Mauricare Limited

Dallington House Care Home

Inspection report

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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?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

The inspection visit took place on 20 July 2017 and was unannounced. This meant that staff did not know we would be visiting.

At a previous inspection carried out on 29 September and 3 October 2016 we asked the provider to make improvements. We found that the provider did not ensure that risks associated with people's care were managed safely or that people were always referred to health care professionals in a timely manner. The provider did not ensure that people's medicines were managed safely. We asked them to improve their practices in relation to their arrangements for monitoring the quality of the service and notifying Care Quality Commission (CQC) of significant events at the service. When we inspected the service again on 17 and 19 January 2017 we found that the provider had not made the required improvements to comply with the regulations and the service was rated inadequate. We placed a condition on the provider's registration to prevent any admissions to the service without the prior written agreement of the Care Quality Commission.

This service has been in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us that most of the improvements have been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures.

Dallington House provides accommodation and care and support for up to 16 older people. There were 11 people that used the service at the time of our inspection, some of whom were living with dementia or similar conditions.

At this inspection we found improvements had been made but further improvement was required before the service could meet the regulations.

There was a registered manager in place who had returned to work following a period of temporary absence. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

People felt safe. Staff knew their responsibilities to help people to remain safe. The registered manager took action where there were concerns for people's well-being.

Risks associated with people's care were assessed and reviewed to provide guidance for staff. Staff took the appropriate action when an accident or incident occurred.

The provider carried out checks on the environment and people's equipment to help people to remain safe. However, doors had been wedged open posing a risk to people should a fire occur. The provider planned to make further checks to make sure furniture was secure where it posed a risk to people.

Staffing numbers were sufficient to provide the support people required. The registered manager followed the provider's recruitment processes. However, on one occasion they did not fully check all of the information available to them before a staff member started to work at the home and records were not kept of the interviews for new staff. We have made a recommendation about this.

People received their medicines when they required them. Staff knew their responsibilities for handling medicines safely.

Staff had the knowledge and skills they required to support people well. There were plans to improve the knowledge of staff where people lacked the mental capacity to make decisions for themselves. People received support from staff members who received training and on-going guidance on their work. New staff received an induction when they started work and they knew their responsibilities. Staff felt supported by the registered manager.

Where there were concerns about people's ability to make decisions for themselves, the registered manager had undertaken assessments to determine people's level of understanding. They planned to make some improvements to these assessments so that they could be sure staff had all of the guidance they required when caring for people.

People were satisfied with the food available to them. Staff knew people's food preferences and their dietary requirements. People had access to a range of health care services to help them to remain healthy.

People were cared for by staff who were compassionate and kind. People's dignity was protected. People's sensitive and personal information was mainly stored securely.

The provider had systems in palace to assess the needs of people moving into the home. People were involved in decisions about their care where they were able to be. People received care and support that was based on their preferences Staff knew the people they cared for and encouraged them to retain their skills.

People had some opportunities to take part in activities that they were interested in. The registered manager planned to make improvements to the range of activities available to people.

People and their relatives had opportunities to give feedback to the provider. They told us that improvements had been made since we last visited the service. People and their relatives knew how to make a complaint or to raise a concern.

The provider had carried out a range of checks on the quality of the service to drive improvement. However, further improvements were required to the provider's recording of their quality checks and recruitment process and to make sure that any identified actions were completed in a timely manner. We have made a recommendation about seeking guidance on good record keeping.

The registered manager was aware of their responsibilities. They had submitted the required notifications to CQC.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Staff knew their responsibilities to protect people from abuse and avoidable harm.

Risks to people in the event of a fire had not been suitably addressed.

There were sufficient staff to offer care to people who had been recruited safely.

People received their medicines when they required them.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were supported by staff who were trained and received on-going guidance about their role.

Where people did not have the mental capacity to make decisions for themselves, the provider followed the requirements of legislation. However, they had not followed this in one instance making the decision themselves.

People were satisfied with the food offered to them.

People had access to health care services.

Is the service caring?

Good

The service was caring.

