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Rivendale Lodge EMI Care 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?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

We undertook an unannounced inspection at Rivendale Lodge EMI Care Home on 29 and 30 August 2017. Rivendale Lodge EMI Residential Home provides care and support for up to 27 older people who are living with a dementia type illness. At the time of this inspection 23 people were living in the home. Everyone was living with a dementia type illness and some had additional health care needs associated with their age and fragility.

There was a registered manager in post. 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.

We had carried out an inspection in June 2015 where we found the provider was not meeting all the regulations. The provider sent us an action plan and told us they would address these issues. At our inspection in August 2016 we found the some improvements had been made however there were still some breaches in regulation. The provider sent us an action plan and told us they would address these issues by October 2016.

At this inspection we found some improvements had been made however the breach of regulation 17 was not fully met and we found further areas that needed to be improved.

The quality assurance systems had not identified the shortfalls we found in people's records. Records did not always reflect the care and support people required and received.

Staff had a good understanding of the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). However, there was no information about how people who lacked capacity were able to make decisions or how any restrictions may affect them.

Staff knew people well. They had a good understanding of people's individual needs, preferences and choices. They supported people to ensure they received the care and support they needed in a way that suited each person. Staff treated people with kindness, compassion and understanding.

Staff had a good understanding of providing person-centred care. They knew and understood people as individuals and supported them to make individual and everyday choices. People were supported to engage in a range of activities of that suited their individual needs.

People received their medicines as prescribed. There were systems in place to ensure medicines were ordered, stored administered and disposed of safely. Risk assessments were in place and staff had a good understanding of the risks associated with the people they looked after. They supported people safely whilst helping them to maintain their independence.

There were enough staff to meet people's needs. Recruitment records demonstrated there were systems in place to ensure staff were suitable to work at the home. Staff received the training and support they needed to enable them to meet people's needs. Staff were able to recognise different types of abuse. They told us what actions they would take if they believed someone was at risk of harm or abuse.

People's nutritional needs were met. They were supported to eat and drink a variety of food that they enjoyed and met their individual needs and preferences.

People were supported to have access to healthcare services when they needed them. This included the GP, district nurse and chiropodist.

Rivendale Lodge was clean and tidy. There was ongoing maintenance and redecoration which ensured the home was maintained to an appropriate standard.

We found a number of breaches of the Regulations 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 this report. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

Rivendale Lodge was safe.

There were systems in place to ensure medicines were ordered, stored, administered and disposed of safely.

There was ongoing maintenance and redecoration which ensured the home was maintained to an appropriate standard.

There were enough staff to meet people's needs. Recruitment records demonstrated there were systems in place to ensure staff were suitable to work at the home.

Staff were able to recognise different types of abuse and told us what actions they would take if they believed someone was at risk.

Risk assessments were in place and staff had a good understanding of the risks associated with the people they looked after.

Is the service effective?

Requires Improvement

Rivendale Lodge was not consistently effective.

Staff had a good understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). However, there was no information about how people who lacked capacity to make specific decisions were able to make decisions or how restrictions may affect them.

Staff received the training and support they needed to enable them to meet people's needs.

People were supported to eat and drink a variety of food that met their individual needs and preferences.

People were supported to have access to healthcare services this included the GP, district nurse and chiropodist.

Is the service caring?

Good

Rivendale Lodge was caring.

Staff knew people well and treated them with kindness, understating and patience.

People were supported to make their own decisions and choices throughout the day.

People's privacy and dignity were respected.

Is the service responsive?

Good

Rivendale Lodge was responsive.

Staff had a good understanding of providing person-centred care. They knew and understood people as individuals.

There was a range of activities taking place and people had enough to do throughout the day.

There was a complaints policy in place and visitors told us they would raise any worries with staff.

Is the service well-led?

Requires Improvement

Rivendale Lodge was not consistently well-led.

People's records did not always reflect their care and support needs.

The registered manager had developed an open and positive culture at the home. Staff were committed to improving the lives of people who lived there.

Rivendale Lodge EMI 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.

This was an unannounced inspection on 29 and 30 August 2017. It was undertaken by one inspector and an assistant inspector.

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 the information we held about the home, including previous inspection reports. We contacted the local authority to obtain their views about the care provided. We considered the information which had been shared with us by the local authority and other people, looked at safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we reviewed the records of the home. These included staff training records, three staff files including staff recruitment, training and supervision records, medicine records complaint records , accidents and incidents, quality audits and policies and procedures along with information in regards to the upkeep of the premises.

