

Havering Care Homes Ltd

Abbcross Nursing Home

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

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

Summary of findings

Overall summary

This unannounced inspection took place over two days on 21 and 22 September 2016.

Abbcross is a purpose built 26 bed care home providing accommodation and nursing care for older people, including people living with dementia. The service is accessible throughout for people with mobility difficulties and has specialist equipment to support those that need it. For example, hoists and adapted baths are available. 25 people were using the service when we visited.

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

At the last inspection in July 2015, we found three breaches of regulations. Systems were not in place to ensure that people received safe care and treatment and care and treatment was not designed in way that ensured people's need and preferences were met. Records were not accurate and the quality of the service was not adequately assessed or improved.

At this inspection we found that action had been taken by the registered manager and the breaches were met. Risks were identified and systems put in place to minimise risk and to ensure that people were supported as safely as possible. Most records were now computerised and were found to be up to date and appropriately completed.

Systems were in place to monitor the service provided and people were asked for their feedback about the quality of service provided. Any issues identified were recorded and action taken.

People received safe care and treatment. Any wounds or tissue viability issues were reviewed at weekly clinical meetings to ensure that the necessary action had been taken.

Systems were in place to ensure that people were not being unnecessarily or unlawfully deprived of their liberty. However, systems were not always in place to ensure that decisions were made in people's best interests.

People told us they felt safe at Abbcross and they were supported by kind, caring staff who supported them and treated them with respect. We saw several examples of this. However, we also saw two occasions when staff were not as caring and supportive as needed. We discussed this with the registered manager who agreed to address the specific issues.

People were encouraged to do things for themselves and staff provided care in a way that promoted people's dignity.

People told us that the food was good and that they could have a drink when they wanted. People's nutritional needs were met and if there were concerns about their eating, drinking or weight, this was discussed with the GP and support and advice were sought from the relevant healthcare professional. We have recommended that lunchtime arrangements and support be reviewed to ensure that people have a pleasant meal time experience and receive the support they need.

The arrangements for administering medicines were safe.

Systems were in place to safeguard people from abuse and staff were aware of how to identify and report any concerns about people's safety and welfare.

Staff received training and support to carry out their duties and competently provided people with the support they needed and wanted.

The provider's recruitment process ensured staff were suitable to work with people who need support.

An activities worker was employed and recreational activities and events were available. People said that they were happy with the activities offered.

Complaints were taken seriously and concerns were addressed. People were happy to talk to the registered manager and managing director to raise any concerns that arose.

People lived in a clean environment that was suitable for their needs.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good 

The care provided was safe. People received their medicines safely.

Risks were identified and systems put in place to minimise risk in order to ensure that people were supported as safely as possible.

Staff were trained to identify and report any concerns about abuse and neglect and felt able to do this.

There were sufficient staff on duty to meet people's needs.

The provider's recruitment process ensured that staff were suitable to work with people who need support.

The premises and equipment were maintained to ensure that they were safe and ready for use when needed.

Is the service effective?

Requires Improvement 

The service was not consistently effective. Systems in place to ensure that people received care and support in line with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards were not robust.

Although people told us that they were happy with the food and drink provided, the lunchtime experience was not always positive.

People were supported by staff with the necessary skills and knowledge to meet their needs. The staff team received the training they needed to support people who used the service.

People's healthcare needs were identified and monitored. Action was taken to ensure that they received the healthcare that they needed to enable them to remain as well as possible.

Is the service caring?

Requires Improvement 

The service was not consistently caring. Although people told us, and we saw, they were treated with kindness we also saw two occasions when staff were not as caring and supportive as

needed.

People's privacy and dignity were respected. They were encouraged to remain as independent as possible and to do as much as they could for themselves.

When needed the service provided support to people at the end of their life.

Is the service responsive?

Good ●

The service provided was responsive. Systems were in place to ensure the staff team were aware of people's current needs and how to meet these.

People were encouraged to make choices and to have as much control as possible over what they did and how they were cared for.

Activities and entertainment were provided and an activity worker was in post to support this.

Complaints were taken on board and action taken to address any concerns or issues.

Is the service well-led?

Good ●

The service was well-led. People were positive about the changes the registered manager had made since they came into post.

Staff told us that the registered manager was accessible and approachable and they felt well supported.

People were consulted about changes to the service and the provider sought their feedback on the quality of service provided. Their comments were listened to and addressed.

