Croft Care Homes Limited

Laughton Croft Care Home with Nursing

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

The inspection took place on 25 February 2015 and was unannounced.

Laughton Croft Care Home with Nursing is registered to provide accommodation and personal care for up to 36 older people and people living with either dementia, a physical disability, sensory impairment, or a mental health problem. There were 27 people living at the service on the day of our inspection.

There was a registered manager in post at the time of our inspection. 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.

Summary of findings

At our last inspection in July 2014 we asked the provider to take action to make improvements to respecting and involving people, cleanliness and infection control, safety and suitability of the premises and how they ensured the quality of the service. The provider sent us an action plan and told us that these actions would be completed by 23 October 2014. On this inspection we found that the provider had not made all of the required improvements.

The Care Quality Commission is required by law to monitor how a provider applies the Mental Capacity Act, 2005 and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way. This is usually to protect themselves or others. Two people living at the service had their freedom lawfully restricted under a DoLS authorisation.

Staff understood safeguarding issues and knew how to recognise and report any concerns in order to keep people safe from harm. However, people's safety was not always maintained, because staff did not always follow safe medicine administration, storage and disposal procedures and people were at risk of not receiving their medicine. Furthermore, the provider did not ensure that the service was consistently clean and that safe infection control procedures were adhered to and people were at risk of using equipment that was not clean.

People were cared for by staff who were supported to undertake training to improve their knowledge and skills to perform their roles and responsibilities. People had their healthcare needs identified and were able to access healthcare professionals such as their GP or psychiatrist. Staff knew how to access specialist professional help when needed. However, their care plans did not always reflect any changes in their plan of care following healthcare reviews.

People and their relatives told us that staff were kind and caring and we saw some examples of good care practice. However, we found that people were not always treated with dignity and respect. People were not supported to follow their hobbies and pastimes and had little contact with the outside world.

At this inspection we found that the provider was not meeting our legal requirements for cleanliness, medicines and governance. You can see what action we told the provider to take at the back of the full version of the 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.

Staff did not always follow correct procedures when administering medicine.

The provider did not maintain a safe and clean environment.

Staff had access to safeguarding policies and procedures and knew how to keep people safe.

Is the service effective?

Requires Improvement

The service was not always effective.

The provider was meeting the requirements of the Deprivation of Liberty Safeguards. Staff had received appropriate training, and had an understanding of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. However, staff did not always follow correct procedures when obtaining consent from people.

People were cared for by staff that were supported to develop their knowledge and skills to carry out their roles and responsibilities.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always treated with dignity and respect.

Staff treated people with kindness and compassion if they were distressed and upset.

Is the service responsive?

Requires Improvement

The service was not always responsive.

A complaints policy and procedure was in place and people and their relatives told us that they would know how to complain.

People were not encouraged to maintain their hobbies and interests including accessing external resources.

People's care plans did not always accurately reflect their current care needs.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider did not seek the views of people who lived at the service to make improvements to the service.

The provider did not make the improvements that they told us they would do. Quality monitoring systems had not been embedded into the service.

Summary of findings

Staff and people found the registered manager approachable and felt able to raise concerns with them.	

Laughton Croft Care Home with Nursing

Detailed findings

Background to this inspection

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

The inspection took place on 25 February 2015 and was unannounced.

The inspection team was made up of two inspectors, an expert by experience and a specialist professional advisor. A specialist professional advisor is a person who has expertise in the relevant areas of care being inspected, for example, nursing care. We use them to help us to understand whether or not people are receiving appropriate care to meet their needs. An expert by experience is a person who has personal experience of using services or caring for someone who requires this type of service.

Before the inspection we looked at previous inspection reports and we reviewed other information that we held about the service such as notifications, which are events which happened in the service that the provider is required to tell us about, and information that had been sent to us by other agencies. We used this information to help plan our inspection

We looked at a range of records related to the running of and the quality of the service. This included staff training information and staff meeting minutes.

We also looked at the quality assurance audits that the registered manager and the provider completed which monitored and assessed the quality of the service provided.

During our inspection we spoke with the registered manager, a registered nurse, the housekeepers, four care staff, the chef and the activity coordinator. We also spoke with11 people who lived at the service, three visiting health and social care professionals and six visiting relatives. In addition, we observed staff interacting with people in communal areas, providing care and support.

