managed. This inspection found that medicine management was safe and there was a lot of improvement with regard to protecting people who used the service, although not all of the improvements were completed or embedded.

People's legal rights were understood and being promoted although where people had authorised a representative to act on their behalf the detail of those authorisations was not always confirmed. Some of those details were noted, but further improvements were needed

People enjoyed the meals provided but the service were unable to evidence the diet people received was nutritionally balanced. This was because there was no set menu and the cook had not received training in the subject. We have recommended that the service uses current, researched based, best practice in providing nutritious diets for people living with conditions relating to older age or disability.

Whilst Lakenham Residential Home provides a wide variety of communal space there were no environmental adaptations to promote independence for people living with dementia. We recommend the providers consult current guidance on the design of environments for people living with dementia and take that guidance into account for any future upgrading.

An effective recruitment policy protected people from staff who might be unsuitable or unsafe to work in a care home. However, we recommend a review of the service recruitment policy to ensure all aspects of the recruitment procedures are recorded.

Some care plans lacked the detail to ensure people's needs were fully understood and planned for. Some staff recording showed a lack of understanding in how to respond to a change in people's needs. Some risk management was reactive to a problem rather than based on continual assessment and response. However, people's needs were being met.

Staffing arrangements promoted people's safety although some people felt the staff were sometimes unable to respond as they would have wished.

People, their family members, staff and health care professionals commented positively about the improved management and standards of care at the home.

People described a caring, friendly, patient and compassionate staff team.

Staff received the training, support and supervision needed to do their work. The registered manager monitored and worked with staff to improve their practice and find ways of improving people's lives. The staff worked with community professionals for advice and to improve safety for people.

People said they were confident any complaint would be listened to and followed up. The quality monitoring surveys used at the home were being reviewed; people could make their views known.

The order of improvements at the home was based on risk.

We found one breach in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3). You can see what action we asked the provider to take at the back of this 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?

Good 

The service was safe.

Staffing arrangements promoted people's safety although some people felt the staff were sometimes unable to respond as they would have wished.

Safety was promoted through recruitment practice, medicine management, servicing and maintenance and the safeguarding of vulnerable adults.

Individual risk management promoted people's safety.

Is the service effective?

Requires Improvement 

The service was not always effective and some improvements were needed.

There were positive comments about the food provided and a strong emphasis on providing sufficient drinks, but there was no set menu and no information to check people received a nutritionally balanced diet.

People living with dementia had no environmental adaptations to help them find their way around the home.

Not all details of authorisations to consent on people's behalf were in place, but this was a work in progress.

Staff were trained, supervised and supported in their role.

People's health care needs were met through contact with external health care professionals as needed.

Is the service caring?

Good 

The service was caring.

Staff showed compassion and care for the people using the service. People were treated with dignity and respect.

People were made to feel valued and at home. Their views were

sought and respected.

Is the service responsive?

The service was not always responsive.

In some care plans, which should describe people's needs and how to meet them, there were gaps in information. There were some gaps in communication, which could increase risk. Not all care plans promoted person centred care.

People felt confident any complaint would be responded to and any issues were dealt with.

Staff were very responsive to the day to day needs of people, acting quickly when they saw their support was needed.

Requires Improvement ●

Is the service well-led?

The service was well-led.

The provider's vision of compassionate, high standards of care had been promoted by a competent registered manager.

People received a safe service, where risk management had improved.

People's views were sought and where improvement could be made this was done.

Plans for continuing review and improvement were in place.

Good ●

Lakenham 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 inspection took place on 5, 12 and 19 July 2016. The first two visits were unannounced. Two adult social care inspectors completed the inspection.

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.

We reviewed any notifications we had received. A notification is information about important events which the service is required to tell us about by law.

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.

Our inspection in September 2015 found medicine management was not safe. We returned to check improvements had been made in March 2016 and found there was significant improvement but not all risk had been managed. This inspection only looked at the risks still outstanding, with regard to managing medicines in a safe way.

We spoke with six people using the service who were able to comment directly on their experience and two people's representatives. We looked at the care plans and records of care of seven people and a variety of medicine records.