Staff were kind and they respected people's dignity. Information about people was not always stored securely.

Staff knew the people they supported and involved them in decisions about their care wherever possible.

People were supported to maintain their abilities.

Is the service responsive?

Good

The service was responsive.

People received support that was centred on them as individuals.

People had some opportunities to take part in activities they were interested in.

People and their relatives knew how to make a complaint.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

People, their relatives and staff had opportunities to give feedback on the quality of the service.

Staff received support and were aware of their responsibilities.

The provider carried out checks on the quality of the service. These required further improvement including recording actions that the provider had undertaken.

The registered manager understood their responsibilities under their registration with Care Quality Commission.

Dallington House 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 a comprehensive inspection. The inspection visit took place on 20 July 2017 and was unannounced. The inspection was carried out by two inspectors and an expert by experience (ExE). An ExE is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection visit, we reviewed the information that we held about the service to plan and inform our inspection. This included information that we had received and statutory notifications. A statutory notification contains information relating to significant events that the provider must send to us. We contacted Healthwatch Leicestershire (the consumer champion for health and social care) and the local authority who has funding responsibility for some people using the service to ask them for their feedback. We received feedback and took this into account when making our judgements.

We spoke with seven people who used the service and with two visiting relatives. We also spoke with the registered manager, the provider, two senior care assistants, three care assistants and a cook. A health care professional was visiting who we spoke with about their views of the care provided at Dallington House Care Home. We also received feedback from another health care professional after our visit.

We observed care and support being provided so that we could understand people's experiences of care. We looked at the care records of five people who used the service. We also looked at records in relation to people's medicines, as well as documentation about the management of the service. This included policies and procedures, training records and quality checks that the registered manager had undertaken. We looked at four staff files to see how the provider supported and had recruited their employees.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection carried out on 29 September and 3 October 2016 we found that the provider did not ensure that risks associated with people's care and medicines were managed safely. This was a breach of Regulation 12 safe care and treatment. We issued a warning notice requiring the provider to meet their legal obligation in relation to Regulation 12 by 9 December 2016. When we inspected the service on 17 and 19 January 2017 we found that the provider had not made the required improvements to comply with the regulation. We took enforcement action and placed a condition on the provider's registration to prevent any admissions to the service without the prior written agreement of the Care Quality Commission. At this inspection we found that the provider had made significant improvements. However, we remained concerned about the fire safety.

People's health and well-being were assessed and reviewed. Where people were at risk of falling they had the equipment they needed. People's walking frames were within their reach. Equipment was available to alert staff if a person had got out of bed in the night was in place. This was assessed as being in their best interest to offer them help when they woke during the night to help protect them from falling. Where people were at risk of injury to their skin due to them being unable to change position independently, staff followed the guidance they had been given. Staff supported people to change position using equipment. They did this carefully and in line with the risk assessments in place. The registered manager explained that they were concerned about the condition of one person's skin. They told us that they had made a referral to health care professionals for advice and support. Care records documented that this had occurred.

Where people might display behaviour that could injure themselves or others, guidance was in place to support them that staff followed. Staff knew how to redirect one person's attention when they became upset and they recorded when people had become upset. These records described the incident and what had occurred. We found that these records did not always document why it was thought these incidents had occurred. The registered manager told us that health care professionals analysed these records and offered advice on the support to be offered to people. They told us that they would analyse the incidents in the time between visits from health care professionals to see if there was any additional action they could take to reduce the occurrence of these incidents.

People received their medicines when they needed them. One person told us, "I get my tablets regularly and I am happy that they [staff] look after them. I'd get them mixed up." When staff handled medicines they did this safely and in line with the provider's policy. We also saw that medicines were locked securely when left unattended by staff and accurate records were kept of its administration. We observed a staff member administering medicines. We found that they did this safely and stayed with each person to make sure they had taken their medicines. We heard them say to one person, "Are you going to take your tablets?" The staff member engaged in eye contact and helped the person to take them. Staff checked at the end of their shift that people had been offered their medicines to prevent a mistake from occurring.