We looked at the care plans or daily care records for nine people. A care plan provides staff with detailed information and guidance on how to meet a person's assessed social and health care needs. In addition, we undertook a Short Observation Framework for Inspection (SOFI) at lunchtime. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We asked the local authority and commissioners of healthcare services for information in order to get their view on the quality of care provided by the service.

Requires Improvement

Is the service safe?

Our findings

During our inspection in July 2014 we found that the registered person did not ensure that service users and person's employed for the purpose of carrying out the regulated activity and others who may be at risk of exposure from carrying on of the regulated activity were protected against acquiring an infection. This was because they did not maintain appropriate standards of cleanliness and hygiene. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider sent us an action plan which set out how they planned to address the areas highlighted. At this inspection we found that improvements had not been made and this placed people at risk.

Two relatives shared their opinion about the standards of cleanliness in the service. One said, "It's not bad, but sometimes needs hoovering up." Another person's relative told us, "The company could do with spending a little money around the place, but the girls work round it quite well."

There was evidence that the standards of cleanliness were not properly maintained. For example, we saw a soiled bath chair in one bathroom, and the cups for morning coffee were stained inside and out. Staff agreed that they were not fit for use as they would not use them themselves Furthermore, we noted in one bedroom that although the person's bed had been made that morning, care staff had not removed and replaced their soiled bed mat. In a bathroom there was a bar of soap for communal use at the wash hand basin. In addition, we found the laundry was cluttered with clean and dirty clothing stored in the same area. This meant that potentially infectious substances could be transferred onto linen and clothing that was considered clean and there was a risk of cross contamination and the spread of infection.

Although housekeeping staff had undertaken training there was evidence that the control of substances hazardous to health (CoSHH) guidance was not being followed. Cleaning fluids had been decanted and diluted into alternative containers and the product name had been hand written on the container. There was no date recorded to confirm when this action was taken. This meant that staff did not have access to a safety information label on the container with the risk of harm listed as well as emergency first aid procedures.

We found that the registered person had not protected people against the risk of infection. This was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection in July 2014 we found that the registered person did not ensure that service users and others who had access to premises where a regulated activity was being carried on were protected against the risks from unsafe and unsuitable premises. This was in breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider sent us an action plan which set out how they planned to address the areas highlighted. At this inspection we found that improvements had been made. For example, damaged furniture had been removed and the roof had been repaired. This meant that the registered person was no longer in breach of this regulation.

People told us that staff looked after their medicines and supported them to take them. One person said, "They look after all my tablets and my insulin and stand there while I take them. Lately I've been able to do my own insulin but they've watched me do it." However, medicines were not always administered, recorded, stored or disposed of safely.

For example, one person had difficulty swallowing their medicine in tablet form and their medicine dissolved on their tongue. There was a risk that their mouth could become sore and the tablet may be absorbed at the wrong rate and not be effective. However, the nursing staff were aware of this, but did not liaise with the GP to find an alternative form that the person would find easier to swallow. Another person received a medicine for controlling diabetes on five consecutive evenings, but they were not prescribed the medicine at this time. This meant that there was a risk that their blood sugar levels could fall outside the normal safe range and the person could become seriously ill. At lunchtime we saw that a person was prescribed a pain relief gel for their arthritis. The person was eating their lunch and the registered nurse did

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Is the service safe?

not ask them if they required the gel, but recorded in the person's MAR chart that the gel had been refused. We saw recorded in another person's care plan that they had their medicine covertly, crushed into their food. We saw the registered nurse put their medicine into their food without crushing it. Their plate of food spilled over their knees and it was unclear if the person had taken their medicine.

We found out of date nutritional supplements for three people who had passed away that had not been disposed of as per the provider's medicines policy. In addition, there were several packs of drugs on top of the medicine trolley for a person who had passed away that had not been disposed of or stored securely. We looked in the drug disposal record book and found that there had not been an entry made for over three weeks. This meant that out of date and unwanted medicines were not disposed in a timely manner.

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 12 (f)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they felt safe living in the service. One person said, "Oh yes, I feel safe. When I'm alright I can do everything for myself, but they really do look after me when I can't." Another person told us, "It's great, I couldn't look after myself. I'm safe here. There is always someone about." Relatives told us they felt their loved ones were safe at the home. One relative said, "They are safe here, she is on one to one care and when I'm not about there is always someone with her." Another relative said, "He is definitely safe here. He was in a home before and they couldn't cope with him. They seem to know how to handle him here and there is always staff about."