We spoke with seven staff members, the registered manager and the provider. We looked at other records connected with how the home was run, including recruitment records, records of staff meetings and quality monitoring. We received information from six community health and social care professionals.

Is the service safe?

Our findings

Our inspection of September 2015 found that the premises and equipment were not properly maintained to ensure people's safety. The premises and equipment were now found to be in a safe state.

A maintenance technician, employed since August 2015, had set up comprehensive systems to ensure equipment was serviced regularly and safely maintained. Three different outside contractors carried out regular tests and audits of the premises and equipment. Records were maintained and a diary was used for staff to notify when failures occurred.

One window was observed to be opened too wide, which meant people might be at risk of falling. The technician responded to this by immediately adjusting the restraining device. There were also some worn treads on two stairways. The technician pointed out that these stairs were not used by residents, only staff.

There had not been a fire drill since August 2015 but one was planned for 13 and 14 July 2016. Personal evacuation plans had been completed on all people using the service and were kept in a file next to the main fire panel and available for emergency services, in the event of a fire.

A whole home risk assessment had been carried out. However, one fire escape at the western end of the building was steep and had not been a risk assessed and a large safe might pose a risk if a person entered it. The technician said they would ensure those risks were reduced.

Our inspection, September 2015, found that medicine management at Lakenham Residential Home, was not safe. The follow up inspection in March 2016, found there was significant improvement. However, some further action was needed to make sure that all people's medicines were handled in a safe way. At this inspection we found that medicine management was safe. There was detailed information for staff about when 'as required' medicines could be administered. This provided the information staff needed to be consistent in the use of the medicine. The registered manager had introduced competency forms to check whether staff continued to administer medicines safely. There had been no medicine errors since the previous inspection.

Staff were recruited following checks on their suitability to work with vulnerable people. For example, each person had completed an application form and been interviewed. References were sought and a DBS check was completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. The registered manager showed how there were systems in place to ensure no recruitment check was missed. However, it was current practice not to make a record of the interviews potential staff attended. This meant there was no record of discussion relating to any issues recorded in people's employment application or in their DBS report.

We recommend a review of the service recruitment policy to ensure all aspects of the recruitment procedure are recorded.

Accidents and incidents were recorded and monitored. There were two separate books kept to record accidents and incidents but no entry could be found for one accident, which had been notified to the Care Quality Commission. This meant that any response could not be checked as part of the inspection. However, the registered manager said "I know exactly who has fallen and why (since she had been manager)". The registered manager carried out an audit of accidents and incidents in order to look for trends or recurring patterns in events and take remedial action.

People told us they felt safe at Lakenham. The provider also asked people this in their quality monitoring survey. People, their family members and staff said that on the whole there were enough staff. Staff said people's needs were met. However, one person said there had been occasion when their call bell had not been answered quickly enough when they needed the toilet. Another said, "I won't say they're very responsive...sometimes they're in the middle of a job, y'know, sometimes they're rushed off their feet". A health care professional said staff seemed to be "rushed off their feet".

A person's family said they could always find staff when they needed to. We found that staff were able to provide the care and support people needed in an unhurried way, with patience and kindness, during our visits.

The registered manager said the provider currently decided on the staffing rota. This was based on resident numbers and staff feedback about people's needs. The rota showed that the staffing numbers corresponded to people's assessed needs. We had received information to say staff were working very long hours but this was not found to be the case, based on talking to staff and the staffing rota.

The registered manager said the rota had flexibility because she made herself available at busy times, and staff confirmed this. In addition, the provider was within the premises at all times. Care staff also undertook some additional duties, such as the laundry. Support staff included a maintenance technician, activities worker and domestic staff. The registered manager said the service was advertising for additional staff members to both cover an expected staffing shortfall and to be able to increase staffing numbers if people's needs increased.

People were protected from abuse and harm. Most staff had received training in how to protect people from abuse. We informed the registered manager of one staff member who said they had never received the training. Staff knew how to respond to any concerns, including how to take concerns to the local authority, police or CQC if they felt this was necessary. One staff member said, "I would inform the (registered manager), CQC or the police". The registered manager demonstrated how to protect people through raising safeguarding concerns in line with local protocols and working with the local authority vulnerable adults safeguarding team. The service had whistle blowing policy and safeguarding policies in place. These included how the staff were protected if they raised a concerns and who they could contact outside of the organisation if they felt this was necessary.

