Solent Cliffs Nursing Home Limited

Solent Cliffs Nursing Home Limited

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?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

This inspection took place on 21 May and 28 May 2015. It was unannounced.

Solent Cliffs Nursing Home Limited is registered to provide personal care, nursing care and accommodation for up to 40 older people and people living with a physical disability. At the time of our inspection there were 34 people living at the home. They were supported by a total of 65 staff. People had a variety of nursing needs. Accommodation was arranged over two floors in a combination of single and shared rooms. There was an enclosed garden with seating areas, a main lounge, dining area, conservatory and a quiet lounge.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are "registered persons". Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The manager had been registered with us since January 2012.

Staff were aware of the need to obtain people's consent to their care and treatment. However where people lacked capacity to make certain decisions, the service

Summary of findings

was not consistent in how it applied the principles of the Mental Capacity Act 2005 and its associated code of practice to make sure decisions were made in the person's best interests.

We saw occasions when the actions and language used by some members of staff did not demonstrate that they respected people's dignity and individuality.

People did not consistently experience care and support that was based on their needs and how they preferred to be supported. They were not always assisted to be independent and have their own routine. The service had identified that people's care plans were not always fit for purpose and was taking action to address this.

The service did not always manage risks effectively to ensure people's safety and wellbeing were promoted.

Staff were aware of their responsibilities to report any concerns about possible abuse. The service had procedures to follow in the event of emergencies.

There were enough staff to support people to the required standard and to keep them safe. The provider carried out the necessary recruitment checks before staff started work. Staff were supported in their responsibilities by effective training and supervision.

Arrangements were in place and followed to store and administer medicines safely. People's health and welfare were supported by access to other healthcare services and by arrangements to make sure they had enough to eat and drink.

Although we observed examples of some staff not treating people with respect, people had positive, caring relationships with other staff who supported them. Staff often took steps to promote people's dignity and privacy. People were able to participate in decisions about their care and support, and their views were listened to, although not always acted on.

Where people were identified as needing nursing care for a particular condition, there were detailed care plans in place. However other care plans and risk assessments lacked the necessary detail.

A variety of leisure activities, hobbies and entertainments were available to people. The service recorded and managed complaints in order to learn from them and improve the service.

There was a friendly, homely culture with open communication between the staff, people living at the home and their relations. Staff felt supported and motivated. There was a management system in place and arrangements were in place to monitor and improve the quality of the service people received. However, these systems were not always effective as they had not identified the concerns we found during our inspection.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see the action we told the provider to take at the end of the full version of this report.

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

The service was not always safe.

The service did not always have arrangements in place to make sure people were protected from risks.

There were sufficient staff to support people safely, and the provider took steps to make sure they were suitable to work in a care setting. However people often had to wait for assistance.

Arrangements were in place for the safe management of medicines.

Is the service effective?

Requires improvement

The service was not always effective.

Where people lacked capacity to make certain decisions, the service did not always have regard for legal requirements about assessing capacity and making decisions in the person's best interests.

Staff were supported by training and supervision to obtain and maintain the skills and knowledge then needed to carry out their roles and responsibilities.

People were supported to eat and drink enough, and had access to other healthcare services when they needed them.

Is the service caring?

Requires improvement

The service was not always caring

Some staff did not always demonstrate respect for people as individuals.

People were able to express their views about the service they received, although their views were not always acted upon.

There were also many examples of caring interactions between staff and the people they were supporting and examples of interactions which preserved people's dignity and privacy.

Is the service responsive?

Requires improvement

The service was not always responsive.

People did not always experience care and support that met their needs and took into account their preferences. They were not always able to follow their preferred routine. Care plans were not consistent in documenting care that reflected people as individuals.

There was a complaints process in place. The service reviewed and learned from complaints to make improvements.

Summary of findings

Is the service well-led?

The service was not always well led.

There was an open, friendly atmosphere in the home. People living there, their relations and staff appreciated opportunities to communicate their views.

The management team had complementary skills and systems were in place to monitor the quality of the service and lead to improvements. However these systems had not identified all areas for improvement.

Requires improvement

Solent Cliffs Nursing Home Limited

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, looked at the overall quality of the service, and provided a rating for the service under the Care Act 2014.

The inspection took place on 21 and 28 May 2015 and was unannounced. The inspection team consisted of an inspector 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. The expert by experience had experience of services for people living with dementia.

