The Orders Of St. John Care Trust

Hayward Care Centre

Inspection report

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Ratings

Overall rating for this service	**Requires Improvement**
Is the service safe?	**Requires Improvement**
Is the service effective?	**Inadequate**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Overall summary

This is the first inspection for this newly registered service . The inspection was unannounced and took place on 11 and on the afternoons of the 12 and 13 of May 2015.

Hayward Care Centre was registered to provide accommodation for up to 80 persons who require nursing or personal care. The service is arranged over five units and at present provides specialist care for people living with complex dementia needs in the Potterne unit. On Avery, Bromham and Keevil unit residential care for people living with dementia is provided. In October 2015 the fifth unit will open to provide nursing care to people living with dementia.

A registered manager was not in post. This post has been vacant since 26 March 2015. An interim manager was in post while a registered manager is recruited to this post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.

Risk management systems did not protect people from harm or from the potential of harm. Risk assessments were not analysed appropriately following an incident or accident. This meant trends and patterns were not identified to prevent them from reoccurring.

Incidents of aggression by people towards each other and accidents were not reported to statutory agencies such as the Local Authority safeguarding adults lead and as required by CQC.

Members of staff on one unit said staffing levels were not sufficient to meet people's needs. They said people were left unsupervised when the senior on duty was in meetings and the other two carers on duty were needed to provide personal care to people.

An induction was not provided to all new staff. The training considered as mandatory by the provider was not provided to all staff. Specialist training to meet the needs of people living with dementia was not provided to all staff. Staff did not have an opportunity to have one to one meetings with their line managers to discuss their concerns, performance and training needs.

People were at potential risk of their health deteriorating. Action was not taken by staff following guidance given to them by healthcare professionals such as the Occupational Therapist.

Staff showed a lack of understanding on seeking consent and making best interest decisions for people who lacked capacity.

The care plans and risk assessments we reviewed were not updated for all the people living at the home and did not reflect people's preferences and their current needs.

Quality assurance visits took place monthly and at these visits the standards of care were assessed. An action plan was set by the area manager following their visit. However, the action plan set in April 2015 had not taken effect.

People said they felt safe living at the home and they were protected from safe management of medicine.

People's dietary needs were catered for. They said they enjoyed the meals served.

We were told complaints were taken seriously and acted upon.

The staff showed a good understanding of promoting independence and choices. We saw staff had good interactions with people and they were clear on how to protect people's rights to privacy and dignity.

Staff said the manager was good and the team worked well together.

We found breaches of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Summary of findings

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

This service was not safe.

There was a lack of reporting of accidents and incidents.

Where risks associated to people's safety, risk assessments were developed. Risk assessments were not reviewed following an incident such as falls.

Staff on the Potterne unit said the staffing levels during the morning were insufficient and did not provide adequate supervision to people.

People told us they felt safe living at the home. People were protected by safe systems of medicines.

Is the service effective?

Inadequate

This service was not effective.

An induction was not provided to all new staff and there was a lack of training to staff. Staff did not benefit from one to one meetings with their line managers where they could discuss concerns, personal development and training needs.

People were placed at risk because advice about their health care needs was not followed.

Staff showed a lack of understanding on seeking consent and making best interest decisions for people who lacked capacity.

People's dietary needs were catered for. People said they enjoyed the meals served.

Is the service caring?

Good

This service was caring.

People and relatives said they had confidence in the care provided at Hayward Care Centre. They said they were listened to and they felt that staff were caring.

Staff showed a good understanding of promoting independence and choice. People's rights were protected. We saw staff use a respectful manner when they provided care and support to people.

Is the service responsive?

Requires Improvement

This service was not responsive

Care plans and risk assessments were not reviewed for all the people living at the home. For some people their preferences on how they liked their care to be met were not part of their care plans. This meant for some people their care plans did not reflect their current needs and how staff were to meet their needs.

Summary of findings

Activities were not meaningful and they were not occurring regularly.

People knew the procedure for making complaints. The log of complaints showed an investigation was conducted and people who complained received a formal written response on the outcome of the complaint.

Is the service well-led?

This service was not Well Led

There were a range of audits which included medicine management, care planning and staffing. Action plans were set by the area managers from their assessments of the standards of care people received. The improvements needed were not consistently put into practice.

Staff told us the management and leadership was good. They said the team was friendly. The manager was approachable and discussions were daily and open with senior staff.