Some people required medicines for when they became upset or were in pain. There was guidance for staff on the reasons they could be offered and clear guidance on their use. A visiting health care professional

commented on the management of a medicine for when a person became upset. They told us, "Their records are good and the protocol is in place for if it is needed. I would recommend it gets reviewed but it has not been used for a while and therefore there is no risk." Accurate records were mainly kept when people were offered these medicines. Where one person had been given pain relief staff were not always recording the time it was given. This was important so that another dose was not offered too soon after the first. A senior staff member told us they would remind staff to do this.

Staff knew their responsibilities for handling people's medicine safely. They knew what to do in the event of a mistake being made. The provider's policy on the safe handling of medicines was available to staff which guided them in areas such as the administration, storage and disposal of medicines. Staff had received training and their competency was checked to make sure they continued to work safely when handling medicines.

The provider carried out checks on prospective staff members to make sure they were suitable to support and care for people. One staff member told us, "I came for an interview. I was asked for ID and proof of address. There was a DBS [Disclosure and Baring Service] check before I started work. Two references were needed, one from my previous employment." The DBS helps employers to make safer recruitment decisions and aims to stop those not suitable from working with people who receive care and support. These checks took place for each new employee. However, we found that on one occasion the registered manager had not viewed one of the checks that the provider had carried for a new employee who had started to work at the service. This was important so that they had all of the information available to them when making recruitment decisions. They took appropriate action when concerns were raised with them about this recruitment decision. They had put measures in place to make sure that this staff member did not work alone with people. The registered manager did not always formally record interviews that staff had attended. However, we found that the registered manager had carried out all of the required checks prior to new employees starting work. They told us they would make improvements to their recording to show how they had reached their recruitment decisions.

There was a sufficient number of staff available to help people to remain safe and to provide them with the care they needed. One person told us, "There are enough staff but I suppose they could always do with more. I don't see or hear the night staff but they do pop their head around the door every hour. Saturday and Sunday [staffing numbers] are just the same as Monday or Tuesday. I pull the red cord if I need help and I don't have to wait long. They are very quick." Another person said, "I did need to pull it once [pull cord] and they did come very quickly, I didn't need to wait." Staff told us that staffing numbers were suitable. One staff member said, "There's more than enough. People don't have to wait." We saw that staffing numbers were sufficient when we visited. People did not have to wait when they requested support and people's care requirements were met in a timely way.

People felt safe living at Dallington House Care Home. One person told us, "I've lived here for a year now and I am safe. My room is safe I don't need to lock the door." Relatives we spoke with told us they had no concerns about their loved ones safety. One relative said, "Dad's happy and looked after well."

Staff knew how to help protect people from abuse and avoidable harm. The provider had made available to them processes to follow should they have concerns. Staff demonstrated their understanding of this. They could describe the different types of abuse and the action they would take should they have needed to. One staff member told us, "If I saw abuse I would speak to the manager. I could go to [provider] or to safeguarding or CQC [Care Quality Commission]." The registered manager worked with the local authority when incidents had occurred. This resulted in them taking action to make sure that people were safe by investigating and responding to safeguarding incidents and to concerns that had been raised with them.

The provider had safe systems in place to support people if they experienced an accident. People received the care and support they required following an accident. This included medical advice being sought where this was necessary. Staff described the action they would take if an accident occurred. One staff member told us, "I would ask for help, see how they are. I would phone for a paramedic if I was concerned about an injury. If there was no injury I'd record it on an incident form." We saw that this action routinely took place where an accident had occurred. One accident record did not fully detail how a minor injury had occurred to one person. The registered manager gave us assurances that the injury was a result of an accident and that they would make improvements to their recording.