There had been some safeguarding concerns since the previous inspection. One was an act of alleged neglect, in that a person said they could not receive the care they needed because staff were too busy. The registered provider took the necessary action to deal with the situation, which included taking staff disciplinary action, protecting the person using the service and informing all relevant people.

Each person had risks relating to their individual needs assessed, although this did not always include using standardised tools, which would provide a consistent approach by staff. Records showed that one person was at risk from poor mobility, pressure damage, depression, poor appetite, refusing medicines and choking. Existing control measures were in place and the risk level and any further action for care workers to

take were recorded. This was usually to raise the concern with senior staff. Where refusal of medication was a risk, staff had informed the GP, as the required risk management strategy described. Good practice measures used to mitigate risks to people included using body maps and providing pictures of any moving equipment the person needed.

Is the service effective?

Our findings

Our inspection of September 2015 found that people's rights were not upheld because people were making decisions on their behalf without the lawful authority to do so.

People's relatives (and others) can only give consent where they have the legal authority to do so, for example through a valid Lasting Power of Attorney (LPA) or appointment as a Court of Protection 'deputy'. The registered manager did not have all the details of LPA to ensure staff were able to act within the law, having the necessary information to comply with the authorisations. However, they were contacting people's families to arrange this.

The registered manager had an understanding of the Mental Capacity Act (MCA), Deprivation of Liberty Safeguards (DoLS) and how to protect people's legal rights.

The MCA provides a legal framework for making particular decisions on behalf of people who 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. One person had decided on a course of action which posed a considerable risk. A staff member described how they had made clear to the person the dangers and we found that health care professionals had become involved so the person's welfare was promoted.

People's capacity to make some decisions had been assessed and recorded, but capacity to make some other decisions was not recorded. For example, whether a person was able to consent to the use of a monitoring device. The registered manager said they would take steps to ensure capacity assessments were undertaken for all decisions where the person may not have capacity to make an informed consent.

People can only be deprived of their liberty to receive care and treatment when this is in their best interest and legally authorised under MCA. The application procedures for this in care home are called the Deprivation of Liberty Safeguards (DoLS). Our inspection of September 2015 found that people were being deprived of their liberty without lawful authorisation.

Staff informed us that some people were not free to leave and some were subject to continuous supervision and control, for their safety and welfare. Authorisation to restrict the person's liberty is required under the MCA. Requests for authorisations had been submitted to the local authority where the registered manager believed people did not have capacity to consent to restrictions on their liberty. One had been authorised at the time of the inspection and the care workers understood why that person was deemed too vulnerable to be allowed to leave the home alone.

People were complimentary about the meals at Lakenham. Their comments included, "Better than some restaurants", "Very good. There is a daily choice and we are always asked" and "Very good and it suits me how it is done." One person said the food was "Okay, it's edible" but they did not get the amount of choice

they wanted. We had received a concern that the meal portions were not sufficient. Each person we asked said they always had a sufficient amount of food; the portion size was not a problem for them.

People were provided with regular drinks, hot and cold including when they stayed in their rooms. A community nurse said they had no concerns that people lacked sufficient drinks. Where diet was a concern this was monitored. One record we examined was detailed and showed exactly what fluids the person had received that day, so this could be monitored.

People's pre admission assessment included their food likes and dislikes. This was then transferred to a care plan, which included monitoring their weight and any specialist dietary requirements. One person, at risk of choking, had been assessed by a specialist and staff were following their advice so as to reduce the risk of them choking on food.

There was no set menu and choice of meal depended on the cook's decision each day. A variety of meals were provided. During one inspection visit the choice was cottage pie or lasagne plus either a hot or cold dessert. Other meals had included mixed grill, chicken curry, fish pie and various roasts. One person's family said, "(The person) ate a curry here and we were very surprised". The cook was aware of one person's dislike to chicken and carrots, which corresponded to what the person had told us. She said no main menu option was vegetarian because people never asked for it. Supper dishes did include some vegetarian options.