Requires Improvement

Hayward Care Centre

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was unannounced and took place on 11May and on the afternoons of the 12 and 13 of May 2015.

On this inspection there were two inspectors 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 care service.

We gathered and reviewed information before the inspection. For example notifications of accidents and incidents. We spoke with local authority safeguarding team, commissioners of the service and food safety officers.

We spoke with people using the service, relatives and friends and staff. We observed the interaction between people and staff and we reviewed records. We looked at care records for 10 people which included care plans, risk assessments, intervention charts, records of visits by social and healthcare professionals and daily reports. Other records reviewed during the inspection included medicine systems, staffing rotas, handover sheets, a training matrix and complaints and quality assurance systems along with their action plans.

Requires Improvement

Is the service safe?

Our findings

Staff said risk assessments were developed where they had identified risks associated to people's care and treatment. Risk assessments were developed for people at risk of falls and for people at risk of malnutrition. Staff said immediate action was taken for people who fell. They said 72 hours observations of the person's vital signs were put into place and sensors mats used to prevent further falls. However the risk assessments for people who fell were not reviewed following a fall. The reports of falls in Potterne unit showed seven people had experienced 25 falls in April 2015. A senior staff member in this unit told us for one person who experienced repeated falls they had made referrals to specialists such as falls clinic, GP visits were organised and other checks were carried out to assess there was no deterioration of health. However, members of staff were not able to confirm the same action was consistently applied for all the people who fell repeatedly.

A senior member of staff told us all incidents were reported to the manager so that trends could be identified and plans implemented to help prevent events and accidents in the future. However, we found that not all incidents had been reported to the Care Quality Commission (CQC) and referred to the Local Authority Safeguarding Adults. We saw documents where people at times became physically aggressive towards each other.

This is a breach of the Care Quality Commission (Registration) Regulations 2009. Regulation18 (5).

A member of staff on Bromham and Avebury unit said staffing levels had improved. They said staff had been recruited to vacant posts and the use of agency staff had reduced. Staff on Potterne unit said there were three staff on duty in the morning and four in the afternoon. A member of staff told us that on Potterne unit, more staff were needed in the morning. We were told GP visits and seniors meetings held at 10am took the senior staff member away from the unit leaving two staff to support 16 people. Staff stated "three is hard work. When seniors leave the unit and one person needs two staff, there is no one supervising the lounge." Staff told us 12 of the 16 people on Potterne unit needed two staff for support with personal care. A third member of staff said the staffing levels were "ok" but not sufficient if they were to provide activities.

Staff on Keevil unit said the staffing levels of four staff throughout the day was sufficient to meet people's needs. They said this meant "three staff doing personal care and one undertaking activities."

One person said "there seems to be enough people around to see to me most of the time." A relative said "Staff are first class but my mother really needs more one to one care now and there aren't enough staff to go around sometimes, especially at mealtimes when people need so much support."

Where people were identified as having care and support needs relating to safe moving, equipment such as hoists were available. Staff told us they had received training in moving and handling, including the effective and safe use of equipment used to assist people to mobilise or transfer from, for example a bed to a chair.

Staff said there were people on Potterne unit who at times expressed their frustrations and emotions using aggression and violence. They said diffusion techniques were used but staff did not give a consistent response to the diffusion techniques used for specific people. For example, "we separate people to calm the situations." Another member of staff said going for a walk helped some people to become calm. Another second member of staff said people's body language was observed as some behaviours were an indication the person was becoming frustrated. They said staff were to "give people time, we ask another member of staff to intervene. We change the subject. "A third member of staff on Potterne unit said staff needed more training to identify triggers.

People on Keevil unit said they felt safe living at the home. One person said "think I feel very safe here, everyone makes sure I am alright." Another person said "lovely place here. Feel safe and secure, girls [the staff] take great care of me" and a third person said "know most people here so feel very safe and sound most of the time." A relative said "know she is 100% safe here, much better than the other home she came from. She can use her frame and walk about as much as she likes without too much danger of falling."

The staff we spoke with told us they had received training in protecting people from the risk of abuse. They told us refresher training of safeguarding of vulnerable adults was provided. Staff had a good knowledge of how to recognise and respond to suspicions of abuse. One staff member told

Requires Improvement

Is the service safe?

us “we have good training in the area and it is frequently raised during meetings. I have been well trained in this”. They understood the processes for reporting concerns and escalating them to external agencies if needed. Staff were confident to raise any concerns with senior staff and the new manager. They also said they would feel confident if it was necessary, to raise issues with external agencies such as the Local Authority Safeguarding Team and the Care Quality Commission. However, the training matrix showed 26 of the 72 caring staff had not attended safeguarding adults training and 16 staff had not attended refresher training in 18 months.