Systems were in place to monitor the quality of service provided. Actions identified during monitoring visits were clearly recorded and followed up.

Abbcross Nursing Home

Detailed findings

Background to this inspection

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

This unannounced inspection took place on 21 and 22 September 2016.

The inspection team consisted of one inspector, a specialist nurse advisor 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 service.

Prior to 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. Before our inspection, we also reviewed the information we held about the service. We contacted the commissioners of the service to obtain their views about the care provided.

During our inspection we spent time observing care and support provided to people in the communal areas of the service. We spoke with six people who used the service, the registered manager, the provider, the managing director, two nurses, one carer, the activities coordinator, the cook and one relative. We looked at four people's care records and other records relating to the management of the home. This included four sets of recruitment records, duty rosters, accident and incidents, complaints, health and safety, maintenance, quality monitoring and medicines records.

Is the service safe?

Our findings

People told us that they felt safe at Abbcross Nursing Home. One person said, "I do feel safe."

When we visited in July 2015 we found that people were not protected as well as they could be and that actions had not been taken to address issues of risk that had arisen. We also found that people were placed at high risk of infection due to unsafe practices, in relation to sterile dressings and wound care. On this visit we found that action had been taken to address these issues and the regulation was being met.

Risks were identified and systems put in place to minimise risk and to ensure that people were supported as safely as possible. For example, emergency call alarms had been fitted in the shower room and dining/lounge to enable assistance to be summoned. People's files contained risk assessments relevant to their individual needs and gave guidance to staff about how to maximise safety. For example, how to distract and calm a person when they became agitated.

All nursing staff and most care staff had received infection control training since the last inspection. Training for the remaining staff was arranged for October and November 2016. A selection of sterile dressings were available and the tissue viability nurse had advised the staff about the type of dressings to be stocked. In the treatment room there was also a guide to wounds and dressings to assist nursing staff. Systems were in place to ensure that people were no longer placed at high risk of infection.

Medicines were kept safely. Medicines were securely and safely stored in two medicines trolleys which were kept locked and attached to the wall to ensure they could not be moved or opened by unauthorised persons. The person responsible for the administration of medicines kept the keys with them during their shift. Controlled drugs were stored safely in a separate controlled drugs cupboard and a controlled drugs record was kept. We checked the controlled drugs and found that the amount stored tallied with the amount recorded in the controlled drugs register. Medicines requiring cold storage were kept within a locked fridge. Minimum and maximum temperatures of the medicines fridge were checked and logged every day, providing evidence that these medicines were kept at safe temperatures to remain effective.

Systems were in place to ensure that people received their prescribed medicines safely. Medicines were administered by nursing staff and senior care staff who had received medicines training and had been assessed as competent to do this. They completed the necessary records to confirm that medicines had been given. Medicines Administration Record (MAR) charts were properly completed and up to date. They included people's photographs to check that medicines were given to the correct person. There was an accurate record of the medicines that people had received. Allergies were also indicated. In line with good practice opening dates were recorded on liquid medicines, drops and creams to ensure that they were not used after the expiry once opened period. A system of monthly medicines audits were in place and these were monitored by the registered manager and the managing director. Any issues were followed up with the relevant person to ensure that they were clear as to what was required.

Some people had nasogastric tubes (tubes going into the stomach via the nose for the administration of

fluid, nutrition and medicines) and systems were in place to ensure that their needs were safely met. Nurses were responsible for managing the nasogastric tubes and had received training from an external clinical nurse specialist. If a person's tube became displaced they returned to hospital for have it reinserted. We looked at the records for people with nasogastric tubes and found that nurses recorded what had been administered via the tube and that there was a consistent record that the necessary safety checks had been carried out before they started this process.

There was a system in place to assess and monitor staffing levels in relation to people's needs. Last year the provider had introduced a person centred software system. This computerised system included people's care plans and risk assessments and recorded staff interventions. The system was also used to calculate and monitor required staffing levels. During the early shift there was one nurse and five carers on duty and one nurse and four carers on the late shift. In response to people's needs and in particular to those living with dementia, an additional carer now worked from 4pm to 8pm as this was identified as a time when people needed more support. In addition there was an activity coordinator, domestic, catering staff and a handyperson.