The provider had made arrangements for checks on the environment and the equipment people used to take place. This was to reduce risks to people living at Dallington House Care home. For example, checks on the safety of the electricity and gas supplies were undertaken. Checks on the temperature of the hot water were routinely tested to prevent a scald risk to people. Checks on fire detection and prevention equipment were also carried out. We found that some furniture required checking. This included checking the wardrobes were securely fastened to bedroom walls to prevent them falling on people. The registered manager told us they would check the furniture. The provider had plans in place so that the service could continue to operate in the event of an emergency such as a fire. These detailed the specific requirement each person would need to remain safe which staff were knowledgeable about. Some bedroom doors were kept open by the use of door wedges. People had agreed to the use of these and risk assessments were in place guiding staff to remove these should the fire alarm sound. However, in the event of a fire the use of door wedges increases the risk of a fire spreading quickly through to other parts of the building and would not close automatically should the alarm sound.

The provider was failing to ensure that the home followed advice and guidance for adequate fire safety to keep people safe in the event of a fire. This is a breach of Regulation 12: safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service effective?

Our findings

At a previous inspection carried out on 29 September and 3 October 2016 we found that the provider did not ensure that they referred people to other health care professionals such as a dietician. These matters were a breach of Regulation 12: safe care and treatment of the Health & Social Care Act 2008 Regulated Activities Regulations 2014. On 9 November 2016 we issued a warning notice under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requiring the provider to meet their legal obligation in Relation to Regulation 12 by 9 December 2016. When we inspected the service on 17 and 19 January 2017 we found that the provider had not made the required improvements to comply with the regulation. We took further enforcement action to support the provider to improve the quality of care people received. At this inspection we found that the provider had made the required improvements.

People were supported to maintain their health. One person told us, "The doctor comes here if I ask to see them and the optician comes here as well." We saw that staff took action where they were concerned about a person's health which included contacting a doctor. One staff member told us, "[Person's] GP came out yesterday. Staff noticed a cough and got the doctor straight away." Care records showed that staff had contacted health care professionals without delay where they were concerned for a person's well-being. This included making a request for a referral for a dietician where this was required. A health care professional told us, "Staff are really supportive." They described how staff worked well to make sure people's health care needs were met. People had access to a range of health care services such as opticians and chiropody. In these ways people's health was promoted and appropriate healthcare referrals were made.

The Mental Capacity Act (MCA) 2005 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 registered manager had completed mental capacity assessments where there were concerns about a person's mental ability to make a specific decision. These were completed in areas such as where people required night time support and personal care. Where a decision was required to be made in a person's best interest, this was undertaken with key people in the person's life. One person's mental capacity assessment and care plan had conflicting information. The registered manager told us they would update the information. This was because the person's mental capacity fluctuated over time and the recording of this was not clear to guide staff.

The registered manager had completed a mental capacity assessment for one person in relation to their medicines. This was because there were concerns that the person was not able to decide that they required it to remain healthy. The registered manager determined that the person lacked the capacity to make the decision that they required their medicines. They had concluded that it was in the person's best interest to receive their medicines. The registered manager told us that they had not consulted with this person's

doctor about this decision. They told us that they would review the assessment in consultation with the person's doctor to make sure that the decision included a medical opinion.

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 hospital are called the Deprivation of Liberty Safeguards (DoLS). The provider had made applications to the 'supervisory body' (the local authority) where they were seeking to deprive some people of their liberty. Where there were conditions that staff were required to follow where an authorisation was granted, we found these were being met.

Staff did not always understand their responsibilities under the MCA. Some staff did not know who was subject to a DoLS authorisation or the reasons some people were being restricted. There was a risk that they might not be fully aware of the arrangements in place that had been made on people's behalf. However, we saw that action was being taken. The registered manager was working with the local authority to improve the knowledge of staff by seeking guidance and support. One staff member told us, "I've heard of it. QIT [quality improvement team at the local authority] are helping us. It's about when a person can't make a decision for themselves. Assessments are done, we're getting training."

People were asked for their consent before care was given. Staff listened to people's responses and acted in accordance to these. We saw that staff did this consistently and this promoted people's rights.