Staff had completed training in adult safeguarding and were able to describe the possible signs and symptoms of abuse. Staff said if they had a concern they would report it to the nurse in charge or to the registered manager.

There were systems in place to support staff when the registered manager or their deputy were not on duty. Staff had access to an emergency folder that contained a day and night time contingency plan to be actioned in an emergency situation such as a fire or electrical failure. We saw that people had a personal emergency evacuation plan that detailed the safest way to evacuate them from the service. Up to date details of facilities providers and peoples' next of kin, their GP and senior staff were kept in the emergency folder.

There was a robust recruitment processes in place that ensured all necessary safety checks were completed to ensure that a prospective staff member was suitable before they were appointed to post. We spoke with a member of care staff who had recently been appointed to the post. They told us that they had a comprehensive induction and had shadowed an experienced member of staff until they were confident to work on their own.

We discussed the current staffing levels with the registered manager who told us they had, "loads of staff". They said they had recently undertaken a staffing level needs analysis and there was one hundred extra care staff hours per week. They said this meant that they no longer used bank or agency staff to cover annual leave or sickness.

Requires Improvement

Is the service effective?

Our findings

Staff undertook training in key areas such as moving and handling, health and safety and mental capacity. In addition, several staff were supported to work towards a nationally recognised qualification in adult social care and some staff had undertaken additional training in specialist subjects such as the care of a person with diabetes or looking after a person at the end of their life. Staff were able to give us examples of how they applied their learning to their practice. One staff member told us, "The training here is good and you can volunteer for other training. For example, I volunteered for palliative care and they seconded me to a local hospice for six weeks."

We spoke with two visiting social care professionals who were visiting to undertake a mental capacity assessment on a person before they met with the person's family and colleagues from healthcare to decide if it was in the person's best interest to live at the service. We found that the person had been allocated an independent mental capacity advocate (IMCA) and an independent decision maker to help ensure the process was undertaken in their best interest. An IMCA provides support and representation for a person who lacks capacity to make a decision.

We saw in some instances where a person lacked capacity to give consent that staff sought consent from a relative rather than follow the best interest decision making process as required by the Mental Capacity Act (MCA) 2005.

We spoke with the registered manager and nursing and care staff about their understanding of the MCA and Deprivation of Liberty Safeguards (DoLS). The MCA is used to protect people who might not be able to make informed decisions on their own about the care or treatment they receive. Where it is judged that a person lacks capacity then it requires that a person making a decision on their behalf does so in their best interests. We saw there was a policy to guide staff in the DoLS and MCA decision making processes. We found that staff were aware that two people were cared for under a DoLS authorisation and the conditions of that authorisation. We found that all the assessments and reviews were undertaken in their best interest. For example, three people received their medicine covertly, we saw that mental capacity assessments had been undertaken and staff had attended a best interest decision meeting to determine if it was in the person's best interest.

We saw where one person lacked capacity to give their consent to care and treatment that they had a lasting power of attorney who signed consent on their behalf. A lasting power of attorney is someone registered with the Court of Protection to make decisions on behalf of a person who is unable to do so themselves.

Care staff told us that several people living with a dementia had behaviour that other people may find challenging. They described some of the triggers that could affect a person's behaviour and how these could be avoided. One staff member told us of a person who sometimes required to be restrained to receive personal care, however, they had not received any formal training in restraint, they had been shown how to hold the person in order to minimise the restriction and keep the person and themselves safe. We found that the person's care plan did not give this information and did not give any indication that restraint was required. We later spoke with the registered nurse who informed us that restraint was not practiced in the service. This meant that staff were not clear about what constituted restraint.

We found that some people had chosen to make advanced decisions about the care they did not want to receive in a medical emergency or at the end of their life. Some people had a do not attempt cardio pulmonary resuscitation (DNACPR) order stored at the front of their care file. A DNACPR is a decision made when it is not in a person's best interest to resuscitate them if their heart should stop beating suddenly. We looked at six DNACPR orders. One DNACPR order indicated that the decision had been discussed with the person, two with their next of kin and the others did not identify who had been involved in the decision making process. We found that where the person lacked capacity to make the decision for themselves there was no evidence that a mental capacity assessments and best interest decision meeting had been undertaken.

People told us that the food was good. One person said, "The food is very good. We get plenty." Another person said, "I'm a poor eater and don't eat meat, they always remember and say this is for me because there is no meat in it." A relative told us that their loved one had their food pureed and added, "They make sure it is separated so it looks ok."