There was a mixed response regarding staffing levels. Some people thought that there were not enough staff and others felt there were. For example, when asked about staff response to the call bell one person said, "Generally speaking yes you have to wait for staff" but another said, "Oh yes staff do come quickly." Staff told us that staffing levels were sufficient to meet people's needs. One member of staff said, "If we are short we do get agency cover which is better." Another said that the additional person between five and eight pm had made a difference and taken a lot of the pressure off. One relative told us, "Occasionally there isn't enough staff but it's got better since [the registered manager] came." Another said, "Staff are there when needed." During our inspection we found that staffing levels were sufficient to meet people's needs.

Staff had received safeguarding training and were aware of the safeguarding policies and procedure in order to protect people from abuse. They were aware of different types of abuse and knew what to do if they suspected or saw any signs of abuse or neglect. Staff were clear they would report anything of concern to the manager and confident that action would be taken. The provider had notified us about potential safeguarding incidents and had worked with the local authority and taken action to make sure people living at the service were protected from risk of harm or abuse. People who used the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent it from happening.

The provider's recruitment process ensured staff were suitable to work with people who need support. This included prospective staff completing an application form and attending an interview. Three of the four staff files we looked at showed that necessary checks had been carried out before they began to work with people. This included proof of identity, two references and evidence of checks to find out if they had any criminal convictions or were on any list that barred them from working with people who need support. Nurse's registration with the Nursing and Midwifery Council was also checked to ensure that they were allowed to practise in the United Kingdom. When appropriate there was confirmation that the person was legally entitled to work in the United Kingdom. For the fourth person we found that although other checks had been made references had not been taken. However, this was prior to the current registered manager being in post. People were protected by the provider's recruitment process.

Staff had received emergency training. There was a fire risk assessment and they were aware of the evacuation process and the procedure to follow in an emergency. A 'fire safety' emergency box was in place. This contained .a plan of the building including where extinguishers and call points were situated, details of cut off points for gas, water and electricity and emergency numbers. Each person had a personal emergency

evacuation plan which provided information about their needs to assist the emergency services in the event of an emergency evacuation being necessary. Therefore emergency information was readily available should the need arise. Systems were in place to keep people as safe as possible in the event of an emergency arising.

The premises and equipment were appropriately maintained. Records showed that equipment was serviced and checked in line with the manufacturer's guidance to ensure that it was safe to use. Gas, electric and water services were also maintained and checked to ensure that they were functioning appropriately and were safe to use. The records also confirmed that appropriate checks were carried out on hoists, pressure relieving mattresses and fire alarms to ensure that they were safe to use and in good working order. Systems were in place to ensure that equipment was safe to use and fit for purpose. People were cared for in a safe environment.

Providers of health and social care have to inform us of important events which take place in their service. Our records showed that the provider had told us about such events and had taken appropriate action to ensure that people were safe.

Is the service effective?

Our findings

People were positive about the care they received. One person told us, "I have been given good support here." Other comments include, "The staff are great and give me great support" and "I think they [staff] are grand."

When we visited in July 2015 we found that staff providing wound care did not have the necessary skills and competence to do this safely. Nursing staff had not received tissue viability or wound care training and there was no information available about skin integrity, pressure ulcers or suitable wound dressings. There was no evidence in the care plans of any structured record of reviews of pressure ulcers, type of dressings required or the dates when they were redressed. During this visit we found that the registered manager and one of the nurses had received wound care training and cascaded this to other staff. Further training was being arranged. In addition wound charts and wound care information was displayed in the clinical room. When needed people had wound care plans in place and wounds or tissue viability issues were reviewed at weekly clinical meetings to ensure that the necessary action had been taken.

Staff told us and records confirmed that they received the training they needed to support people. This included safeguarding, infection control, moving and handling, and food hygiene. One member of staff told us, "I've done all the mandatory training plus some others. For example, Parkinsons and dementia. It's the training we need and it's kept up to date." The registered manager had identified that staff needed more information and training with regards to people's mental health needs. As a result of this staff had received bipolar training and a nurse with mental health experience had been recruited. Most staff had received dementia awareness training and further dementia training was booked for all staff starting in October 2016. One member of staff was qualified as a trainer for moving and handling and they trained other staff and checked their competency. All staff had received this training and the next sessions were planned to update those that needed this. Nurses had been trained to carry out more complex tasks that people needed. For example, to manage the care of people who had nasogastric tubes (tubes going into the stomach via the nose) inserted for the administration of fluid, nutrition and medication. People were supported by staff who received appropriate training to enable them to provide a service that met their needs.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff were aware of people's rights to make decisions about their lives. They were clear that people had the right to and should make their own choices and understood that people's ability to make choices could vary