Individual evacuation plans were in place which described the support needed from the staff to safely evacuate the building.

The provider had an effective system for ordering medicines and the stock control was accurate. Medicines were kept in a locked room within a medicines trolley secured to the wall. People’s records contained good evidence for the use of topical creams and lotions which included a body map to show where topical medicines should be applied and a record showing the frequency of application.

We found in the records that we looked at “as and when necessary” (PRN) protocols were in use. These included the signs that people might display if they had, for example a headache.

Most people’s Medicine Administration Record (MAR’s) were up to date and complete and included as and when necessary (PRN) protocols. This included personalised information about the signs people could display when they experienced pain. However three people had been prescribed PRN medicines but there was no protocol in their records to describe when the medicines should be given . We spoke with the senior member of the care staff about this who told us “yes you are right, there are some that are needed, we are working our way through them and will make sure those ones are done today”.

Inadequate

Is the service effective?

Our findings

An induction was not provided to all new staff. The training matrix provided showed 13 of the 32 staff employed between 2014 and 2015 did not have an induction. A member of staff said “not sure why” an induction was not provided when they started work. They said “the manager at the time went through people and their needs. I picked most of the information from shadowing other staff.” Another member of staff said “I was thrown in. It was a new service, I have just found my feet and things are beginning to get better.” A third member of staff said their induction was delivered through e-learning and the fourth member of staff said they were part way through their induction. They said their competences were checked before they were able to undertake some tasks unsupervised. This meant that the provider could not be assured that all staff were fully prepared to carry out the role they were employed to undertake.

Staff said the quality of the training was variable and they were not always able to attend the training. They said “there are courses running at all times. A trainer visits and sessions have power points, scenario discussions and handouts. Some training is not helpful. It was not suitable.” We were told the training was at a basic level and refresher training was repetitive. For example, “taught it over and over again.”The assistant operations director told us a training programme was planned for all staff.

Another member of staff confirmed End of Life training and dementia training was provided. They said they had not attended the training as staff were not released to attend the training if they were duty on the day of the training. A third member of staff said the training was good and they were able to put the training into practice. A fourth member of staff said “I started a National Vocational Qualification (NVQ) yesterday. I requested the training last year.” They said there was dementia training and they were able to apply the learning.

The training matrix showed the specific training set by the provider as necessary for care staff to meet the needs of people. This training included a Basic and Other Dementia care, fire, moving and handling, pressure care, decision reaction and safeguarding adults training. The matrix showed that 14 of the 72 caring staff had attended Basic Dementia and 33 had attended Other Dementia training. However, 29 of the 72 staff had not attended either Basic or Other dementia training.

Staff were not given the opportunity to discuss their performance, concerns and developmental goals with their line manager. The supervision notes showed only 11 of the 72 caring staff had received a one to one meeting with their line manager between 21 April 2014 and 25 April 2015. One member of staff working at the home for 11 months said a one to one session had taken place. They said “what I want to do, goals and training” was discussed. Another member of staff said “I’ve had a one to one session in January 2015. There is a matrix.” A third member of staff said a one to one sessions with a line manager had not taken place since their employment.

This is a breach The Health and Social Care Act 2008 (Regulated Activities) Regulations 2009 18 (1) (2) (a).

The assistant operations director told us staff had support from the organisation "Admiral Nurse." The role of this nurse was to help staff meet the needs of people living with dementia. Members of staff did not recall any visits from the admiral nurse. One member of staff said "not seen the Admiral Nurse". They said the visits from the admiral nurse happened more often in their previous home. We were provided with copies of the visits from the admiral nurse. There were 11 visits which took place between 05 February 2015 and 7 May 2015. One visit was requested by the manager to "help with up skilling the team in regards to dementia awareness." This visit happened on 12 February 2015 where three sessions were held and seven staff attended. On another visit the admiral nurse spent time with one member of staff on Keevil unit. Other visits happened with day care staff, the manager and deputy and relatives of people.