Before the inspection we reviewed information we had about the service, including previous inspection reports and notifications the provider sent to us. A notification is information about important events which the provider is required to tell us about by law.

We spoke with 10 people who lived at Solent Cliffs Nursing Home and five visiting relations. We observed care and support people received in the shared area of the home. Our observations included use of the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with the registered manager, deputy manager, clinical manager, administration manager, two registered nurses, the activities coordinator and four care workers including a care team manager and a junior care assistant.

We looked at the care plans and associated records of five people. We reviewed other records, including the provider's internal checks and audits, training records, staff rotas, and staff records for the two most recent workers to be recruited.

Requires improvement

Is the service safe?

Our findings

People told us they felt safe and free from the risk of harm. They said they would speak to staff if they were worried or unhappy about anything. One person said, "Oh yes, it is a safe place to be. They don't worry me." People were satisfied their medicines were always available and administered on time.

Our own observations and the records we looked at did not always match the positive descriptions people gave us. Risks were not always managed in a way that protected people while respecting their freedoms. Care plans did not always contain the information staff would need to support people according to their needs. One person had been assessed every month using a standard tool for assessing people's risk of developing pressure injuries. The result was they were a "high risk" but there was no detailed risk assessment or specific action plan to manage and reduce the risk. Two people had care plans which stated "mental capacity toolkit required" but there were no records to show this had been done. Therefore, we could not be assured for these people that account had been taken of their individual needs and capacities in order for staff to support them safely. Another person's communication care plan described the difficulties the person had communicating but did not have instructions for staff on how to carry out effective communication with them. The plan lacked the guidance needed to make sure the person would be supported safely.

We saw examples of care which did not promote people's safety. We saw nine people who were in bed and who either could not reach their call bells or we could not see a call bell in their room. They would not have been able to call for assistance in an emergency. On two occasions we saw containers of powder used to thicken people's fluids which had been left uncovered and at risk of accidental contamination. One of these was in a shared area of the home which meant it also could have been used inappropriately or used for someone it was not intended for.

Failure to consistently provide care in a safe way was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider took steps to protect people from the risk of avoidable harm and abuse. Staff were aware of the types of abuse, the signs and indications of abuse, and how to report them if they had any concerns. They knew about contacts outside the home where they could report problems. They had not seen anything which caused them concern, but they were confident any allegations would be handled by the provider and senior staff in a prompt and effective way.

The registered manager was aware of how to engage with adult services if there was a suspicion or allegation of abuse, although there had been no recent incidents. Induction and refresher training was in place to maintain staff knowledge about safeguarding. Staff were aware of the provider's whistle blowing policy and felt confident to use it. There was an open management culture in which concerns could be raised about people's safety without fear of consequences.

Where risks to people's safety had been identified and care plans had been fully developed to manage and reduce them, people's safety and welfare were promoted. Some people had appropriate risk assessments in place, for instance with respect to falls or pressure injuries. Plans were in place to support people to get out of bed safely, to reduce the risk of pressure injuries by helping people to turn regularly in bed and for people to have thickened drinks if they were at risk of having difficulties swallowing. The registered manager told us they paid particular attention to people's skin care, and used appropriate equipment such as pressure mattresses to reduce the risk. There were no incidents of pressure injuries at the time of our visit.

Arrangements were in place to keep people safe in an emergency and reduce risks to their health. People had personal evacuation plans which showed the assistance they would need in an emergency. Staff were trained in fire safety, first aid and in control of substances hazardous to health (COSHH). The cupboard for hazardous substances was clearly labelled and locked. At the time of our visit one of the bathrooms was being refurbished as part of the provider's programme of improvements. It was clearly labelled "do not use".

There were sufficient numbers of suitable staff to support people and keep them safe. People and their relations were satisfied there were enough staff, although there were occasions when they had to wait if they needed assistance. Staff told us their workload was manageable. The

Requires improvement

Is the service safe?

registered manager told us there were enough staff to meet people's needs, and they used an agency if necessary to maintain staffing levels. We saw staff were able to carry out their duties in a calm, professional manner.

The provider carried out the necessary checks before staff started work. Staff files contained evidence of proof of identity, a criminal record check, employment history, and good conduct in previous employment. The recruitment process consisted of advertisement, short listing and interviews carried out by a member of the management team and a senior clinical staff member. Interviews followed a standard format with a scoring scheme, and records of interviews were retained. Where staff were supplied by an agency, the provider screened them for suitable experience and knowledge. People were supported by staff who were checked for their suitability to work in a care setting.