from day to day. Approximately half of the staff team had received Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) training. Training for the remainder was booked for December 2016. For people with DoLS in place these had been agreed, by the relevant supervisory body. The manager was aware of when to make a referral to the supervisory body to obtain a Deprivation of Liberty Safeguard (DoLS). Records confirmed six people had a DoLS in place and relevant applications had been made to supervisory bodies for others. The registered manager was awaiting their responses. Systems were in place to ensure that people were not being unnecessarily or unlawfully deprived of their liberty.

However, systems were not always in place to ensure that decisions were made in people's best interests. For example, one person received their medicines without their knowing (covertly). Although the GP had agreed that the medicines could be crushed no best interest meeting had taken place and there had been no discussions with the pharmacist or the person's family. There was no evidence that other options, such as liquid medicines had been considered or that the situation had been reviewed.

When we visited in July 2015 we recommended that all resuscitation and best interest decisions be reviewed to ensure that they are properly and fully completed and meet legal requirements. At this inspection we found that this continued to be the case. For example, for two people, with do not attempt resuscitation decisions there was no confirmation that the person did not have capacity regarding the issue and no record of a best interest discussion. One form was wrongly completed as it said this had been discussed with the Power of Attorney but the person did not have one in place. For a third person it stated that there was a Power of Attorney for welfare decisions. However, the person had the capacity to make decisions. The registered manager told us the person had been present during the discussion but there was no record of their involvement, wishes or of the discussion.

The issues highlighted above evidence a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People were provided with a choice of suitable nutritious food and drink. They told us that they enjoyed the food. One person confirmed that they chose their food each day. They added "I like the food. Yes it's nutritious and you can have a drink when you want."

People's menu choice and dietary needs were recorded on a colour coded chart. This enabled the cook and care staff to quickly and easily identify what people needed and wanted and lessened the risk of any errors being made. At the time of the inspection none of the people who used the service had a specific dietary requirement due to their culture or religion. However, the cook told us that the service was able to cater for a variety of dietary needs. At the time of the visit this included diabetic, soft and pureed diet. Therefore people were able to have meals that met their needs.

People were supported to eat and drink sufficient amounts to meet their needs. We saw that there were drinks available in the lounge throughout the day and also available in people's rooms. Some people ate independently and others needed assistance from staff. We saw that some people required a pureed diet and each food was pureed and served separately to enable them to enjoy the different tastes. Staff recorded what people had eaten and drunk and how much. When there were concerns about a person's weight or dietary intake we saw that advice was sought from the relevant healthcare professionals such as a dietician.

We observed lunch time on each of the days and found that the quality of the meal time experience and of the support provided was not consistent. In some cases we saw that people received good support with staff sitting next to them, talking to them and helping them to eat at their preferred pace. However, we also saw a member of staff giving a person their food in silence without any interaction and another member of staff

leaving people to answer the door. Some people had their meal in their chair in the lounge part of the room and a few people used the dining area. We saw that those in the dining area did not always receive the support they needed and that there were not always staff in the area. For example, one person went to the drinks trolley and was drinking out of used cups with leftover tea. They then took another person's half eaten desert to the kitchen server window and were about to be given a spoon to eat it when we informed the member of staff of the situation and they gave the person a fresh dessert as opposed to a spoon. We recommend that lunchtime arrangements be reviewed, changed and monitored to ensure that people are fully supported and that mealtimes are a pleasurable experience.

The registered manager told us that staff supervision (one-to-one meetings with their line manager to discuss work practice and any issues affecting people who used the service) was approximately every three months. Staff confirmed that this happened and also that they had a yearly appraisal. They told us the management team were approachable and supportive. Therefore people were cared for by staff who received support and guidance to enable them to meet their assessed needs.

People were supported to access healthcare services. They saw professionals such as GPs, dietitians and speech and language therapists when needed. One person told us, "Saw the GP yesterday, checked my chest, checked my ear and checked my blood pressure." Another said, "You tell the nurse she gets the doctor. Yes we did see the optician." People's healthcare needs were monitored and addressed to ensure that they remained as healthy as possible.