Staff were not following the advice given to them by external health care professionals. We observed a person coughing and having difficulty in clearing their throat. Care records showed input from an Occupational Therapist (OT) had been sought. The OT report dated 11 February 2015 recommended thickeners in drinks may be needed to help the persons drink and swallow safely. The staff were also advised to seek further input from a Speech and Language Therapist (SALT) for an assessment to determine if any additional changes to food and fluid intake was needed. Reports of health care professional visits showed

Is the service effective?

that on 19 March 2015 a GP's visit was requested because this person was chesty. The presence of chesty coughs may indicate that the individual was aspirating (sucking fluid or a foreign body such as food into the airway when drawing breath). The chef confirmed a pureed diet was served as they had know this individual from where they had lived previously and that they had a chocking incident in 2013. No SALT assessment had been requested as a result of the OT visit in February 2015. The person's records did not include an updated risk assessment to reflect the recent issues with coughing and chocking. As a consequence there was no updated care plan giving clear guidance to staff to follow when this individual was eating and drinking. We showed this record to the Area Manager who could not locate a recent risk assessment or current care plan to ensure the person's safety. An urgent referral to the GP for a SALT assessment was made during our visit. We made a safeguarding referral following this inspection.

This is a breach of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 12 (2) (22) (i).

People's health care plans included their medical history with the action that had been taken to assess and monitor them. This included any contacts from external professionals such as chiropodists, opticians, specialist mental health teams and general practitioners. However, care plans and risk assessments were not updated following advice given by healthcare professionals. For example there was a lack of oral care plans. One person had treatment from the GP for bleeding gums and four people were prescribed with medicines for osteoporosis. Good dental hygiene was important for people with this treatment but oral care plans were not devised

Relatives said they were informed when a doctor or any other health professional was needed or there were any changes to people's care. Staff said GP visits were arranged as necessary . A record of visits from social and health care professionals was maintained which included the nature and the outcome of the visit.

One person told us "I can get up at any time and if I want to go to my room for a nap people [staff] will take me. I like to go to bed early and it's no problem."

A member of staff said they were given handouts with the copies of the Mental Capacity Act (MCA). Two members of staff were not able to recall if they had attended any training relating to the MCA. They said MCA focused on "what is in people's best interest. [The staff] Would not take away people's right to make decisions" Staff said some people could make decisions about their clothes. They said "at lunchtimes we show people the choices of meals and they point at their choice." Another member of staff said "we try and get people to make decisions such as hygiene routines, times to rise or retire, mealtimes and activities." A third member of staff said "we ask people and if they are not able to respond, we show them the choices available."

We were told that most people on the middle level lived with dementia or other forms of cognitive impairment which meant they required support to make certain decisions that affected their lives. The Mental Capacity Act (2005) contains five principles that must be followed when assessing people's capacity to make decisions. Staff we spoke with told us they gained consent from people before they provided personal care. Staff we spoke with were knowledgeable about the requirements of the MCA and told us they always respected people's rights to make their own decisions and to consent to care. When we observed staff with people they asked them for their agreement first before providing any care and support

A member of staff on Keevil unit said the people on this unit were able to make decisions. They said "they [people] have choices and staff are not making decisions for them."

We noted that some people's records showed there had been an application made for Deprivation of Liberty Safeguard Orders. These safeguards protect the rights of people using services by ensuring that if there are any restrictions to their freedom and liberty, these have been authorised by the local authority. Applications for Deprivation of liberty safeguards (DoLS) were made for people who required support from staff to leave the building. We saw were DoLS applications were also made to provide essential care.

Staff said there were people on Potterne unit who were resistive to personal care. We were told best interest decisions were made by staff to provide personal care where it was necessary . They said the people who refused personal care were "usually left for a time but if they continue (to refuse) then it becomes a best interest." We were given an example of a best interest decision taken by a senior for one person with continence needs. They said one person had refused staff support and a best interest

Is the service effective?

decision was taken for the staff to give support without consent. An action plan or a care plan had not been developed on the restraint or strategies to be used when personal care had to be delivered.

We observed people having regular drinks. We spoke to two people after lunch who told us they really enjoyed the food at the home and there was plenty available and lots of choice. People were encouraged to take their meals in the dining room. A senior member of the care staff told us "this encourages people to socialise and residents will often eat more when they eat at the same time as others". We were told that each unit provided the chef with a list of people's special diets and their likes and dislikes.

People's dietary needs were catered for. The chef said they catered for people who had soft, pureed, fortified and diabetic diets. For example, high calorie meals were prepared for people on fortified diets. They said menus were devised on the information gathered from people about their likes and preferences. During our visit we saw snack were available to people on all units. We saw crisps, biscuits and bowls of fruit for people to help themselves.