Medicines were stored and handled safely. We observed part of a medicines round. The nurse observed suitable hygiene practices. They encouraged people to take their medicines, explaining what they were for. They were aware of how people liked to take different medicines and offered them accordingly. They made sure the person had swallowed one medicine before moving on to the next one or the next person. They checked if people were in pain and offered them pain relief which had been prescribed "as required". This was recorded on their medicine administration record (MAR). Tablets and capsules were administered from blister packs. Medicines in other containers such as bottles and eye drops were clearly marked with the person's name and the date the container had been opened.

People's MARs contained the person's name, photograph, date of birth, and information about any allergies. Records were accurate and up to date. The provider had recently changed their pharmacist, and staff told us this had led to improvements in the service. The pharmacist had recently carried out an audit of medicines management at the service and no significant findings had been made. The service carried out its own monthly audit and spot checks of medicines to make sure they were managed safely.

Requires improvement

Is the service effective?

Our findings

People were happy they received effective care and treatment from competent staff, and they could access other healthcare services. People and their relations felt staff were skilled in their roles and were confident in the abilities of staff. One said, "Yes, they are good at what they do. I would say, very good." People were satisfied with the menu choices and said they had enough to eat and drink. Their comments included, "The food is quite all right, really," and, "Yes, the food is good. I am happy with it." People and their relations were confident assistance from other healthcare providers was available when needed. One person said, "I have seen the doctor from time to time when I have needed one. I have no worries on that score." Another told us, "I have been a bit ill and I have seen the doctor and the optician recently."

Staff were aware of the need to provide support and treatment with people's consent. Care workers told us how they could use people's facial expression or body language if they were not able to communicate their consent verbally. We saw examples of people being asked to consent before staff supported them. People's care plans contained forms to record people's consent to their care and treatment but these were not always completed or signed by the person.

Where people were not able to consent to their care or treatment, the provider did not always act according to the Mental Capacity Act 2005. This provides a legal framework for acting and making decisions on behalf of people who lack capacity to make particular decisions for themselves. The registered manager and staff were aware of the Act and suitable procedures and forms were in place which followed the principles of the Act and its associated code of practice. However the implementation of the procedures was not consistent.

One person had been assessed with respect to the specific decision whether they could receive their medicines disguised in food or drink as they lacked capacity to make this decision. It had been agreed this was in the person's best interests.

However another person's capacity assessment was not limited to a specific decision, but stated, "Can [Name] make decisions about her care or placement?" The person's communications care plan stated, "[Name] is generally able to understand questions asked. She is generally able to answer questions and can make informed choices about her care." The same person's care plan contained a record of a decision made to decline a healthcare screening invitation after a discussion with their spouse. The person's own views were not recorded, and this decision was dated one month before their capacity assessment was carried out. These contradictions showed the provider did not consistently assume a person had capacity and did not make timely assessments of people's capacity to make specific decisions.

Another person's care plan contained contradictory information. Two records stated "[Name] has fluctuating capacity" but there were no records to show this was based on a capacity assessment carried out in line with the Mental Capacity Act 2005. A third record stated "[Name] has full capacity to make decisions", however their consent form was not completed. Two people had been identified as needing a capacity assessment, but this had not been done.

Failure to apply the Mental Capacity Act 2005 at all times where people lacked capacity was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which apply to care homes. We found the home to be meeting the requirements of the DoLS. Applications had been made to the local authority as the Supervisory Body to make sure that where people were deprived of their liberty this was done in their best interests and was the least restrictive way of keeping them safe.

People were supported by staff who themselves received appropriate training and supervision to deliver care and treatment to the required standard. Care workers told us they had all completed the provider's mandatory training and also specific training required to support people with particular conditions or needs. They considered their training prepared them adequately to carry out their duties. Records showed training needs were managed and refresher training arranged when it was required. The registered manager told us some staff had identified a need for additional training in moving and handling. They had responded by arranging a "teach the teachers" course for two members of staff who were then qualified to pass on the skills and knowledge acquired.

Requires improvement

Is the service effective?

There was a programme of supervision and appraisal meetings with all staff receiving at least two formal supervisions a year. These were recorded and included performance management, assessment of practical skills, mentoring and personal development. Staff told us they felt supported by these formal arrangements and they could approach any of the senior staff or managers for advice if they needed it.