People received care from staff with the required knowledge and skills. One person told us, "The staff are trained and they know what they are doing. The new ones take a while to adjust." Another person said, "They [staff] are trained well and they know what they are doing." Staff received training that was relevant to their role and which they found useful. One staff member told us, "I've done moving and handling, first aid and end of life care. I'm doing my NVQ two [nationally recognised care qualification]. I enjoy the training and I learn a lot from doing it." Most staff had completed training in topic areas such as health and safety, dementia awareness, safeguarding people and first aid. Staff told us there were on-going plans for the training of staff and they were offered refresher courses so that their knowledge remained up to date.

When staff started to work at Dallington House Care Home they received an induction so that they were aware of their responsibilities. Staff confirmed this. One staff member told us, "I did two shadowing shifts, I did them on nights. There was enough information in the care plans to read." However, we found that the details of staff's induction was not recorded. We discussed this with the registered manager and provider who told us they would make improvements to their recording. Staff received on-going support and guidance from the registered manager. They met with the registered manager to receive feedback and guidance on how well they were performing. These meetings covered training requirements and the support staff needed to do a good job.

People were satisfied with the food and drink available to them. One person told us, "If I wanted a takeaway they [staff] would get me one. You could ask for a different meal if you didn't like it. There is plenty to eat and drink. I know they would get me food if I was hungry in the night." Drinks were offered to people throughout our visit and people were asked for their meal choices from a range of different options available. Staff were aware of people's food and drink preferences as well as their dietary requirements.

Where there were concerns about a person not eating or drinking enough, staff recorded what people had eaten or drank so that they could monitor the amount. We also heard staff discussing what people had eaten or drank and asking each other to remind people to drink well. Specialist advice had been sought where there were concerns about a person's eating. The advice given had been incorporated into people's

care plan so that staff had the guidance they required and were following this guidance when we visited.

Good

Is the service caring?

Our findings

People told us that staff were kind and compassionate. One person said, "They [staff] are kind and very nice, really nice. When you read in the paper about care homes it makes me realise how lucky we are here." Another person told us, "They [staff] are very kind here and they are kind to me." Where people became upset we saw staff calmly reassuring and sitting with them until they were okay. Staff had built good relationships with the people they cared for, listened to them and spoke kindly to them. We also saw that people's rooms were personalised and contained things that mattered to them to help them feel at home.

People's dignity and privacy was maintained. One person told us, "They [staff] always knock on the door even when it's open." Staff promoted a person's dignity when their clothing needed adjusting. They had returned from the bathroom and were assisted to transfer from their wheelchair to an arm chair. This was completed by two staff in a gentle manner. The person's legs were covered at all times to maintain their dignity. Staff knew how to protect people's right to privacy. One staff member told us, "When toileting I close the door and curtains and make sure they are covered up." People's care records were mainly stored securely so that their private and sensitive care records were not available to those who should not have access to them. We did see that the registered manager's office was left unattended at times. This office contained confidential information.

People were involved in decisions about their care where they were able to be. They were asked about the food they wanted, how to spend their time and their preferences for the support they received. People's decisions were respected and we heard staff upholding these when we visited. One person had an advocate in place. This was to help them to make decisions as they were not able to make every choice for themselves An advocate is a trained professional who can support people to speak up for themselves. This meant that people's rights were protected.

Staff knew the people they cared for. One person told us, "Staff know me well and my family." Another person said, "I like to think they [staff] know me well. We have a laugh together." Staff described how they got to know people when they started to work for the provider. One told us, "You get to know people as you go. Staff told me and you sit with the residents." Care records contained information on people's life history and things that were important to them. Staff had a good understanding of these. A relative told us how a staff member had bought in a specific piece of fruit that they knew was enjoyed by a person. We were told this was very well received and the person shared the fruit with others.

People were encouraged to maintain their skills and to remain as independent as possible. One person told us, "I can do what I want to do and I always tell staff when I am going out and where to." Staff were flexible in their approach to helping people to retain their skills. One staff member said, "One person can be tired so I assist them to eat in the morning but I encourage during the meal later on as they are more alert then."

People's families and friends could visit without undue restriction. During our visit we saw that people received visitors who were made to feel welcome.

Good

Is the service responsive?