Good

Is the service caring?

Our findings

One person said “beautiful here, absolutely kind people here” Another person said “they [staff] look after me as well as they can.” A relative said “incredibly kind support staff, dedicated to caring. Mum needs a smile and that’s what they give her.”

A relative said “It’s a wonderful caring place the girls take good care of me and look after me well.” Another relative said “when my father came out of hospital he went into a care home but they couldn’t meet his care needs. This home can. The care here is good and he is enjoying being here.”

We observed staff interacted with people in a kind and compassionate manner. We saw they responded promptly to people who were requesting assistance and they did so in a patient and attentive manner. They ensured people were at the centre of their care. We saw staff listening to people and responding to their wishes. Staff spoke warmly about people which indicated that they held them in high regard. They had good knowledge of individuals and knew what their likes and dislikes were. We observed a member of staff asked one person if the tea was too hot. The member of staff ensured it was served the way the person preferred. Staff said relationships with people were built through trust and good communication.

We observed an incident where a person was becoming very distressed and calling out loudly and this was beginning to have an effect on other people. A support worker spoke quietly to the person, reassuring them and using distraction techniques until calm returned. This incident was dealt with in a way that preserved the dignity of the person concerned.

A member of staff said they respected people’s privacy and dignity by “not taking away people’s choices” and by equitable treatment. Other staff gave us examples on how staff protected people’s privacy and dignity. They said “we knock on doors before entering. Doors are shut when we provide personal care.”

Staff spoke with people while they were providing care and support in ways that were respectful. They ensured people’s privacy was protected by ensuring all aspects of personal care was provided in their own rooms.

Requires Improvement

Is the service responsive?

Our findings

A relative said "I see XX's care plans regularly. Last time X had a service review I was unable to attend. I complained that I had not seen the report and the next day a copy was sent to my home." Another relative said "I have a lot of interaction with care planning. There is always someone to talk to about XX's care."

A member of staff said care plans had people's life histories which told them their preferences. They said "get to know people by their likes and dislikes. There are one page information profiles telling staff people's likes and dislikes." Another member of staff said "speak to people to get to know them" and they read the care plans.

Assessments of needs were undertaken before people were admitted to the home. Staff told us not all care plans were up to date and they were not changed to reflect people's current needs. We were told all staff were responsible for devising care plans with seniors auditing care plans. Staff said they were assigned specific people and this role included arranging reviews with families and ensuring people's care was provided according to their preferences. A member of staff on Potterne unit said care plans were being updated following reviews.

Staff said at handovers when shift changes occurred they were told about people's daily care needs. For example where they were falls. Another member of staff said daily reports kept them informed about people's daily activities and wellbeing.

Staff told us there was involvement from health professional to help them manage difficult behaviour that people may at times exhibit. They said Antecedents, Behaviours and Consequence (ABC) Charts were used by staff to record behaviours before an incident, the behaviours exhibited during and following an incident. Management plans were not developed using the information gathered from the ABC charts.

Personal care plans were in place to instructed staff on the approach to take for people resistive to personal care. For example, staff were to respond in a calm manner, use distraction and to walk away. The staff we spoke with gave us examples on the approaches they used to gain people's agreement for support with personal care. For example, "XX personal care was delivered over 24 hours, staff take it in turns. One staff will distract the person while the other delivers personal care. A banana will calm XX. XX will try and grab and scratch, (staff) just need to explain and XX will stop." The care plans for this person did not include this information. This meant staff were not always using a consistent approach to people who became aggressive and violent when staff were delivering personal care.

End of life care plans were not in place for people with life limiting illnesses. A holistic assessment [how the medical condition impacts on all areas of the person's life] was not in place. There were elements of a holistic assessment such as advance decisions, pain management and district nurse input. Care plans were not in place on how staff were to meet the person's physical, emotional and social care needs.

Malnutrition Universal Screening Tools (MUST) were used to assess people's potential of malnutrition. Eating and Drinking care plans listed the type of diet to be served for example soft or pureed and the support people needed from the staff.

Staff told us there was an activities programme at the home. On the middle floor we saw there were eight people sat in a lounge with the television on a morning programme. At 10:30 am a new member of staff came along and said to these people "We are going to flower arrange today" to which two people said "I do not want to" quite emphatically. The member of staff turned off the television and proceeded to arrange the flowers on their own with people passively watching. No other activity was offered and the television remained switched off. The member of staff undertaking this activity told us this was their first morning working at the home. They said their previous experience was with people who had a learning disability and they had not met the people in the lounge before. Due to this the staff member told us she was having difficulty in engaging people with dementia and did not feel that she had the skills and competencies to fulfil the role she had been asked to complete.