People were supported to eat and drink to maintain a healthy diet. People told us they had no complaints about the food and we saw it was presented in an appetising way. Where a person needed liquidised food, care was taken to prepare the different meat and vegetables separately so that it looked as appetising as possible. There was a certain amount of choice available: on the first day of our inspection people could have beef curry, beef bourguignon or a jacket potato with salad for lunch. People told us there was enough to eat and they were not hungry. One person said, "I sometimes wake up in the night and if I want a slice of toast and a hot drink, they will get it for me."

Special diets, for instance if people were living with diabetes or had an allergy to shellfish, were taken into account, as were people's preferences. People were supported to have meals in their rooms, in the dining area or in armchairs in the lounge. Where people were assisted to eat, this was done in a kind and gentle way with staff talking with and encouraging people. The assistance given was unhurried and staff took time to make sure people were happy.

People and their relations told us other healthcare providers were engaged promptly when required. Records in care plans showed when there had been appointments, for instance with the person's GP or a chiropodist.

Requires improvement

Is the service caring?

Our findings

People gave us positive feedback about the caring nature of staff. Their comments included: "It is very good here. I think they are very attentive," and, "They are very caring and respectful, and what is nice we have a bit of fun." People's relations were equally positive. One said, "I chose this because I wanted somewhere safe and secure, with kindness and a homely feel. The staff are wonderful and make a real fuss of [Name]." People felt staff knew about their wishes and preferences: "Yes, I think they know me pretty well and they are friendly with you."

Although staff respected people's dignity in the majority of interactions we saw, there were a small number of examples where people's individuality and dignity were not respected. On one occasion a member of staff called out across the room about a person, "That one there…He's a new one…Just arrived." We observed staff talking about a person with other healthcare professionals over the person's head, and without acknowledging the person. The staff member said, "Where's he come from?" When talking about people, some staff tended to refer to them as "patients", and on one occasion people occupying certain rooms were called "the noisy ones".

Other staff members were able to describe to us practical steps they took to preserve people's dignity when assisting them with personal care. We saw they took care to close people's doors when they assisted them and used their names when addressing them or discussing them with other members of staff. At the time of our visit works were in progress to convert a bathroom into a wet room. The registered manager told us one of the reasons for this was to help staff preserve people's dignity.

Failure to consistently treat people with dignity and respect was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff said they had time to get to know people and we saw they were aware of people's preferences and life stories. We heard one care worker say, "You know me [Name]. I cook your dinners don't I, and it's beef curry today. I know you like your curries." Staff said they took time to find out people's preferences, for instance by seeing how they responded to different types of music. New staff worked alongside a more experienced care worker to "get to know everybody". Staff also took steps to understand care and support from the point of view of people they were supporting. They told us they had tried drinking thickened fluids to know what it was like.

We saw examples of caring interactions, such as a nurse offering tissues after they had administered eye drops. People were appropriately dressed and clean. Staff were attentive to covering people again if their clothes became dishevelled. We saw examples of gentle support as people moved about the home. Staff made sure hot drinks and other items were within reach, moving side tables and other furniture if necessary.

People were able to make decisions about their care and support. We heard staff asking about people's preferences: "Here we go [Name], where would you like to sit?" and "Can I get you a drink of tea or coffee?" Staff were ready to help if needed: "Can I help you at all or would you like to have a go?"

Staff told us they offered people choices, for instance about the clothes they wore, hot and cold drinks and when they got up in the morning and went to bed, although we found evidence this was not always the case. For instance, people told us they would prefer more frequent showers or to get up earlier in the day. They told us they were able to participate in games and activities with people, and helped them with pampering, such as doing their nails. If people wanted to, they could help them to go for walks outside the home. The service listened to suggestions made about the service by people and their relations. Examples included the installation of a vending machine for hot drinks, more availability of butter with meals and a communications book for relations to record suggestions.

Staff were aware of possible equality and diversity issues, although there were no such issues at the time of our inspection. People were able to participate in religious services conducted by visiting ministers either individually or in groups according to their wishes.

Requires improvement

Is the service responsive?

Our findings

People gave us varying views about the care and support they received. Some were very happy and said, "I feel very well looked after" and "I would recommend it here." All of the visiting relations said they would recommend the home. However one person found the service provided was rather restrictive: "Oh they care and the girls are lovely but you do feel like you have to toe the line." Other people raised concerns about how long they had to wait for assistance and how they had to adapt their routine to fit in.

