Blanchworth Care Homes Limited

Breadstone Care Home with Nursing

Inspection report

Breadstone
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced comprehensive inspection took place on 5, 6 and 10 October 2016.

Breadstone House Care Centre is a care home with nursing care for up to 35 people, most of whom are living with dementia. On the day we visited 32 people were living there. The home is a converted house and has a passenger lift to reach two floors where people are accommodated. There is also a third floor and a mezzanine floor serviced by stair lifts. There was manager who had applied to CQC to become the 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.

Care plans for people were not always person centred and complete to ensure staff knew how to meet peoples individual needs when they were living with dementia. This was a 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 environment could be improved as there were some areas that required decoration, repair, new carpet and furniture. The provider had planned to commence the improvements required. We have made a recommendation about improving the environment for people living with dementia. Not all areas and equipment were clean, although recent improvements had been made. We have made a recommendation that infection control procedures are improved. The services quality assurance system had not identified all the shortfalls.

People and their relatives told us they felt safe in the home. Staff knew how to keep people safe and were trained to report any concerns. People were supported by staff that were well trained and had access to training to develop their knowledge.

People were treated with kindness and compassion and we observed staff engaged with people in a positive way and they were caring when they supported them. Relatives felt welcomed in the home and told us the staff were kind but sometimes people had to wait for assistance.

People were able to make some choices and decisions and staff supported them to do this. Staff knew what people valued and how they liked to be supported. Peoples care was regularly reviewed. External healthcare professionals supported people when required and people living with dementia were well supported by visiting mental healthcare professional and their GP.

People had a choice of meals and we observed most people ate their food and could have a second helping. When people required assistance with their food staff supported them and gave them time to enjoy their meal. People had a range of activities to choose from which included exercise classes, arts and crafts,

musical entertainments and skittles. There were links with the local community with trips out organised.

The manager and the service quality manager monitored the quality of the service with regular checks and when necessary action was taken. Staff felt well supported by the manager. Staff meetings and relative meetings were held and they were able to contribute to the running of the home.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The home was not clean and people were at risk when staff did not follow infection control procedures. The manager had taken immediate action for most identified shortfalls.

People's medicines were not always managed safely to ensure people were receiving medicines correctly.

Improvements were needed to the environment to ensure peoples safety and provide a pleasant home. The provider had plans to improve the environment for people.

People's care and support needs were assessed to monitor the staffing levels required but the deployment of staff could be improved to meet people's needs.

People were safeguarded as staff were trained to recognise abuse and to report any abuse to the local authority safeguarding team.

People were protected from the risk of being cared for by unsuitable staff by thorough recruitment practices.

Is the service effective?

Requires Improvement

The service was not always effective.

The environment did not effectively meet people's needs when they were living with dementia.

People's dietary requirements and food preferences were usually met for their well-being but their dining experience was not always dignified.

People had mental capacity assessments and Deprivation of Liberty Safeguards had been applied for when they were unable to live without supervision.

People had access to social and healthcare professionals and their health and welfare was monitored by them.

People were supported by staff who had completed their training and regular updates. Individual staff supervision meetings were completed regularly to monitor staff progress and plan additional training.

Is the service caring?

Good

The service was caring.

People were treated with compassion, dignity and respect.

Staff treated people as individuals and positively engaged with them.

People bedrooms were personalised with their own mementoes.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Peoples care plans did not provide sufficient detail. There was insufficient guidance to support people living with dementia.

People took part in activities and had individual engagement with staff..

Complaints were investigated and responded to appropriately.

Is the service well-led?

Requires Improvement

The service was not always well led.

The quality assurance systems need to be more robust to identify all shortfalls.

Regular quality checks ensured that people were safe and improvements were made.

The manager was accessible to staff and people and had made improvements to benefit people.

Regular resident and staff meetings enabled everyone to have their say about how the home was run.