We observed lunchtime in both dining rooms. Staff showed people the meal choice on offer and they made their choice. People who required assistance to eat their meal

were served their meal before lunchtime. We were told this enabled staff to be free to assist them to eat. Care staff sat with people and assisted them eat their meal at their own pace. Where a person did not like the choices available there were alternatives such as a baked potato. People were not offered condiments, sauces or napkins. If a person had food on their hands or face staff gave them a wet wipe. We saw one person use their wipe and then hand it to the person sat beside them.

We observed that once the main course was served in one dining room, the desserts were plated up and the cook took the heated food trolley to the other dining room. The hot desserts were then cold by the time they were served to people. We mentioned our concerns about the way lunch was served with a member of staff who agreed with us and said, "Some will eat it whatever it is like." This meant that desserts were served before people were ready to eat them and left to go cold.

Where a person was at risk of weight loss, their risk of malnutrition was assessed and their meals were recorded on a food intake chart. However, we saw a member of staff completing these charts a couple of hours after lunch had been served. We are unsure how accurate this recording would be as they told us they completed them from memory.

The chef who told us that they were aware of the people who had special dietary needs such as having their food pureed or who needed additional nutritional support if they were at risk of weight loss. Furthermore, the chef told us that it was often difficult to make changes to the menu as several people were unable to say what foods they liked or disliked. They told us that they had overcome this by having tastings of new foods and the staff observed a person's reaction to different foods and reported back to the chef. As a result a new four week menu was being introduced.

People were supported to maintain good health and had access to healthcare services such as their GP, optician and dietician." People had a "This is Me" booklet which provided important information about them. If the person was being admitted to hospital they took this booklet with them so hospital staff had information about their needs and preferences.

One person's relative told us that staff always informed them of any changes in their loved one's condition. They said, "They've just told me that it's changed [medicines]. Sometimes the doctor comes and sits with us if they have changed things." We spoke with a visiting healthcare professional who told us that because of the way care staff had supported a person to settle into the service they were able to reduce the psychiatric medication that they were prescribed. We found that nursing and care staff responded to people's changing healthcare needs. For example, where a person had become agitated they requested that their psychiatrist reviewed them.

Requires Improvement

Is the service caring?

Our findings

During our inspection in August 2014 we found that the registered person did not in so far as is reasonably practicable, make suitable arrangements to ensure the dignity, privacy and independence of service users and they did not treat service users with consideration and respect. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider sent us an action plan which set out how they planned to address the areas highlighted. At this inspection we found that they had addressed the areas identified in their action plan and were no longer in breach of the regulation.

We saw some examples of good practice. However, we did observe some examples of care practices that did not support a person's right to dignified care. For example, one person was sat in their wheelchair in the centre of the lounge in full view of other people and their visitors. A large disposable mat was placed on the floor under their chair in case the person was incontinent of urine. This meant that the person's continence problems were not being effectively managed leading to physical discomfort and a lack of dignity. Furthermore, when the person was not in the lounge the mat was left insitu, this was a trip hazard to other people and members of staff.

We observed lunchtime in both dining rooms and found that the social experience could be improved. Lunchtime was more task orientated than a social event and there was little interaction from the staff. Another person was sat in an armchair and their meal was on their knee. We noticed that their food was spilling off their plate onto their trousers. They did not have a table within their reach and staff took no action to support the person.

Some people told us that they were involved in decisions about their care and how they spent their time. One person said, "I get up and go to bed when I want. I usually get up about 7.30 and they bring me my medication, then they bring m my breakfast in my room. I have supper about 10ish, usually Weetabix."

People and their relatives told us that staff were caring. One person said, "They are a special kind of person. I think they are fantastic people." One relative said, "They are brilliant, outstanding, look after my relative big time." Another relative said, "I'm happy with the attitude and care. I feel it's the nearest thing to home."

We saw that some staff interacted with people living with dementia with kindness and compassion. For example, we observed one member of care staff reassure a person who had become upset because they thought they owed money to the local shop. The staff member spoke with the person calmly and gently turned their attention to something else.

People and their relatives told us that staff treated them with dignity. One person said, "They usually shout, "Can I come in and some knock." One relative who regularly visits their loved one said, "Staff always ask if we want to be left on our own. Always give me respect if I want a bit of privacy, but they are never far away." However, we also found some comments in the shift handover sheet that lacked sensitivity. For example a person at risk of developing pressure damage on their bottom was recorded as having, "a sore bum."