The cook said they had not received any training in how to plan a nutritious diet or specialist diet for older people. However, they had information displayed, for example, on how to increase calories where a person's eating had reduced and how to reduce risk from choking.

We recommend that the service uses current, researched based, best practice in providing nutritious diets for people living with conditions relating to older age or disability.

Lakenham Residential Home was originally a convent and it maintains many features associated with its use at that time. As such, people benefit from a lot of space and a large variety of communal rooms, plus stunning views of Westward Ho! One person said how they felt they were living in a mansion and they loved sitting by the large window with its panoramic view.

A large proportion of people living at Lakenham live with the condition of dementia. This means it is harder for them to understand their environment and so maintain their independence. There were many features of the home décor which made this more difficult for them, for example, patterned carpet. Where pictorial signage might help them, such as showing toilets, lounge and dining areas, this had not been done.

We recommend the providers consult current guidance on the design of environments for people living with dementia and take that guidance into account for any future upgrading.

People and the family members we met said they were very happy with the care provided by the care workers, one describing it as "Very excellent". Another saying, "Great care. The girls are marvellous". One community nurse described senior carers as "Good" and "Excellent".

New staff employed said how they had been able to spend time learning their role from shadowing senior care staff or deputy managers. They described undertaking the nationally recognised Care Certificate, the detail of which should provide all relevant information for staff when new to care work. They said that they felt very confident in asking where they were not sure about anything.

The registered manager had produced a training matrix, identifying where training needs had lapsed. They had made arrangements for any training necessary training updates. For example, fire safety training was arranged for the following week. Care staff said they were happy with the training they received and they were encouraged to undertake qualifications in care. One listed the training they had already planned, including the safeguarding of vulnerable adults and how to protect people's legal rights. Two senior staff had completed an advanced course in dementia care.

We had received information that staff understanding of safe moving and handling might not be sufficient for people's safety. We asked staff a question about safety when using a hoist and their answer indicated a lack of knowledge. We informed the registered manager who said they would check staff competence. Already in place were competence checks for other aspects of staff's work.

One person was at high risk of pressure damage and that risk was increasing. A staff member was unsure whether the person was still receiving visits from a community nurse in relation to pressure damage, which showed there were gaps in staff knowledge, which could impact on the person's care. A community nurse told us they were not attending the person at the time because there was no current pressure damage.

People were supported to maintain good health and have access to health care services. Records showed that medical advice was sought appropriately, such as GP, community nurses and occupation therapy. People living with diabetes confirmed that they had regular appointments with relevant health care professionals, such as podiatry and eye care.

There was a programme of face to face staff supervision, although this had not included non-care staff. Staff said the supervision gave them an opportunity to discuss any practice issues and put across their views. Staff said they found the registered manager, and all senior staff, very supportive and helpful.

Where the practice of a staff member needed close monitoring the supervision sessions provided the opportunity for feedback about their practice, about improvement or to discuss where weaknesses remained.

Is the service caring?

Our findings

Lakenham provided end of life care with the support of community nurses. One nurse said, "Anything you ask they do. They follow advice", and "The carers are lovely and the staff are really sensitive". Five of the six professional opinions about the care at Lakenham was positive and the sixth said they had no specific concerns about the care.

The registered manager was introducing documents called "Thinking about your future health care" so people could be sure their wishes for end of life care would be known and understood. However, most people did not have this document in place at the time of the inspection and so people's future needs and wishes were not gathered for all people, including one who was at the end of their life. This meant their wishes might not have been taken into account.

Staff were observed being very attentive to people's needs, identifying when a person needed their attention or support. One person said they were very happy and felt they "belonged" at the home. People's family members said, "They speak to (person using the service) gently and caringly", "They are very kind and nothing is too much trouble", and "They are so good to him. He has peace of mind".

Staff understood the importance of engaging with people effectively; they communicated with people at eye level, and showed patience. One staff member said, "It is very rewarding to see the smiles on people's faces".

One person required a medicine before the nurse arrived to attend them. Staff did this, as agreed, in preparation for the nurse's visit. This meant that the person was calmer and less upset by the procedure.