Breadstone Care Home with Nursing

Detailed findings

Background to this inspection

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

This inspection took place on 5, 6 and 10 October 2016 and was unannounced. The inspection team consisted of one adult social care inspector and a nurse specialist adviser.

Prior to the inspection we looked at the information we had about the service. This information included the statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by law. We asked for a Provider Information Return (PIR) but did not receive one this time. 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 spoke with the manager, the service quality manager, the provider, two nurses, three care staff, a catering assistant and an activity coordinator. We spoke with two people who use the service and six relatives. We spoke with two healthcare professionals. We looked at information in five people's care records, two staff recruitment records, staff training information, the duty rosters and quality assurance records. We checked some procedures which included medicines and safeguarding adults. We also contacted social and healthcare professionals that visited the service to obtain their view of the service.

Requires Improvement

Is the service safe?

Our findings

People were not protected against the risks associated with inadequate infection control procedures. Several areas of the home smelt of urine. The smell was particularly acute upon entering the home. The manager felt the carpet was responsible for holding the smell and had requested that new carpets be fitted and these were expected within the next two weeks.

Some commode seats had not been cleaned between use and were rusted. Subsequently 16 new commodes were ordered to replace them. Hoists seen in the bathroom on the first floor were not clean but were immediately cleaned when this was brought to the managers attention. The home had one sluice on the first floor. A care staff member explained how they transported commode inserts to the sluice carefully and did not pass through any communal areas. The legs and wheel of the trolley used to service drinks and snacks between meals were particularly dirty. A spot check by the manager on 15 September 2016 had highlighted the kitchen trolley needed to be cleaned and this and other cleaning concerns had been raised during the staff meeting on 22 September 2016. When we asked who cleaned the trolley staff were unclear who was responsible. The manager clarified the staff responsibilities and the schedules for deep cleaning the kitchen were identified as monthly. One hand towel bin in a bathroom was not working to avoid staff touching it with clean hands. When this was raised with the manager she made plans to order a new bin. Some communal chairs were not clean and may need replacing.

One person told us their bedroom and ensuite toilet was regularly cleaned. Two relatives told us, "It is always clean." Another relative commented on an unpleasant smell which they said had improved. People were not offered the opportunity to clean their hands prior to lunch, there was hand cleaner available but it was not used.

We recommend recognised infection control guidelines are followed to ensure people are protected from the risks associated with inadequate hygiene standards.

There were mostly safe medicine administration systems in place and people received their medicines when required. A number of medicine administration records did not contain instructions for staff to administer topical prescribed cream and where to apply them. This was unsafe practice and staff had requested body charts of where to administer cream at a recent staff meeting. A prescribed thickening agent for two people's drinks was incorrectly stored and administered. A thickening agent was decanted from a large box to two unlabelled containers for two different people with no instructions on them and no named person. We shared our concerns with the manager and they were unaware the large boxes were still being decanted and stopped the practice immediately.

There were protocols for staff to follow when medicine was prescribed 'as required'. This enabled all staff to make the correct judgement of when to administer them. A GP visiting the service told us they completed a six monthly review of people's medicines. Medicines were generally safely stored. Dates of opening medicines not on the monitored dosage system were recorded on the majority of items inspected. This enabled staff to discard them within the appropriate time for their efficiency.

There had been one medicine error recorded and the GP and family were informed and the correct procedure was followed to prevent the same error. A staff member told us any gaps in staff signatures on the administration records were followed up to ensure people had their medicine. The manager told us nurse medicine competency checks required completion.

Most people were living with dementia and there were sufficient staff to meet people's basic care needs. However deployment of staff may need to be improved. There were two occasions when people were not supervised in the communal rooms during the inspection visit. There were eight staff from 7:00 until 19:00 hours which usually included two nurses. The manager was supernumerary and supported staff when necessary. Agency nurses were used when nursing staff were on annual or there was sickness. The agency only used staff people knew and this ensured the staff also knew them well. One agency nurse told us they liked working at the service and knew the people well. Staff told us there were enough staff to meet people's needs. One relative said, "Sometimes you have to look for staff." A healthcare professional also told us they had to search for staff sometimes.