We also looked at five care plans and risk assessments along with other relevant documentation to support our findings. We also 'pathway tracked' people living at the home. This is when we looked at their care documentation in depth and obtained views on their life at the home. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

During the inspection, we spoke with people who lived at the home, two visiting relatives, and eight staff members including the registered manager. Following the inspection we contacted five healthcare professionals who visit the service to ask for their feedback.

People who lived at Rivendale Lodge were unable to verbally share with us all of their experiences of life at the home because of their dementia needs. Therefore we spent time sitting and observing people in areas throughout the home and were able to see the interaction between people and staff and watched how people were being cared for by staff in communal areas. This included the lunchtime meals. We also 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.

Good

Is the service safe?

Our findings

At our last inspection in August 2016 we found the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because guidelines were not in place to ensure topical creams were administered in a safe and consistent way. An action plan had been submitted by the provider detailing how they would be meeting the legal requirements by October 2016. At this inspection we found improvements had been made and the provider is now meeting this regulation.

We saw that people were happy and relaxed in the presence of staff. They approached them freely and looked pleased when they saw a familiar face or heard a familiar voice. Visitors told us their relatives were safe at the home. Staff told us people were safe because they were looked after by staff who knew them well.

There were systems in place to manage medicines safely. Some people had been prescribed topical creams. There was guidance in people's bedrooms to show which creams people required and staff recorded when these were applied. There were body maps to show where exactly the cream was required. Where creams had been prescribed to be applied to pressure areas to help prevent soreness, body maps showed all areas that should be considered. Most creams were applied only when people needed them and there was information to show when this was required, for example if a person's skin appeared dry.

Medicines were ordered, stored, administered and disposed of safely. Regular medicine checks and audits were completed to ensure there were no shortfalls and identify areas that needed to be improved. A senior staff member was allocated the administration of medicines each day. Only staff who had completed their medicine training were able to administer medicines. Formal assessment of competencies was not completed. However, following training staff were supervised to ensure they were safe before they gave people their medicines unsupervised. There was information in the Medicines Administration Records (MAR) folder that showed which staff were able to give medicines and who required supervision.

MAR charts detailed the medicines people had been prescribed and when they should be taken. They included people's photographs, and any allergies. Medicines were given to people individually and staff signed the MAR only when people had taken the medicine. The MAR charts were well completed and demonstrated people had received their medicines as prescribed. Where people had been prescribed 'as required' (PRN) medicines there were protocols for their use. People took these medicines only if they needed them, for example if they were experiencing pain. Some people required their medicines to be crushed before they could take them. Where people required their medicines crushed we found appropriate professional advice and guidance had been sought and documented. When people were given medicines that had been crushed they explained to the person that these were their tablets and made sure the person was happy to take them.

Risks to people's safety were managed well. There were a range of individual and environmental risk assessments in place. These related to people's mobility, risk of falls and nutrition. Risk assessments had identified that some people were at risk of pressure area damage and there was information about what

interventions were required to prevent pressure damage occurring. This included the use of pressure mattresses and regular changes of position. Where people were at risk of falling there was guidance to keep people safe. For example, ensuring people were wearing appropriate footwear, using appropriate mobility aids and having sensor mats in place at night to alert staff when they got out of bed.

Some people were living with health related conditions. Staff had a good understanding of how to support people appropriately. There was guidance for staff to ensure people's diabetes was managed safely, this included what the normal blood sugar levels were for each person with guidance on when to inform the GP or other health professional. Where people had a seizure there was information about what had happened before and after the seizure and the duration of it. This information could help staff identify if there were any patterns, and for health professionals to evaluate the person's epilepsy. Staff had clear understanding of how to support people during a seizure, they told us what action they would take to support and comfort the person to ensure they were safe. Where appropriate, staff knew when to contact other healthcare professionals. Accidents and incidents had been recorded with the immediate actions taken. There was further information to which showed the incident had been followed up and action taken to prevent a reoccurrence.