The environment met people's needs. There was a lift and the building was accessible for people with mobility difficulties. There were adapted baths and showers and specialised equipment such as hoists were available and used when needed. We saw that Abbcross was clean and adequately maintained. In addition to individual bedrooms there was a large combined lounge and dining area where most people spent their time. There was also 'dementia friendly' garden with a fish pond. Some bedrooms were in need of refurbishment and the provider had already started to do this and further work was planned.

Is the service caring?

Our findings

People were positive about the care and support they received. They told us that staff were kind, caring and respectful and that their privacy and dignity were maintained. One person said, "Quite good really nice if anyone complains about them it's a sin." Another commented, "I love it. Since I came here it felt like home." A relative told us, "It's very good, the staff are caring and loving. They always knock before they come in."

We mainly observed that staff supported people in a kind and gentle manner and responded to them in a friendly and patient way. We also saw an example of caring and thoughtfulness. It was one person's birthday and they had a balloon saying happy birthday tied to their chair. Staff brought in a cake and sang happy birthday. They gave the person a present of a cushion which had the picture of their beloved pet on it.

However, we did also see two occasions when staff were not as caring and supportive as needed. One person asked to be taken to their room. A member of staff responded, "No we just brought you down not long ago. You have your lunch and then you go to your room." The person kept calling and two members of staff were close by but ignored them calling and didn't offer any reassurance when the person became more anxious and agitated. The person continued to call and was eventually taken out of the lounge. Another person was in their room crying and indicating they didn't want to be at the service. A member of staff stood by the door and said they would be back later to take the person downstairs. They did not offer any comfort or reassurance to the person. These were discussed with the registered manager who agreed to address the specific issues.

People's privacy and dignity were maintained. Staff said they respected people's privacy and dignity by knocking on doors before entering rooms. When supporting them with personal care they ensured people were not too exposed and that doors and curtains were closed. People's care plans noted if they preferred to be supported by a person of the same gender for personal care. We saw that when the hoist was being used in the lounge to transfer people staff used a blanket to cover them and to help maintain their dignity. They also reassured the person throughout the process.

Residents' and relatives' meetings had taken place and minutes from these were displayed on the notice board. People were asked for their opinions about what happened at the service and to them. This also displayed information about forthcoming events. In the entrance lobby there was a television screen which showed the names and photographs of staff on duty and the daily menu. This information was provided in response to feedback from relatives. However, although this information was useful for visitors, people who used the service did not usually go into this area and therefore did not benefit from the information. We recommend that information relevant to people who use the service be accessible to them.

People were encouraged to remain as independent as possible and to do as much as they could for themselves. For example, to eat independently. A member of staff told us that during personal care they encouraged people to do what they could for themselves. For example, by handing them a flannel and encouraging them to wash their face.

People's personal information was kept securely and their confidentiality and their privacy was maintained. We saw that any paper files were kept in the nurses' station, which was a small area in the corner of the lounge area.

When needed the service provided care and support to people at the end of their life. This was in conjunction with the local hospice and the GP. At the time of the visit nobody was receiving end of life care.

Is the service responsive?

Our findings

People were positive about the way the staff responded to their needs. One relative told us, "[My parent] is receiving the level of care required.

At the inspection in July 2015 we found that the lack of detailed and specific information about people's needs placed them at risk of not consistently receiving the care that they required. Since then a computerised care delivery and monitoring package had been implemented and care plans were updated when they were transferred to the new system. The details and consistency of the information had improved and provided staff with the necessary information to give people the support they needed. For example, for one person the care plan detailed the size of catheter needed and how often it should be changed. Another gave clear moving and handling information including the type of hoist and sling size to be used and also details about how the person preferred to be supported.

People's individual records showed that pre-admission assessments had been carried out by the registered manager or trained staff. Information was also obtained from other professionals and relatives. The assessments indicated the person's overall needs and gave staff the initial information they needed to enable them to support people when they started to use the service. People and their relatives were involved in planning their care and in developing their care plans. One person told us, "They've got that downstairs. They come and ask me and involve me in it."

We saw that care plans were reviewed each month and updated as and when necessary. Care plans and assessments were computerised and the system automatically flagged up when information needed to be reviewed and if this was not done then it was flagged up as overdue. This meant that staff could clearly see what needed reviewing and the management team could monitor this very quickly and easily. Changes in people's care needs were communicated to staff during the handover between shifts and recorded on the system. One member of staff told us, "[Registered manager] always checks that you know things when you are off." This meant that staff had current information about people's needs and how best to meet these.