The manager told us the care staff were deployed in three groups with two members in each group who supported a group of people with mixed dependencies to ensure staff had equal workloads and were able to give person centred care. We observed meal times were not well managed and people and staff displayed some anxiety. People were waiting more than 35 minutes in the dining room before their lunch was served and one person complained they had to wait too long and in between courses they became anxious to leave. One person living with dementia was supported by the staff in a lounge when they were displaying signs of anxiety. A twilight care staff member provided additional support to the night staff team of three staff and worked from 18:00 to 22:00 to help ensure people were supported when going to bed. There was also an additional care staff member who started work at 6:00 to assist people getting up.

Many areas of the service required decoration and upgrading to improve the environment for people. People were able to access an internal courtyard area however on the first day of the inspection the door to the courtyard was locked for the majority of the day. People were not able to access the garden independently. The courtyard had gas bottles that may be unsafe for people living with dementia and the shed that was there was unsightly and needed repair. In one area we found equipment was not always safely stored to enable people to pass safely. One person's pressure relieving mattress pressure was set too high for the person's weight. We shared this with the manager and quality manager who were concerned the situation may have caused damage to the person's skin and they rectified the situation immediately. The services improvement plan had identified some areas for improvement and the provider told us they planned to start renovating the home and replace furniture. A new wet room had recently been completed where people were able to have assisted showers and the dining room had been decorated.
The maintenance person maintained the health and safety log monthly where checks to the environment were completed including fire safety. We looked at completed records of safety checks, for example, fire bells, call bells, hoists and electrical portable equipment. Legionella disease checks of the water systems had been completed six monthly and water samples had been sent for analysis. The service quality manager completed regular fire drill training with the staff during some monthly visits of the service which were recorded in the fire log.

Safe recruitment practices were followed before new staff were employed. The correct checks had been made to safeguard people and ensure staff were suitable and of good character. The recruitment records we checked were complete. Potential new staff were introduced to people in the home to see how they engaged with them.

The staff we spoke with had completed safeguarding adults training and most were able to describe what

the term safeguarding referred to and how they would report any concerns. One person told us they felt safe in the home. One relative told us they felt the person was safe and they visited twice a week. Another relative said, "She is safe here, the staff look after her well." Safeguarding referrals had been made to the local authority safeguarding team and CQC. The manager had taken the appropriate action when concerns were identified and completed thorough investigations.

People involved in accidents and incidents were supported to stay safe and action was taken to prevent further injury or harm. Accident records had detailed information and preventive measures were looked at and acted upon where required. One person had fallen and sustained a head injury. Regular observations were recorded to ensure the person had no complications. A body chart had recorded where the bruising was. The accident form had been accurately completed to include assessing any duty of candour by the nurse on duty but had not been reviewed by the manager. One person had been referred to a physiotherapist as they were a high risk for falling. Some people had a sensor mat to alert staff they were moving and may not be able to move without assistance. A monthly accident audit recorded a sensor mat was added for one person and the GP had been informed. The home was not using any bed rails. However the least restrictive alternative of a very low bed with a soft safety mat beside it was used should people roll out of bed.

Risk assessments were in place to support people individually to be as independent as possible. Peoples care plans recorded good evidence of the regular review of risk assessments. We found risk assessments in place for people falling, their nutrition, how to move them and for risk of skin breakdown. The level of risks were recorded to ensure the correct action would be taken. Health and safety risk assessments were completed for the service which included all areas and fire risk assessments. These were regularity updated to ensure any actions were completed to prevent hazards. In one area we found equipment was not always safely stored to enable people to pass safely.

There were arrangements in place to keep people safe in an emergency and staff understood these and knew where to access the information. There was a detailed contingency plan which covered emergencies for example, power failure, loss of information technology and adverse weather conditions.