There were enough staff working each shift to ensure people received the care and support they needed. One staff member said, "I've never worked anywhere before where there has been enough staff to do your work and spend time with people. We've got that here." Another staff member said, "If someone needs more care, if they're unwell or become challenging we just tell (the registered manager) and she will get more staff in." There were four care staff throughout the day and two at night. There was a kitchen assistant who supported people with their breakfast and hot drinks throughout the morning. There was an activities worker each afternoon. Their shift also included supporting people with their lunch and supper meals. There was a twilight worker who worked between 7pm and 10pm. They supported people who remained in the lounge which enabled the care staff to support people who required personal care or wished to go to bed. In addition to care staff there was a chef, housekeeper and laundry assistant working each day. Throughout the inspection we saw staff were busy but were able to work at a pace that suited each person. Staff had time to spend with people engaging and supporting them to move around the home. Staff absence was covered by staff who worked at the home and staff told us they were happy to do this. The registered manager said there was very occasional use of agency staff and they would always be supported by staff who were familiar with people and the home.

Safe recruitment processes were in place. Recruitment records included application forms, identification, references and employment history. Each member of staff had a disclosure and barring checks (DBS). These checks identify if prospective staff are barred from working with children or adults.

Staff had received adult safeguarding training. They were able to tell us about different types of abuse, what actions they would take if they believed someone was at risk and how they would report their concerns. Staff told us they would report their concerns to the most senior person on duty at the time. They told us if they had any concerns they could contact the registered manager at any time. Staff understood their own responsibilities in order to protect people from the risk of abuse. They were aware they could report concerns to external organisations. There was information about safeguarding in the staff office, this included what actions to take and telephone numbers for the local authority safeguarding team.

At the time of the inspection there were ongoing building works at the home. A conservatory had been built and work was on-going to make the garden safe and accessible. Measures were in place to keep people safe. Identification for all contractors was in place and the majority of the work took place outside of the home. This meant minimal disturbance for people. There was an ongoing maintenance and redecoration plan to

ensure ongoing improvements throughout the home. There were regular servicing contracts in place, for example the gas, electrical appliances and water temperature. There were regular fire checks and each person had their own personal evacuation and emergency plan. There was guidance for staff on what action to take in case of an emergency and there were local arrangements in the event the home had to be evacuated.

Requires Improvement

Is the service effective?

Our findings

Staff knew people well and had the skills to look after them. People approached staff when they needed support or assistance and staff responded to them appropriately. Visitors told us staff looked after their relative well and understood what they wanted and needed. Healthcare professionals told us staff contacted them appropriately and were helpful and efficient. However, despite people's positive comments, we found areas of practice which were not consistently effective.

Staff demonstrated an understanding of the Mental Capacity Act 2005 (MCA). The 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 MCA says that assessment of capacity must be decision specific and it must also be recorded how the decision of capacity was reached. There were mental capacity assessments in place but these were not decision specific. The assessments had not been fully completed to show whether the person had capacity or not to make a specific decision at a specific time.

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. DoLS applications had been submitted for people who did not have capacity and were under constant supervision by staff. Copies of the applications and authorisations were available to staff however, there was no information in people's care plans about whether people were subject to DoLS and what staff should do to minimise restrictions. There were forms in people's care plans which showed staff had discussed DoLS with people. The registered manager told us these discussions had taken place to inform people about DoLS restrictions and how these might affect them. However, there was no information to show if people had understood what had been discussed with them. There was no information to show these had been discussed with people's representatives.

Where people were unable to make their own decisions best interest decisions had been made on their behalf. The registered manager told us discussions took place with people's relatives before best interest decisions were made. There were records of how some decisions had been made and who was involved. However, these did not always include any information about what the representative said or thought and how this was used to make the decision. There were no supporting mental capacity assessments to determine what decision the person lacked capacity to make.

Consent forms were in place, these included personal care, administration of medicines and the use of pressure mats. These had been signed by the registered manager to demonstrate this had been explained to the person. However, there were no supporting mental capacity assessments to determine what decision the person lacked capacity to make. There was no information to demonstrate if or how the person had

understood.
There was no information to show that people's relatives or representatives had been involved. Some care records stated people had lasting power of attorneys who could act on the person's behalf. The registered manager told us she had copies of these. However, there was no information about what these covered which meant staff would not be aware if anyone could legally act on the person's behalf.

These issues above are a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite these concerns staff had a clear understanding of mental capacity and DoLS. They told us most people at the home were able to make some decisions, this included what to wear, what to eat and where to spend their time. One staff member told us, "Even though someone might not be able to choose their meal they can still push food out of their mouth or refuse to eat it if they don't like it." We asked staff about one person who was sitting in a reclining chair. We asked if this person was being restrained. Staff explained this person liked to sit with their legs elevated whilst they watched television. They told us the person was able to inform them when they would like to get up from the chair and this was respected. One staff member told us, "We understand about restraint, we're careful when we put small tables in front of people. We make sure it's because they need it and it's not to stop them getting out of the chair." Throughout the inspection we observed staff asking people's consent before providing care and support. We heard staff saying, "Is it alright if…" and "Would you like to….."