Our findings

Following our last inspection on 17 and 19 January 2017, we placed a condition on the provider's registration to prevent any admissions to the service without the prior written agreement of the Care Quality Commission. No new admissions to the home had occurred since this time. The provider had a process in place to assess new people to the service. This was important so that they could be assured that they could meet people's care requirements.

People received care and support that was based on things that mattered to them and their preferences. One person had requested to stay in bed as they had an unsettled night. This was respected and the person was gently supported to prepare for the day when they chose. Another person had declined a main meal and chose a snack. This request was carried out by staff.

People's care plans detailed people's daily routines and we saw records showing that staff had carried out the tasks required of them. People were involved in developing their care plans which meant they were part of planning the type and level of support they received. One staff member confirmed this. They told us, "We talk to those who can be involved in care plans." People's care plans contained information about each person's specific requirements and were detailed about the level and type of support they required. We found that staff demonstrated a good understanding of the information within people's care plans.

The registered manager reviewed people's care needs. This was to make sure that staff had the most up to date information available to them when supporting people. Records showed that care plans were reviewed at least twice in the last six months or when a change had occurred to people's care requirements. People and relatives we spoke with confirmed that they were involved in updating care plans and that they reflected their decisions and wishes.

There were some activities available for people to take part in if they wished to. One person described the activities worker as, "The best person." One person was reading a book whilst another was listening to their preferred radio station. Some people preferred to spend time in their own room occupying themselves. This was described by staff as their own choice and was respected. Activities people had undertook recently included nail care and a garden fete. People's care plans detailed what type of activities they were interested in and some of these were reflected on an activities planner that was on display for people. We read that one person had expressed an interest in visiting the seaside and this was discussed during a residents meeting. Staff were looking at ways to make this happen. Some people felt that activities could be improved but were not unduly concerned. The registered manager recognised that the activities to people could be improved further and they were looking at ways to do this. Staff agreed. One staff member told us, "On activity days it is fine. We could do with a staff member on the other days to help."

People could give feedback to the provider about the quality of the service they received and could do so through the residents meetings. Topic areas including the menu, staffing and the equipment within the home were all discussed. People were satisfied with the standard of care they received.

Another way people could offer their feedback was through the provider's complaints procedure. People and their relatives knew how to make a complaint should they have needed to. One person told us, "If I was worried about anything I would talk to a carer, any carer. Then I would get in touch with a senior or [manager]." Another person said, "If I needed to complain I would talk to one of the carers first, then a senior carer and then the manager but I have no need to complain. I have a good quality of life. I would rate here as four and a half out of five." The provider had a complaints procedure that was displayed for people and their visitors so that they knew the procedure to follow. They had received no complaints since our last visit. However, there were systems in place to respond to any received.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection carried out on 29 September and 3 October 2016 we found that the provider did not have effective systems in place to assess and monitor the service to improve quality and safety. These matters were a breach of Regulation 17: good governance of the Health & Social Care Act 2008 Regulated Activities Regulations 2014. On 9 November 2016 we issued a warning notice under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requiring the provider to meet their legal obligation in relation to Regulation 17 by 9 December 2016. When we inspected the service on 17 and 19 January 2017 we found that the provider had not made the required improvements to comply with the regulations. We took further enforcement action to support the provider to improve the quality of care people received. At this inspection we found that the provider had made some of the required improvements.

The registered manager told us that 'spot checks' were undertaken by them to make sure that staff were working in line with the provider's expectations of them. These checks were not recorded as having occurred. This was important as we had received information of concern about some staff working at the home and we could not be assured that action had been taken to look into this. The registered manager told us that they had no concerns about the practice of staff but that they would record their checks detailing any actions that they had taken.

We saw that cleaning audits were in place. These had identified that some areas of the home required attention. However, action had not been taken to make the required improvements. The lounge area, furniture and some bedrooms were unclean in places. Some old furniture was being stored in the garden area and these had not been identified as needing removal. The registered manager agreed with our observations and told us they would make improvements to their checks. The provider's fire risk assessment was reviewed in February 2017. Actions had been identified as needing to be undertaken but these were not signed off as completed. The registered manager told us they would check to make sure that the required improvements had been undertaken.