Requires Improvement

Is the service effective?

Our findings

The environment was not dementia friendly when people living with dementia moved around the home. Some areas needed additional colours to differentiate places or obscure areas where people were not safe to go. Access to stairs and the lift were not safe. At lunch time people waited in the main dining room for some time and there was nothing to engage or interest them. There was no background music on or magazines or newspapers to look at. A group of mainly independent people had chosen to dine together in the reminiscence room. The vintage memorabilia that could be touched or used there offered a positive choice. The lounge was small and quieter than the main dining room and maybe conversations were easier for people.

The meal time experience for people on the first inspection day was not dignified when some people had to wait for their food. One person became restless and wanted to leave. The tables were laid by care staff prior to lunch and people were not involved in this activity or invited to join in. None of the tables were supplied with cruets even though they were available and we reminded staff. The manager reflected the staff may have been anxious when we watched them and did not respond as they usually did. People were given a visual choice of the meals provided. One person was eating on their own in the conservatory and commented their meal was cold. A care staff member took the meal to be reheated.

We recommend the service explores the relevant guidance on how to make environments used by people living with dementia more 'dementia friendly'.

People's dietary needs and preferences were documented and known by the catering staff and care staff. The catering assistant showed us a list of people's individual dietary preferences and needs and this was updated on a weekly basis. The record for one person was different to their care plan as they did not like milk or cereals. There was no reference to this in the kitchen record. Jugs of squash and snacks were available in the lounges. However in the middle lounge, where the majority of people were, they were unable help themselves to drink and were not offered drinks outside of the regular drink round in the morning.

People were referred appropriately to the dietitian and speech and language therapists if staff had concerns about their wellbeing. Staff followed the Malnutrition Universal Screening Tool (MUST) guidance and weighed people as required to monitor their risk of malnutrition. Where people were at risk of malnutrition they were weighed weekly and had well maintained food charts of what they had eaten and how much. One person at risk of malnutrition had three complimentary meal drinks daily and the GP had referred them to the speech and language therapist for dietary support. The care staff we spoke with had a good understanding of which people needed fortified drinks. All meals were fortified but one person was about to trial a new range of highly fortified ready prepared meals. One person told us they had a varied vegetarian diet and particularly like the salads provided. One relative told us the food was good and another told us their relative had put on a bit of weight since they had moved in this year. One person commented, "The food is edible, I'll eat it."

People had access to health and social care professionals. Records confirmed people had access to a GP, dentist, an optician, a chiropodist and a community psychiatric nurse (CPN). One record confirmed a person had been visited by an occupational therapist as they were at risk of falling. A mental healthcare professional told us the manager had involved them early when people living with dementia needed additional support. They told us there were improvements in the service and the manager welcomed their specialist advice. We noted that when one healthcare professional had visited there was no record in the person's care plan about the visit and any outcome.

People's rights were protected because the staff acted in accordance with the Mental Capacity Act 2005. Some staff had completed training on the Mental Capacity Act 2005 (MCA) which 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's mental capacity assessments and 'best interest' records had been completed where required. Their relatives and the GP who had been involved were included in the best interest record. Examples of best interest records were for one person to remain at the service and to have all their care provided. Mental capacity assessments and best interests records were not used for all specific complex decisions, for example related to the use of sensor mats or sheets.

The manager had identified a number of people who they believed were being deprived of their liberty. They had made DoLS applications to the supervisory body. We checked whether the service was working within the principles of the MCA to complete Deprivation of Liberty Safeguards (DoLS). 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 are called the Deprivation of Liberty Safeguards (DoLS). The manager had made 28 DoLS applications where required and these were still awaiting an outcome from the supervisory body. Some were outstanding since 2014.