Care staff told us about their experience of working with people in the service. One said, "I love it here, I have family experience of Alzheimer's and so I understand, I really like the people I care for."

Requires Improvement

Is the service responsive?

Our findings

People had their care needs assessed and personalised care plans were introduced to outline the care they received. For example, where a person was at risk of choking on their food, we saw that they had their food pureed so as they could swallow it easily. Their care file recorded the risk assessment and action staff would take if the person choked. We looked at the care file for a person assessed at risk of developing pressure sores. We saw that they had a body map in their care file that identified the areas most at risk. This supported care staff to meet the person's individual care needs.

We looked at the care files for nine people and saw evidence that people or their close relatives had been involved in decisions about their care. Their care plans were person centred but did not always accurately record their individual need and preferences. For example, we saw that the information recorded after a care plan review did not reflect the person's changing care needs.

Where a person was unable to communicate their needs and preferences, care staff involved the person's close relatives. One relative told us, "I am fully involved in their care and have regular planning meetings with social services, their community psychiatric nurse and the manager." Another relative told us, "A few weeks ago I was given a copy of the latest care plan to comment on, I had no problems with it, it covered everything needed."

We saw that staff had a handover at the beginning of each shift to share the care a person had received and if there had been any changes to their condition or care needs. One member of care staff told us that they found the shift handover very useful and added, "If I have been away for a longer period of time I ask the senior staff for a more detailed update."

Care staff told us that they had a thorough knowledge of the people they cared for and their individual support needs. They spoke of people who had lost the ability to communicate verbally or were unable to find the right words to describe their needs. Staff told us that each person had a communication plan that provided information on non-verbal cues and the use of body language. They said this helped understand the best way to communicate with the person and made them aware of the triggers that may upset the person. For example, we saw recorded the actions staff should take to support a person who did not like noisy environments.

Two visiting social care professionals spoke highly of the care staff for their knowledge and understanding of the care needs of the person they had come to visit and how the person's overall wellbeing had improved. One said, "Staff have turned her round, they've helped her obesity problem and now they have special equipment in place to help maintain her mobility, a hoist and a purpose built wheelchair." We saw that this person was now able to spend time in the garden.

There were three external enclosed areas accessible to people. One had raised decking with garden furniture and we were told that this was the designated smoking area for people who lived at the service. Another was an enclosed garden area off one of the lounges. In the third area we found that two people kept chickens and ducks there. One person told us about the pleasure they got from looking after them, "I get a buzz out of them. They keep me going." However, despite the service having extensive grounds we did not see any accessible garden areas for people who did not smoke or look after the chickens and ducks.

We heard a person in the lounge call out, "Please can someone wipe my eyes." A member of care staff who was reading a magazine with another person replied, "In a minute." They did not address the person by their name or attend to the person's request. A few minutes passed before another staff member entered the lounge and attended to the person's care needs. We were concerned by the way the first staff member addressed the person's request for help. They did not offer help or seek assistance from other staff members, and the person was left to wait until assistance arrived.

Some people told us that staff sometimes took them out for walks or shopping. However, one person said, "I wish I could get out a bit more. When I went to the seaside before I came here I used to see people in wheelchairs from homes like this. We've never been out as a group from here. You'd think once a year we could." A relative told us, "They do take her shopping occasionally the last time was a couple of months ago."

We met with one of the two activity coordinators. They told us that they had no previous experience of the role prior to

Requires Improvement

Is the service responsive?

being appointed to post. However, they had been supported to attend a reminiscence workshop and dementia awareness training and this had helped them understand how they could support people living with dementia. We asked why there were no obvious signs of activities taking place. They said it was difficult to organise group activities, that people needed one to one support. They said, "I don't plan my day, it depends on how the residents are when you come in. I play it by ear." Later we saw that they were not making best use of their time to support people as they were sat in their office sewing labels on people's clothing rather than engaging with people.

Relatives told us that they were welcome in the service at any time. One relative said, "I can come at any time, I work shifts." Another relative said, "If my relative wakes up and in a good mood, they call me and tell me that it would be a good day to take them out. It works well."