People were encouraged to make choices and to have as much control as possible over what they did and how they were cared for. We saw that people made choices about what they did, where they spent their time and what they ate. A member of staff told us that giving people choice was "encouraged." They said, "People don't have to go to bed and can get up when they want. They can have breakfast in their room." One person said, "Sometimes I wake up myself. There is no force to get me up or go to bed. I decide when I go to bed."

Arrangements were in place to meet people's social and recreational needs and there was an activities organiser each weekday. People were happy with the activities on offer. One person told us, "We have a very good time. I enjoy myself very much here." Another said, "I draw, colouring, always got something to do. I make decorations. A third told us, "I have prepared things for the oven and made sponge cakes." Outside entertainers visited. One person told us that people came in to sing and another said, "Men came here dressed in dad's army uniform and gave me a book on dad's army and the home guard."

People used a service where their concerns or complaints were listened to and addressed. The service's complaints procedure was displayed on a notice board in a communal area. People informed us that they felt comfortable that if they raised any concerns these would be listened to and acted upon. People and their relatives told us they would talk to the manager if they wanted to make complaint. One person said, "I would complain to the nurse in the blue uniform. Another named the administrator, registered manager and managing director as people they would complain to. They had not made any complaints but felt they would be listened to if they did. A record was kept of any complaints and what had been done in response to these. There had not been any recent complaints.

Is the service well-led?

Our findings

People told us that they were happy with the management of the home. They knew the registered manager and the managing director. They told us that they would be comfortable raising any concerns with them. One person told us, "[Registered manager] is very good, they do their very best."

When we visited in July 2015 we found that there was not an accurate or up to date record of the care that people needed or had received which placed them at risk of receiving inappropriate care or not being supported in a timely manner. We also found that work was needed to ensure that robust and effective monitoring and improvement systems were in place. During this inspection we found that there were effective systems in place to assess and monitor the quality of the service and to implement any necessary improvements.

Most records were now computerised and were found to be up to date and appropriately completed. One member of staff told us that the computerised system made it quicker to complete and was more accurate. Another said it was much better and a lot quicker and easier to keep up to date.

The registered manager and the managing director monitored the quality of the service provided. This was by direct and indirect observation and discussions with people who used the service, relatives and staff. The computerised recording system enabled the management team to check at a glance that required interventions had been carried out by staff. This and other details of what was happening in the service were displayed on the computer screen in the manager's office. Any overdue or uncompleted tasks were automatically flagged up. The registered manager had worked a full range of shifts to enable them to monitor the service at those times and to see at first-hand any issues or practices that needed to be addressed. Both the registered manager and the managing director visited the service unannounced outside their normal working hours to check the quality of service being provided.

The registered manager had also introduced weekly clinical risk meetings to monitor and address any clinical issues. For example, tissue viability, nutrition, swallowing, diabetes and infections. The managing director carried out monthly 'directors' audits. Any actions were clearly identified, prioritised and colour coded to indicate priority. When the necessary action had been taken this was also recorded. External consultants also carried out quality audits every three months and made reports of their findings and recommendations for improvement. People were provided with a service that was monitored to check that it was safe and met their needs.

The provider sought feedback from people who used the service and their relatives through quarterly quality assurance surveys. Feedback was formally sought from staff twice yearly. In addition the consultants and managing director also spoke to people during their visits. People were consulted about what happened in the service. They were asked for their opinions and ideas. They told us that there were meetings and that changes had been made as a result of the discussions. For example, in the care and the decorations. People used a service which sought and valued their opinions and these were used to improve and develop the service.

There were clear management and reporting structures. There was a registered manager in overall charge of the service and in addition to care staff, there were nurses who led each shift and were responsible for the service when the registered manager was not there. Staff told us that changes made by the registered manager had been "for the better." One member of staff said, "You can talk to [registered manager] and they are clear about what they expect." Another told us that when they had raised any issue with the registered manager it had been dealt with. They added that both the registered manager and the managing director took time to talk to people, relatives and staff.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Systems were not in place to ensure that decisions made in people's best interest were in accordance with Mental Capacity Act 2005. Regulation 11 (1) (3).