People were supported by staff that had access to a range of training to develop the skills and knowledge they needed to meet people's needs. Eight staff had completed NVQ level three award in health and social care or equivalent and three had completed level two. Staff told us their training was up to date. One staff member told us, "Training is really good I have just finished a {Qualification and Credit Network} QCF level three qualification and I have done NVQ level two in health and social care." They also told us they had completed dementia care training over two days and Mental Capacity Act training. The staff member planned to complete a diabetes course which was advertised on the notice board. They told us four people were living with diabetes and they wanted to know more about the disease. Another care staff member told us the training was "amazing" and they were up to date. One nurse told us they were completing Mental Capacity Act training the next day

A programme of training to maintain and update staff knowledge and skills was in place and staff were informed when their training was due. Staff had completed a range of training to include dignity and respect, health and safety, moving and handling, infection control, fire safety and food hygiene. The manager told us there were approximately 40 different courses staff could access some were for nurses only. A computer and paper copy was kept of staff training and certificates were awarded on completion. Nurses had completed syringe driver and tissue viability training in the last 12 months. One member of staff told us they had completed a course about behaviours from people that challenged them and explained how they would use diversion methods to support people living with dementia.

People were supported by staff that had individual supervision meetings and appraisals. One nurse told us

they had individual supervision meetings and peer support from the clinical lead nurse. The manager had a chart where staff individual supervision meetings were planned. Staff supervisions were in progress but some clinical nurse supervision were overdue.

Good

Is the service caring?

Our findings

People were treated with kindness and compassion. One person said, "The staff are very good indeed, they are excellent." The relative of one person we spoke with was positive about the home and said whenever they raised issues with the manager they were dealt with effectively and they felt the person's health had improved. They referred to the fact that many of the staff had worked in the home for a number of years and this provided continuity. One relative told us the staff were "wonderful, kind and caring". Another relative said, "The staff are kind and friendly and speak to people nicely when I visit." A mental healthcare professional had noticed improved areas where people living with dementia could look at and interact with articles of memorabilia.

An agency member of staff told us the care at the service was good and staff responded quickly when people needed additional support. They said the service was organised and staff completed peoples care needs and they checked the record were complete. Health professionals told us the staff knew people well and they were caring towards them. We observed several staff engaged with one person who was anxious and they tried to reassure them everything was alright and spoke with them frequently which seemed to calm them.

All the interactions we observed between staff and people were attentive and caring. After lunch we observed staff talking with people in the lounges. Two relatives visiting together said they were happy with the home but felt the swopping of the dining room with the lounge was a retrograde step as people were now not able to look out of the windows at the garden and the new lounge area was not so sunny. When this was fed back to the home and quality manager they were receptive to this and discussed how they could achieve a better experience for people. The next day we visited there was a lounge area in the large light and airy dining room where people could see out of the window and some people were dining in the smaller lounge. The impact on people looked positive, there was more room to move around the lounges, more choice of where to sit and people were looking out of the windows. Relatives commented on this positive improvement for people. The activity person also had more room to support people. The atmosphere was more calm with people engaged with flower arranging in several areas of the home.

People's rooms were personalised where this was appropriate for them and had photographs of their family and friends and some of their own treasured possessions. One person told us they were supported to have regular holy communion in their own bedroom. They also kept in touch with family and friends on their telephone.

There was information in the entrance to the home for people and their relatives which included the latest CQC inspection report. We looked at some letters of compliment from relatives. A relative had written on the Carehomes website a year ago. They said "Staff were very caring, and welcoming when we visited, and eager to ensure that he got the care he needed. And also helped with his physiotherapy when they could, we had no worries or complaints."

Requires Improvement

Is the service responsive?

Our findings

Care plans we looked at were not always person centred and did not document a person's wellbeing on a daily basis. During the inspection the manager asked staff to begin writing about what people do and how they feel each day to inform the care plan reviews and make them more meaningful. Each person had a record of their daily routine and what they usually liked to do. Care plans were not always comprehensive or up to date. For example one person's care plan noted their leg was swollen in June 2016 but there was no subsequent record to inform or document the current condition. The same person was prescribed two different topical creams and neither were referenced in their care plan. There were no directions as to where and how to apply these topical creams in either the care plan or using a body map.