The registered manager had carried out a range of other quality checks to monitor the service that was helping them to deliver good quality care. We saw that they analysed accidents and incidents including where people had fallen. This had helped them to make sure that all of the action necessary had been taken to try to prevent a reoccurrence. Other areas that the registered manager was checking included the kitchen, health and safety processes and staff files. Where improvements were required, records detailed the action the registered manager had taken. Some recorded checks did not always detail that action had been taken where it was needed. The registered manager gave us their assurances that it had. They told us they would make improvements to their recording.

At our previous inspection carried out on 17 and 19 January 2017 we found that the manager did not understand their responsibilities to report events such as accidents and incidents to CQC. This breached regulation 18 (Registration) Regulations 2009: notification of other incidents. At this inspection we found that the registered manager understood their responsibilities and had reported significant events to us. They had returned from a period of temporary absence and they were clear about which events they needed

to notify CQC about. We also found that following a significant incident, they took action to try to prevent a similar event occurring in the future.

During our visit we saw that the ratings poster from the previous inspection had been displayed in a prominent position. The display of the poster is required by us to ensure the provider is open and transparent with people who use the service, their relatives and visitors to the home.

People and their relatives generally felt that the service was well-led. One person told us, "It's all pretty well done I would say." A relative said, "[Registered manager] is approachable. She will always help if she can. There are frequent residents meetings and they've taken up the suggestions like wearing uniforms." People and their relatives confirmed that the provider visited often and asked them for their feedback. The provider had taken action where suggestions for improvement were given. On display in the entrance hall were comments from early 2017 including the need for a new staff lift. More recent feedback had been requested by the provider during June and July 2017. We read many positive comments. These included, 'There is still room for improvement but on the whole much better' and, 'I think there is clear evidence that the overall standards are improving. The general feeling amongst staff has much improved.'

The registered manager and provider were working hard to drive improvement. There were action plans in place following our previous inspection detailing what action the provider had taken to make improvements. This included improvements to the management of medicines and prompt access for people to receive health care. The provider and registered manager recognised they had further improvements to make. The provider had employed a new quality manager to help further with driving improvement and they were due to visit the home shortly to offer their support. The registered manager was working with the local authority's quality improvement team. This team offers their support to services to help make any required improvements.

Staff felt supported by the registered manager and provider. One staff member told us, "I've found her [registered manager] okay. I always can talk to her about a service user." Another said, "They are trying to make it better. They meet with us more. It's got better staff wise. They all seem dedicated." Another staff member commented, "Any concerns and I will go to the manager and they will try and address it. They always show me a way around things." Staff confirmed that they had opportunities to give suggestions to the registered manager about how the service could improve and that these were considered. Staff received praise about things that had gone well. Staff told us this helped them to feel valued.

Staff were clear about their responsibilities. This was because the provider had made available to them procedures and policies. Staff demonstrated a good understanding of these. One staff member described what they would do should they have concerns about the practice of a colleague. They told us, "If one of the staff were doing something not suitable, abuse or something, you would go and tell someone. To the manager and I would go to [provider] if needed." Staff were aware of other organisations such as CQC that they could share their concerns with if required. We saw that the registered manager made sure that staff knew about their responsibilities by holding team and individual meetings for staff. The expectations of staff were discussed with them during these meetings.

The provider had aims and objectives for the service that they strove to achieve. For example, we read that the service aimed to provide care that was focused on each person and that respected people's dignity. Staff were knowledgeable about the aims and we saw them working in ways that promoted these when we visited.

The provider's record keeping of some of their quality checks and of their interviews of staff during

recruitment did not occur. Whilst we were told of the improvements they were unable to demonstrate what had happened.

We recommend that the provider seeks advice and guidance about good record keeping based on current best practice.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider was failing to ensure that the home followed advice and guidance for adequate fire safety to keep people safe in the event of a fire.