When staff commenced work at the home they completed a period of induction. This included an introduction to the day to day running of the home, shadowing other staff to meet people who lived there and reading care plans.

Staff received ongoing training and supervision. There was a training matrix which showed the training staff had received and when it was next due. The registered manager had good oversight and we saw future training had been booked for staff. Training included mental capacity, moving and handling, infection control, dementia and first aid. Staff who administered medicines received medicine training and regular updates. Some staff had completed medicine training for their own learning and knowledge but as they did not give medicines they did not receive updates. Formal competency assessments were not completed however the registered manager and senior staff were observant of other staff throughout the inspection. Staff told us they were confident any poor practice, for example in moving and handling, would be identified and addressed promptly. Staff were encouraged to undertake further training and development such as health and social care diplomas at various levels. Staff received regular supervision throughout the year. This identified any areas where staff may need further training or support. It also allowed staff time to discuss any concerns they may have or support they had identified themselves. There were regular team meetings which were also used as part of staff supervision. Staff were reminded about their responsibilities and updated about changes to the home. Staff told us they felt supported by the registered manager and their colleagues. They were able to discuss their concerns at any time.

People's nutritional needs were assessed and met. The cook and staff had a good understanding of people's dietary needs, likes and choices. People were provided with a choice of food and drink that suited their individual needs and choices. Nutritional assessments had been completed and detailed the type of diet people required, this included pureed and diabetic. Some people had difficulty in swallowing and required thickened fluids. Staff were aware of this and told us how they prepared the drinks. People were weighed monthly and this helped staff to identify if people were at risk of malnutrition. If people had lost weight or required professional support such as the dietician or speech and language therapist (SaLT) this had been sought appropriately. Some people were not weighed regularly due to their general frailty. Staff told us they

observed people and could tell if they had lost weight because, for example, their clothes would be loser and their skin would be dry. They told us if they had any concerns they would contact the person's GP.

People were provided with a choice of freshly cooked meals each day. Staff used their own knowledge and recorded information to help them support people to make their own food choices. Most people ate their main meals in the dining room, we saw they sat in friendship groups and were supported by staff where needed. Where people required support staff sat with the person, maintained eye contact and engaged with them throughout the meal. Staff supported people to enjoy meals at their own pace. When people had finished their meal we heard staff asking if they would like any more. People were supported, as far as possible, to maintain their independence at mealtimes. This included the use of plate guards, ensuring food was cut to the correct size and prompting and reminding people to eat. Some people had their meals served in bowls. Staff told us they had found this enabled people to manage their meals independently.

There was a nutrition folder available to staff. This included information about people's individual dietary needs, choices and preferences. Staff recorded what people ate at each meal and the quantity. Staff told us, "If someone isn't eating today we can look at yesterday's records and see what they were like then. If people don't eat for three days we will contact the doctor."

People were supported to maintain good health and received on-going healthcare support. Staff liaised with health care professionals when required. When there was a change in their health, people were referred to see the GP or other appropriate professional. Records and discussion with staff confirmed they regularly liaised with a wide variety of health care professionals. This included the community nurses, chiropodist and local dementia in-reach team. This meant systems were in place to ensure people received care and treatment from the appropriate healthcare professionals.

Good

Is the service caring?

Our findings

Visitors told us the staff demonstrated a caring and compassionate attitude towards people. They told us they were able to visit the home at any time and were made to feel welcome. There were warm and friendly interactions between staff and people. People were comfortable with the staff and they freely approached staff and chose to spend time in their company.

Staff knew people really well. They had a good knowledge of them as individuals, their needs, likes and choices and what was important to each person. Staff greeted people with a smile and spoke to them in a cheerful voice. This helped people to feel relaxed in their company. People were supported at their own pace and staff were relaxed and unhurried and people were able to spend their day how they chose. We saw people sitting with friendship groups. One staff member said, "People can sit wherever they like but they do like to sit in the same place, everyone knows not to sit in (person's name) seat." This was said with sensitivity and humour.

People were treated with dignity and respect. They were supported to maintain their own personal hygiene and were dressed in clothes of their choice. The hairdresser had visited the home and we observed staff complimenting a person on their appearance. Staff offered people food protectors at mealtimes which helped people keep their clothes clean. One person was wearing an item of clothing that was in need of repair. Staff spoke discreetly to the person and asked if they would like to change what they were wearing. The person agreed and was supported to choose something different. People's bedrooms were personalised with their belongings such as photographs and mementos. Bedroom and bathroom doors were kept closed when people received support from staff and we observed staff knocked at doors prior to entering.