Care plans did not provide sufficient direction for staff to effectively meet the needs of people. Dementia care needs were not recognised in sufficient detail to evidence best practice, especially in terms of behaviour or risk of deterioration due to lack of activity and engagement. One person living with dementia had a communication care plan that described their communication as non-verbal. When the person was agitated the plan told staff it may mean any number of issues for example pain, hunger or their environment may be affecting them. There was no specific care plan for their mental health needs. There was not enough detail on how to support people individually living with dementia and the manager agreed to address this shortfall.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person told us they knew about their care plan and they had signed it as correct and felt the service was responsive to their needs when they became anxious.

We noted during one lunchtime one person was unable to hear what was being said to them. Other people on the same lunch table were able to tell us the person usually wore hearing aids. We informed the manager and they made several unsuccessful attempts to find them. The person was unable to communicate with their peers and visitors.

Mouth care assessments had been carried out in all the care plans we looked at and care plans for mouth care were completed and reviewed. The recent recommendations by The National Institute for Health and Care Excellence (NICE) for mouth care in care homes had been included. Staff sought the advice of tissue viability nurses when assessing wound care and followed their recommendations.

One relative said "Mum has been here for three years, the home is comfortable and some [staff] want to do the best they can put they are pushed." Another relative told us, "Some staff have been here for a while, so that's got to be good."

Three healthcare professionals we spoke with were complimentary about how the service responded to peoples changing needs by referring them for specialist support when required. Each week the manager

informed the GP before they arrived who required a visit so they could look up their past details before they arrived. Handover information between staff at the beginning of a shift ensured important information about people was shared and acted upon where necessary to monitor their progress. Staff had handover records to complete to monitor different aspects of peoples care. The information from the handover records was recorded in care plan number one for everyone which was not always appropriate. The inclusion of daily records may help to monitor peoples care and all staff could record what happened each day.

People had a range of activities they could be involved in each week. There were two activity staff who shared the week's activities and care staff were allocated to complete activities at the weekends. One person told us they had been out in the garden they said, "Its lovely here, I liked my garden." A member of staff said, "People do a lot of gardening activities in the summer." Several people were flower arranging when we visited. One relative told us the person had been out on a boat trip and to see a play. They had also made an Easter bonnet and had played the homes piano.

One of the activity organisers told us some people had individual activities. They took people for walks to the end of the long driveway. They gave individual hand massages and sang with one person in their bedroom and looked at photographs with another person. They knew people well and what they liked to do. They said one person liked to dance when the musical entertainer came. The summer fete held in the grounds had raised money for people to out on outings. There was a lot of equipment available for craft activities. We saw people were being helped to draw round their hand to make a colourful collage out of material. Group activities included armchair fitness, card games, skittles, pampering sessions, musical entertainment and a 'pat dog' visited the home. At weekends staff sometimes played the local 'talking newspaper' so they could hear local news. One person told us they did a lot of knitting for charity blankets.

There was a complaints procedure and policy for people and their relatives to see. Complaints and concerns were taken seriously and used as an opportunity to improve the service. There had been one complaint in the last 12 months and four in 2015. The complaints were investigated thoroughly and written responses had been sent where appropriate. Two anonymous concerns raised with the service had also been thoroughly investigated and a report written. One relative told us they had attended relatives meeting and were able to raise minor concerns there which were always addressed. The concern they raised had been about an unpleasant odour from carpets. There was a plan to replace several carpets.

Requires Improvement

Is the service well-led?

Our findings

The manager had not identified all the issues we noted during the inspection when they completed the services quality assurance systems. There had been improvements to the service but shortfalls remained.

The manager had notified CQC about significant events. We used this information to monitor the service and ensure they responded appropriately to keep people safe. The provider information return (PIR) was not received by us this time as the provider told us their internet connection had been down and they had lost several emails, to include the one where we asked for the PIR prior to the inspection.