Our own observations and the records we looked at did not always match the positive descriptions some people and visiting relations gave us. People did not always receive support and assistance in a timely manner. Some people told us staff came promptly when they used their call bell, but three people told us they experienced delays. One person said they could wait up to half an hour.

One person became anxious while we were in their room because they felt ill. They could not reach their call bell because it was on the floor under their bed. We pressed the call bell for them and observed they had to wait 15 minutes before a care worker came into their room. The care worker reassured them, but had to go away again to find a colleague to assist them to reposition the person safely. Later in the day we saw the same person's call bell was once more on the floor under their bed. They would not have been able to call for assistance although staff were aware they were unwell.

Most people living at the home were not able to move about independently, but those that could were not always assisted to be independent. One person told us, "I have struggled a bit with standing but they've been trying everything to get it right for me and I think the stand-aid with two people always with me works best. They've really done their best for me." However another person said, "They don't get me up because of my walking, but I can walk with a frame. I just have to lie here or sit there. They make me go in a wheelchair because it's quicker for them. They're so busy you have to do as you're told. I use it when my son comes, it's over there." A third person said, "They are quite nice here but I'd love to have more independence. I've got a walker and I'd like to get around a bit."

We saw examples where people's support was not appropriate to their abilities and independence. For instance, two people were given drinks in adapted beakers when they could use standard cups and saucers. One of them said they had "no idea" why this happened. The other person had a visitor who offered to take the lid off the beaker, and the person was able to drink normally. The person was happier like this and their relation did not know why they were given drinks in an adapted beaker. A third person became annoyed when a care worker insisted they use a spoon rather than a fork. They were able to eat independently and make their own decisions about how they ate, but the care worker put food on a spoon for them despite them saying, "No, no, don't do that."

Other people were concerned they could not follow their preferred routine for daily living. We spoke to one person at 9:45am and they told us, "I'm not one for staying in bed. I've been waiting to get up since eight o'clock. They put me to bed and once I'm in I stay here. I have a shower once a week, you do what they say." Another person said, "I'd like a shower daily, that's what I'm used to but my allocated day is a Tuesday and I unofficially manage to get one on a Friday as my hairdresser comes in." A third person, who could not reach the call bell in their room, called out repeatedly, "Help, help, I can't get up." Staff, including the registered manager, were aware this person wanted to get up, but it was after lunch before they were assisted to get dressed and sit in the shared lounge.

People were not always involved in planning their own care and support. Two visiting relations told us they had been involved in all the care planning conversations without the person themselves. We saw the registered manager discussing paperwork relating to a third person's admission with their relation when the person was sat elsewhere in the shared lounge. When we discussed this with the manager, they told us they had carried out a pre-assessment in hospital the previous day when the person had not been responsive and had been unable to participate. However they described the person as "much brighter" and "a different person" on the day of our inspection. It was not clear why they could not participate in the discussions about their care.

People's care and support was based on care plans which were of varying standard. Where people needed nursing care for particular conditions, there were detailed plans. Observations, such as weight, blood pressure and heart

Requires improvement

Is the service responsive?

rate, were made and recorded monthly. Care plans were based on forms which prompted for the person's strengths, needs, problems, risks and planned care, but the content did not always follow this format.

There were cases where the plans reflected people's abilities, preferences and gave clear instructions how staff should support them. For instance, "[Name] is assisted with some of her personal care needs, She is able to wash her hands and face when given a flannel. She is able to brush her hair and sit forward to assist with dressing. [Name] prefers to have a shower." In other cases care plans did not contain the information staff would need to support people according to their needs and preferences.

The registered manager told us they were in the process of reviewing all care plans as they were transferred to a computer based system. They were assessing different formats for the new care plans. They also showed us a proposed "My Journal" which was intended to record information about people's preferences and chosen routines.

Failure to provide appropriate care and support which met people's needs and reflected their preferences was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported to take part in a variety of leisure activities and hobbies. These included knitting, music, exercises, bingo and reminiscence. There were visits by entertainers and a "pets as therapy" dog. Staff told us where possible they based activities on people's interests and life history. The service employed a full time activities coordinator who spent time with people, particularly those who were supported in bed. The activities coordinator read to people and took them for walks in the garden or nearby community. However, some people told us there were things they could no longer do. One person said, "I'd love to go to church if someone could take me." Another said, "Oh I loved gardening. I'd like to get out there but I can't do anything like that now."