The service had a complaints policy. People and their relatives told us that they had never had the need to make a complaint and told us that they were aware of the process if needed. One relative told us, "I've never had a need to complain, but first I'd mention it to the manager and if nothing done, I would put it in writing." Another relative said, "I've never complained but feel I can talk to them."

Prior to our inspection we were made aware through our notification procedures of concerns raised by a relative about the care their loved one had received. We looked at the outcomes of the internal investigation and saw that appropriate action had been taken by the registered manager to address the concerns raised

Requires Improvement

Is the service well-led?

Our findings

During our inspection in July 2014 we found that the registered person did not protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to regularly assess and monitor the quality of service provided. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider sent us an action plan which set out how they planned to address the areas highlighted.

At this inspection we found that improvements had not been made to the quality and safety of the service. For example, we found insufficient evidence to support the provider's claim that quality monitoring system had been embedded into the service. We found that the daily cleaning checklist was completed for all bedrooms. However, our observations identified that these were not effective. We saw that the provider had undertaken a building audit in October 2014, however we found no evidence that the actions had been completed to address areas that were in need of attention.

The medicine fridge temperature had not been recorded for 12 out of the previous 24 days. On one occasion it was recorded as 32 degrees. The normal range is between two and eight degrees. No action had been taken by staff to store the medicines at a safe temperature. The provider's medicine policy clearly states that if the fridge temperature falls out of range the medicines should be put in a sealed container and stored in an alternative fridge. The registered nursing staff had not followed this guidance. This meant that systems and processes were not operated effectively.

There was no regular programme for staff meetings and their frequency was inconsistent. Where areas of concern had been identified and shared with staff, such as medicines management and cleanliness there was no recorded evidence of actions to be taken and progress made with these actions.

We found no documented evidence that staff had received supervision or an appraisal. Some of the staff we spoke with could not recall having had supervision in the last six months. The registered manager told us that they could not commit to regular supervision for all staff and they intended to introduce a new procedure where staff would receive supervision from a group leader, but this was still at the planning stage.

We looked at two care plan reviews undertaken on 13 February 2015. We noted that several errors and problems had been identified in the care plans, but these had not been actioned. There was no evidence that improvements to the quality of the care plans had been made.

An untoward accident and incident log was maintained by the registered manager. Incidents were investigated and the outcomes were recorded.

Overall, there was no evidence of continued improvement and evaluation of the service and the provider had not made sufficient improvements and continued to be in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because systems and processes were not operated effectively to assess, monitor and improve the quality and safety of the service.

People and their relatives told us that the registered manager was accessible. One person said, "The manager is great, always cheerful, always something to say." Another person said, "Always comes and has a natter with me nearly every day." One relative said, "The manager is pretty good, you can talk to her."

A visiting social care professional told us that the registered manager and their deputy were approachable and made themselves available to speak with them. This comment was supported by care staff who said the registered manager was approachable and if they were unsure about anything they could ask them.

Staff had access to a whistleblowing policy. Since our last inspection we had received two whistleblowing concerns from staff who worked at the service. However, we were unable to discuss with them if changes had been made since they had raised their concerns as both staff were no longer employed by the provider. Other staff confirmed that there was a whistleblowing policy and described how they would deal with any behaviour or incident that they

Requires Improvement

Is the service well-led?

witnessed which caused them concern. A member of care staff said, "We are as bad if we don't report it." We saw a copy of the whistleblowing policy in the registered manager's office.

The provider had a mission statement and staff had access to a resident's rights policy that included guidance on respect, dignity, privacy, choice and independence. Staff understood people's rights. One staff member told us, "I like it here because it is home to them, and it is all about the residents." Another member of staff spoke about the support they received from the registered manager. They said, "Very supportive. Very hands on. If you have a problem she's there, she puts a pinny on."

We found that ten relatives responded to a satisfaction survey on October 2014. They responded that the service was mostly clean and tidy, that staff were friendly and that the service was welcoming. However, when we spoke with people and their relative's only one could recall a questionnaire and they said, "Never seen much other than a couple of tick boxes in the past." Furthermore, they could not recall ever being invited to attend a relatives or residents meeting. Relatives told us they only time they met up with other relatives was when they were visiting. They said, "Everyone really becomes part of the family, we are all on first name terms."

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 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 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **People who use the service and others were not protected against the risk of infection**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **People who use the service were not protected against the unsafe management of medicines.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision **Systems and processes were not operated effectively to assess, monitor and improve the quality and safety of the service.**