One person wanted to move from one seat to another, and then back again. The care assistant helped them move, finding a 'lost' hand bag in the process. They then put a blanket over the person's legs and adjusted another person's blanket, for their comfort. When hot drinks were provided there was always a reminder it was hot. When afternoon sponge cake was offered each was cut to the size of portion the person wanted. Our observations such as these showed staff were caring and attentive.

The provider said in the PIR that caring is the most important aspect of the service they provide and that all staff were "vetted for experience and character and only those that are regarded as sound character (are employed)".

People had their privacy respected and were treated with dignity. For example, attention was given to how the person wished to present. One had chosen to have only female staff attend them and people said they could rise, retire and spend their day the way they chose.

The registered manager was described by staff as "Always mingling with the residents because she has their welfare at heart". Whilst some residents were able to make their views about the service and their needs know, many were not, which meant that staff needed to interpret people's behaviour, which is what we saw.

Is the service responsive?

Our findings

People spoke highly of the care they received. Their comments included, "Very excellent" and "Very good." The registered manager said that prior to any person admitted she, or a deputy manager, would assess the person's needs so as to be sure the home could meet them. Most people using the service had been admitted before the registered manager was in post and so she had not undertaken most people's assessments. Assessments were then transferred to a plan of care at admission.

A plan of care should provide detailed information about a person, their wishes and needs, so that staff understand the person as an individual and can support them to live the life they want. It should also include details relevant to maintaining the person's health and well-being.

Each person had a care plan but there was no indication on the plans that the person using the service had been involved in the plan or reviews. One person's family said they did not think the plan was discussed with the person, other than relating to their weight. Another person's family member said they had been involved in the care planning, on their family's behalf. Conversations with staff and the registered manager showed that people's preferences were understood and promoted through the care planning. The balance of risks and benefits involved in their care were discussed and agreed with them. People's choices were respected. However, records did not always demonstrate this.

Care plans did not always provide enough detail. One person had a medical condition which had the potential to lead to complications in their health. Their care plan made no mention of how the condition could affect the person and the checks staff could make to help protect them from those complications. The person said they had agreed a strategy for managing their weight but there was no detail in their 'planned action of support' to meet the goal of improving their diet. However, the person said that the necessary health care checks and treatments needed to maintain their health were in place.

Some people had very complex needs, physically and emotionally. One person was at the end of their life. Each health care professional involved in their care said the care workers were meeting the person's needs and believed they could not do more. However, whilst their physical needs were being met and their emotional needs may have been met, the care plan did not convey an understanding of those needs and how staff should support the person in the situation. For example, cultural and faith needs were not included.

Staff made daily entries of each person's care. Some of those entries were minimal in content, often recording the facts around routine care provided, including "Didn't eat breakfast" and "Pad was dirty". Some of the concerns recorded had led to contact with health care professionals, who told us they had no concerns about the care being provided. However, one person's records indicated that care workers did not really understand the degree of care and support the person needed from them and so may not have responded as well as they might, in what was a difficult situation. There were many records of care or diet refused but no record of discussing this with the person or offering alternatives. For example, "Breakfast taken – ate very little. Lunch taken – ate very little. Needs to be turned after lunch".

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)

Community professionals said staff followed their advice and made appropriate contacts, for example, letting the district nurses know if a dressing needed replacement. However, records and conversations with staff showed that contact was sometimes reactive to a concern. For example, care plans informed staff they should contact the district nurses if an area of skin was red. Staff were not regularly reviewing the risk, recognising when risk was increasing and, where necessary, seeking advice to prevent the redness, and thus promoting people's health.

One person had succumbed to pressure damage whilst at Lakenham but this was now "fully healed" and they were discharged from the community health care team. A nurse said that the equipment they had requested to protect people had been provided.

Staff tried hard to provide personalised care. For example, one person, living with dementia, had a reduced appetite. Staff knew they had a strong liking for coffee and so they arranged for coffee flavoured build up drinks that increased the likelihood of them being taken.

Staff were observed offering people choices about how they spent their time, rise and retire, eat and drink. For example, one person did not like company and so chose to stay in their room. Staff had tried to improve their room for them, by turning their bed so they could see the views from the window.