The manager had a very good understanding of the individual needs of people. One carer staff member spoke very highly of the current manager saying they had worked with four different managers whilst they had been at the home and the current manager was very easy to talk to and was approachable. They said the manager was both responsive and effective when issues were raised with her. We found her very thorough when investigating any concerns raised about the service and in protecting people from potential safeguarding risks.

Quality assurance systems were in place to monitor the quality of service being delivered and the running of the home. Internal audits were completed monthly and included care plans and medicines. Shortfalls were identified and action was taken. For example a medicine audit in June 2016 had identified topical prescribed creams were not stored safely and were not carried forward on the medicine record. The July 2016 medicine audit recorded the actions had been completed. Good practice was observed in relation to the safe storage of topical creams. They were kept in locked drawers in people's bedrooms.

The monthly visit record completed by the provider's service quality managers had clear information covering different areas each month and what action the registered manager must take. There was an action to record the activities planned and to post what was happening each day on the wall. This was in place when we visited. The August 2016 visit looked at the three monthly infection control audit and care plans reviews. One care plan audit we looked at had been reviewed and there were improvements and only two minor notes to further improve the records.

People and those important to them had opportunities to feedback their views about the home and quality of the service they received. There were feedback forms available for people and their supporters to complete but none had been completed. Quality assurance questionnaires had just been sent to relatives and professionals to complete. Some had been returned and the manager told us the main negative comments were the malodour in the communal areas. The replacement floorcovering for the communal areas had been ordered to eliminate any unpleasant odours. The
manager told us the results from the questionnaires would be shared with people and their relatives at the next meeting. The manager told us about the spot checks they completed of peoples bedrooms and their toothbrushes were checked to ensure the staff had completed personal care. Actions were identified from the spot checks but the completion date was not recorded. Twice a year or more often if necessary a night spot check was made by the manager to ensure people were well supported during the night. We had been

made aware of an incident from a night spot check where a member of staff was suspended and left the service.

Meetings were held with staff, people and their relatives. We looked at the minutes for a residents meeting in August 2016 and a separate relative's meeting held in September 2016. There were six people at the residents meeting and two relatives. In the meeting people had said they were happy with the food and current activities provided. One person had said they really enjoyed the art. People had said how they were happy with the staff and one person said; "They [staff] were very pleasant and another person said "They [staff] were reasonable and fair."

Sixteen people and relatives had attended the meeting in September 2016 and a complete record of people's comments and the managers replies had been made and distributed. There had been a lot of discussion about the passenger lift being out of order for some time. The manager had used a stair climber to ensure all people were able to join in with the annual fete and the provider had agreed to purchase a new one for the service so people were not inconvenienced should the passenger lift fail. The malodour was discussed and people were told about the imminent new flooring. A relative had commented how the home smelt better since the new cleaner had been employed and how helpful they were. Plans for people to have a Christmas lunch in a local restaurant were discussed and several suggestions were recorded. The manager informed everyone about the 'This is me' books she had ordered and asked for family's help in completing them. Once completed they could be kept in peoples bedrooms to inform staff about peoples individuality and what had contributed to their values, hopes and wellbeing.

Minutes of a staff meeting held on 22 September 2016 included many topics for discussion when thirteen staff attended. For example the manager spoke to staff about the importance of people having enough drinks throughout the day particularly when they had an indwelling urinary catheter. Laundry staff requested that staff were more careful when sorting laundry as they were not following infection control procedures correctly. Staff fed back they had found the deployment of staff effective with group allocations to ensure there was an even workload in each team of two staff. The manager relayed to staff about the 'spot checks' audits when peoples bedrooms were checked and sheets were tucked in over air mattresses which decreased their efficiency. All staff had a copy of the minutes for their reference and to help ensure topics covered were addressed.

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
Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People who use services were not protected against the risks associated with incomplete care plans. Regulation 9 (1) (3) (b).