There were a range of activities for people which included games, sewing, cooking, basic fitness/physical activity, and art activities. The activity programme was enhanced by bringing in additional activities from the community such as the hairdresser, and local church ministers.

A full time activities co-ordinator oversees the involvement of staff in the activities programme. Staff in each area of the Home were provided with a folder full of ideas and

Requires Improvement

Is the service responsive?

suggestions for one to one and small group activities. The co-ordinator had a team of volunteers coming in to support the activities. These included a pianist, a person who supports the chair based exercise programme, a technology specialist, people who chat to people and provided pampering sessions to people. Staff said they were responsible for people's wellbeing which included providing meaningful activities for people. A member of staff said organising activities in Potterne unit was easier in the afternoons as more staff were on duty in the afternoons.

The activity coordinator gave us a clear vision of what was to be achieved in terms of developing the activities programme. These were the development of the outside areas to include a sensory garden, the establishment of a sensory room and a digital reminiscence room. On Keevil unit we saw a member of the support staff playing a number form of Hoopla. Apart from a few activities taking place in Keevil unit people were general sitting around in lounge areas with little to do. We observed staff involved with the demands of providing care for example, drinks, medicine rounds, mealtimes and personal care.

People knew the procedure for raising concerns or to make a complaint. One person said "only minor niggles, nothing really serious" and "the girls and things were sorted". Some relatives said they had raised issues but felt that nothing had happened as a result. A relative had pointed out on Keevil unit that there were no chairs for visitors and to date there are still no portable chairs available.

Staff said when complaints were received they recorded the nature of the complaint and passed it on to the senior on duty. Another member of staff said complaints were investigated by the manager.

The provider's complaints procedure was displayed on the notice board in the home. It informed people and their relatives on how to make complaints and included was the process followed for investigating complaints. The contact details for other organisations were also included which people could contact if they were not satisfied with the outcome of their complaint. For the three recorded complaints an investigation was conducted and the complainant received a written response with the outcome of their complaint.

We recommend that the service seek advice and guidance about end of life care planning in order to build on and develop its provision.

Requires Improvement

Is the service well-led?

Our findings

There was a lack of reporting of incidents. Where people living at the home received some contact as a result of the aggression of another person a previous safeguarding matter that had not been monitored or reported appropriately. This meant people may not have been safe.

Accidents and incidents were analysed to identify trends and patterns. The area manager undertook a risk analysis for people who experienced repeated falls. The report of the risk analysis had identified the people at risk of falls and those who were experiencing repeated falls. The action from the analysis was for care plans and risk assessments to be reviewed following a fall. We found this action was not happening consistently as risk assessments and care plans had not been reviewed as required. This had not been identified by the homes internal auditing system .

The area manager told us audits were undertaken for example, medicines and care plans. These audits were used to assess and analyse that people received a consistent level of care that met their needs. A visit from an area manager was undertaken on 27 April 2015 and on this visit a sample of four care plans were evaluated. The report from this visit identified areas needed for improving the quality of care plans. We were provided with the home action plan dated April 2015 which assessed the main areas needed for improving the service which included staff training and staffing levels. We found consistent improvements over time were needed in these areas.

A registered manager was not in post. The provider had appointed an interim manager while they recruited for a registered manager.

One member of staff said “I enjoy working here. I am where I want to be. The manager is very good always around if we need him.” Another member of staff said the manager was “moving things forward.” The manager “listens and is a good communicator.” A third member of staff said “the manager is ok, the team is friendly. We are all here for the residents.” Another member of staff said “I can’t fault the team. We came from different homes and we work well together. The manager is really good. Team meetings are monthly.”

Senior staff members told us daily meetings took place at 10am with the manager. These meetings kept them informed about the home. They said the meetings gave the staff an opportunity to have open discussion with the manager.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents Important events that happen to people were not reported as required by the Care Quality Commission of allegations of abuse. Regulation 18 (5) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Members of staff were not appropriately prepared for the roles they were to perform. Staff were not enabled to deliver appropriate care to people living with dementia because training was not provided to all staff. Staff did not benefit from one to one meetings with their line manager to discuss concerns, their performance and training needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People were placed at risk because staff were not following the advice given to them by external health care professionals. Regulation 12 (2) (I)