People's equality and diversity needs were respected and staff were aware of what was important to people. People were able to maintain relationships with those who mattered to them. We observed visitors being welcomed by staff. There was information about what gender of staff people would prefer to care for them. Where appropriate people were supported to maintain their religious and spiritual needs. A local church group held regular services at the home for those who wished to attend.

Through our general observations and the SOFI we saw interactions between staff and people were kind and thoughtful. Staffs approach to people was gentle and they demonstrated patience when supporting people. They responded appropriately when people were distressed and spoke to them using their preferred name. Staff used their knowledge of people to support them appropriately. One person had become restless and was walking around the lounge. The person then asked how long they had been in hospital. The staff member explained they were not in hospital but were staying at the home. The staff member said, "It's much nicer here than hospital, you don't have to worry." The person then relaxed, sat in a chair and had a sleep. Another person had approached us, they appeared to be looking for something. We supported the person to return to a staff member. The person relaxed and smiled when they saw a familiar face. The staff member supported the person and helped to identify what they were looking for. We observed two people sitting on a sofa, a member of staff was chatting with them. The staff member then sat

with people, there was no conversation but people were relaxed and enjoying the company.

People were supported to remain as independent as possible. Some people spent a lot of time walking around the home and engaging with others. They were supported to do this. Staff were observant in ensuring pathways were clear for people to walk and free from hazards. They also ensured people had time to rest and sit and eat their meals. Where appropriate people were supported by ensuring they had the correct mobility aids and were prompted and guided when walking. We saw people using the stairs; they took their time and walked very slowly. Staff supported them by not hurrying them and allowing them time to continue at their own pace.

People were involved in decisions throughout the day. This included their day to day care and support and what they wanted to do. We saw staff offering people choices, they were reminded about activities that were happening and asked if they would like to join in. Most people spent the day in the lounge but they were able to return to their rooms as they wished. Staff knew people well and they were able to tell us about people's personal histories, care needs, likes, dislikes, individual choices and preferences.

Good

Is the service responsive?

Our findings

People received care that was personalised to meet their individual needs and choices. Their preferences were recognised and people were treated as individuals. Staff knew people well and had a good understanding of their individual needs and preferences.

Before people moved into the home the registered manager completed an assessment to ensure their needs would be met at the home. This also ensured people would fit in with those who currently lived at the home. The assessment was with the person and their representatives. It included information about the person's support and health needs, their likes and dislikes and how they liked their care to be provided. There was information about what time people liked to get up and go to bed and what they may like to do during the day. The information from the assessment was then used to develop the care plans and risk assessments and these were regularly reviewed.

We found people received care that was person-centred and reflected their individual choices and preferences because staff knew people well; they had a good understanding of them as individuals, their daily routine and likes and dislikes. Care plans contained information about people's needs in relation to personal care, mobility, pressure area risks, nutrition, health and personal preferences. They included information about people's preferences, what they liked to eat and drink and what was important to them in relation to personal hygiene. For example, if they preferred a bath or shower. One person had dentures but declined to wear them, this information was available to staff. Care plans did not include all the information about people. However, this did not impact on people because staff had a good understanding of the support and care they needed. We saw people received the care they required in relation to their needs for example regular pressure area checks and continence care. Staff ensured people received good continence care by regular prompting and support. A member of staff remained in the lounge at all times and which enabled them to respond to people's needs promptly.

Staff were regularly updated about changes in people's needs. Handover's took place at each shift change where staff were informed about any changes to people's care and support needs. There was a communication book where staff left information for their colleagues such as hospital appointments and changes to their medicines. After a period of leave staff were updated in detail about people's needs. One staff member told us, "After we've been on leave the manager will talk us through all the changes to people's needs. She makes sure we know everything that's happened."

There was a dedicated staff team who supported people to engage in a variety of activities throughout the week. There was an activity program displayed however, the activity worker told us the program was not always followed. They explained on that particular day they had planned to undertake exercises with people however people had not participated. They told us they had changed this to a game they knew people enjoyed which involved throwing soft balls. The staff member said, "People enjoy that, they can see what they are achieving when they knock the skittles over." We observed staff engaging with this activity. They supported people to participate and encouraged and praised their achievements. There was information in people's care plans about what they liked to do. One person enjoyed watching television and was supported

to do this each morning. Due to their dementia type illnesses some people were less able to participate in group activities and they were supported to receive one to one activities. This included hand massage, talking with staff and reading books. Throughout the day staff spent time with people to ensure they were not isolated and had opportunities to engage with others.