The service had a complaints process which was displayed at the entrance to the home and included in welcome packs which were given to people when they moved in. Complaints and actions taken in response to them were documented and where appropriate the registered manager carried out an analysis of the underlying causes of the complaint. The manager told us of two complaints which they considered could have been managed better. This showed they learned from complaints to improve the service people received and the complaints process itself.

Requires improvement

Is the service well-led?

Our findings

People told us the home was well organised and there was a culture which encouraged them to speak up about any issues or concerns. They said all the staff were approachable and the registered manager was warm and friendly. Visiting relations said they were always made welcome when they visited and they found there was a homely, relaxed feel to the home. People and their relations consistently told us they appreciated the regular meetings at which they could freely express their views about the service.

The registered manager communicated caring, inclusive values. They said they were working to make the service more homely, and all staff were trying to make a difference for people. They considered there was a "happy environment" in which visitors were encouraged to attend at any time and were offered refreshments and meals during their visits. They looked for best practice guidance from a number of sources, including national and local government guidelines. They had made improvements based on feedback and comments from people and their relations. These included changes to the fabric of the building, for instance installing new window blinds, and changes to the way they worked such as making members of the management team more available to visitors. The manager said they had a well motivated staff team, and there had been examples of staff leaving for another service who asked to come back later.

Staff were positive about the environment in the home. They felt it was a "lovely" and "a good home". They said they all got along and formed a good team with high morale. There were open communications with the management team. Staff said they found people were happy, settled in quickly and thought of it as their home.

The management team consisted of the registered manager, deputy manager, clinical manager and administration manager. Each member of the team brought different skills and expertise to the service. Trained nurses were responsible for overseeing the care workers. There were regular staff meetings for the trained nurses and care workers. These meetings were minuted and we saw they were used to improve staff knowledge about the care and support people needed. Examples were the use of equipment such as nebulisers to help them breathe comfortably and PEG (percutaneous endoscopic gastrostomy) to provide food by a tube directly into the person's stomach.

The registered manager encouraged staff to reflect on their practice in delivering care and support and to learn from their experiences. They included their own experiences and learning in this. However this system had not addressed the concerns we identified around some staff not respecting people as individuals and not listening to people when they expressed a view about how they wanted to be supported.

The registered manager was conscious of the need for good communications and team building, and to make sure care workers felt valued. They took advice from other professionals, such as members of the emergency services and members of multi-disciplinary teams when planning peoples care. Staff were happy they could contribute to the running of the service and their views were received positively.

Systems were in place to monitor and audit the quality of service people received. Care plan audits had led to plans for improvements, although these were still in progress at the time of our visit. Regular audits were in place which covered equipment, including pressure mattresses, maintenance and health and safety. Actions arising from these included the cutting back of trees which were blocking people's view from their rooms. Contracts were in place for the servicing of equipment. The management of medicines was audited every six months by the deputy manager. An external audit had been carried out by the service's pharmacist in February 2015. This had identified minor errors in the use of letter codes in the recording of medicines administered, which had been passed on to the registered nurses.

However, the registered manager's system of audits had not identified all the concerns that were apparent during our inspection. Where concerns had been identified they had not led to timely actions to make improvements. These included the lack of risk assessments and sufficient detail in some care plans, and the inconsistent involvement of people in planning their own support. Some capacity assessments did not contain decision specific information or were missing. The accessibility, use and response to call-bells had not been reviewed.

Requires improvement

Is the service well-led?

The registered manager reviewed the accident book, falls logs and complaints log every month. Lessons were learned from these, and if appropriate changes were made to people's care plans. People's weight was monitored and flagged red if they had lost significant weight since the last check. Actions were taken, including consultation with the person's GP.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **People's care and treatment was not consistently appropriate, and did not meet people's needs or reflect their preferences. Care and treatment was not designed with a view to achieving service users' preferences and ensuring their needs were met.** **Regulation 9 (1) (a) (b) and (c) and (3) (b).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **Service users were not consistently treated with dignity and respect.** **Regulation 10 (1).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The registered person did not consistently act in accordance with the Mental Capacity Act 2005.** **Regulation 11 (3).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Care and treatment were not always provided in a safe way. The registered person did not always assess risks to**

This section is primarily information for the provider

Action we have told the provider to take

the health and safety of service users and do all that was reasonably practicable to mitigate such risks. The registered person did not always ensure that equipment was used in safe way.

Regulation 12 (1) and (2) (a) (b) and (e).