People's family members commented on staff's ability to provide sympathetic care. One said, "They discovered who he is and what makes him content". Without exception people said the care they received was good. Their comments included, "Very nice staff and they don't order me around".

People and their family members told us they believed any complaint or concerns would be dealt with promptly; they had confidence in the registered manager and provider response. There was a complaints policy in place and the registered manager and provider were very visible at the home to listen to people and their family members. The registered manager said there had been no complaints since she was employed. However, the June 2016 staff meeting included, "I have received complaints from families about the standard of ironing". The complaints procedure stated that a written record would be made of any complaint, but this had not been the case on this occasion. The registered manager said that the issue of the laundry had been investigated and dealt with. It had not been included in the complaint records because not considered a formal complaint.

An activities worker was employed at the home. Activities included arts and crafts, exercise sessions and gardening. People were asked what activities they wanted to do and we saw people looking at photographs and engaged in puzzles. One to one engagement was arranged for Fridays when time was allotted for spending time with people in their rooms, for example, talking about their family and local connections of importance.

A sensory pack was recently purchased; it included smells such as tomatoes and tobacco. It was hoped this would stimulate conversation based on people's memories.

Two people told us about the entertainment, in particular, a violinist who brought instruments so people could join in. The activities worker had planned to make additional instruments for people to shake.

The activities worker said they were collecting additional information about people and their lives so they

get ideas of what people might like and what to chat with them about.

Is the service well-led?

Our findings

Our inspection of September 2015 found that no one person was in overall control to assess, monitor and improve the quality of the service and assess, monitor and mitigate risks. This inspection found the registered manager, employed since this previous inspection, had filled that role.

This inspection found that the provider had not displayed the home's rating, following their September 2015 inspection, as they are required to do. The registered manager was unaware this needed to be displayed. The rating was displayed within the home before the end of this inspection.

The registered manager started her role as manager on 29 February 2016 and was registered with the Care Quality Commission on 24 May 2016. They said they had prioritised their work with breaches in regulations being addressed first when new in post. They said, "I am using a gradual, thought through process toward improvement".

Community health care professionals said they could see clear improvements since the new manager arrived, including that staff were happier in their work and communication was improved. However, one said how difficult it was to contact the home, with the telephone not always answered promptly. The registered manager accepted that this could occur as she was often to be found around the home and not in the office. How this could be improved would be considered.

People using the service, their family members and staff felt the home was well-led. One family member said, "Having a manager here is very positive because they are more involved with the residents, recognising their needs".

The inspection of September 2015 found that the provider had not notified incidents which are required to be notified to the Commission so that risks connected with the service could be assessed. The registered manager had ensured that all notifiable incidents were now reported.

Risks to people's health and safety were now being mitigated. For example, the registered manager was carrying out spot checks on staff practice. A programme of audits had been devised and was being put into action. Those actioned were the premises and equipment, pressure wounds, medicines and infection control. Those yet to be actioned were care plans and an audit of people's views, through questionnaires, but these were already planned. People's safety had been the priority when she took up her post as manager.

The provider described his vision for the home as, "Our values are simple... Humanity. Treating the service user as your mum". He had handed over the role of running the service on a day to day basis although still maintaining a close observation of the effectiveness of the service and a monitoring role.

This September 2015 inspection found that people's opinion about the service had been surveyed and people had therefore been able to comment about the standard of service they received. The registered

manager was devising another survey so that people could comment about the service in 2016. She said she was reviewing the questions people were asked and might make some amendments toward continuous improvement.

Areas identified by the registered manager for improvement were followed up. For example, practice issues, raised with staff in staff meetings in April and May 2016. These had included the correct bags staff should use to promote infection control. The registered manager said she made sure she is regularly out of the office and observing staff practice. A staff member said, "There is a vast improvement since the (registered manager) arrived. They are so involved in residents and staff, who get full support. She has added a lot of positive energy".

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 17 HSCA RA Regulations 2014 Good governance Regulation 17 Records in respect of each service user were not always complete and did not describe how decisions were made. Regulation 17 (2) (c)