There was a complaints policy and procedure and complaints were recorded and responded to appropriately. Visitors told us they did not have any complaints or concerns but if they did they would raise them with staff or the registered manager. They told us they were confident any issues would be responded to appropriately. The registered manager told us any concerns were addressed as they arose which prevented them becoming formal complaints.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in August 2016, the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because the provider's quality assurance framework was not robust and had failed to identify a number of shortfalls. An action plan had been submitted by the provider detailing how they would be meeting the legal requirements by October 2016. At this inspection, we found some improvements had been made but the provider was still not meeting the requirements of Regulation 17.

There was a quality assurance system in place however these had not identified the shortfalls we found in people's records. Where shortfalls had been identified there had not always been action taken to address these issues. At our last inspection in August 2016 that there was a lack of information about how consent was sought or how decisions were made on people's behalf. Some improvements had been made but had still not been fully addressed.

We also identified at our last inspection in August 2016 that there was a lack of guidance in place for people who were living with health related conditions. There was now guidance in place for people who were living with diabetes. However, there was a lack of guidance for people who lived with other health related conditions. Some people were prone to seizures. There was no information about what may cause a seizure, how the person may be afterwards or when to request medical support. One person had not experienced a seizure for many years, there was no guidance about what action staff should take in the event of a seizure occurring. Some improvements had been made. There were now seizure monitoring forms in place. These were completed when people had a seizure. There was information about what had happened before and after the seizure and the duration of it.

Where people were living with other health related conditions, which included asthma and Parkinson's disease there was no information about how these conditions affected each individual. The deputy manager had obtained relevant guidance about these, and other, health related conditions from reputable sources such as NHS websites and The National Institute for Health and Care Excellence (NICE). NICE provides national guidance and advice to improve health and social care. However, these provided general information which was not specific to each person. Staff had a good understanding of how people's health conditions affected them and the care and support they needed to maintain their health. However, the lack of consistent guidance meant people were at risk of receiving care that was inappropriate or inconsistent.

People's records did not always reflect the level of care and support they required and received. Staff had a good understanding of people, their care needs and how to support them. There was a stable staff team with minimal use of agency staff. Two people were not weighed regularly, staff told us how they observed these people were not losing weight, and this had not been documented. Although people's hygiene was well-maintained records demonstrated that some people did not have a regular bath or shower. Staff told us this was usually because people had declined but this had not been recorded. Staff completed records when people engaged in an activity. Some records showed the person had not taken part in many activities throughout the month. Staff told us this would be because people had declined to take part. However, there

was no information to explain this. One person was observed displaying behaviour that could cause themselves harm, staff supported this person appropriately but there was no guidance in place for staff.

Other care plans and assessments contained contradictory information. One person's assessment stated they were able to get dressed independently however their care plan stated they needed support to do this. There were forms in people's care plans which showed staff had discussed DoLS with people. However, these did not have people's names on them so staff could not always be sure the information related to the correct person. Staff had a good understanding of people, their health and care needs and how to support them. However, the lack of consistent guidance meant people were at risk of receiving care that was inappropriate or inconsistent. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had identified areas where improvements were required. From our discussions with visitors, staff and from quality assurance feedback it was clear relatives were regularly updated and felt involved with their loved one's care. However, this was not always evident in people's records. This had been identified in the PIR as an area that would be developed over the next year. Not everybody had personal histories in place. Staff told us they were trying to obtain this information from families to have a better understanding of people's interests and lifestyles. The registered manager told us that the pre-assessment form had been re-developed and more of this information would be gathered at that time.

The registered manager had good oversight of the service. She worked at the home most days and was a visible presence throughout the home. One staff member told us the registered manager, "Is very hands on and always listens." People knew her and approached her freely. Visitor's told us she was approachable and they would be happy to discuss any matters with her. There was an open culture at the home. Staff understood their roles and responsibilities. They told us they felt well supported by the registered manager and could discuss any issues with her. There was not a high turnover of staff at the home with five staff having worked there for at least ten years. Staff were rewarded for their long service which demonstrated they were valued by the provider and registered manager.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Where people did not have the capacity to consent, the registered person had not always acted in accordance with legal requirements.