Woodland Healthcare Limited

Mr 'C's

Inspection report

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Website:

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Ratings

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

Overall summary

Mr 'C's is registered to provide nursing care and support to 40 people who may have dementia care needs.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

This inspection took place on 19 and 25 August 2015 and was unannounced. There were 24 people living in the home at the time of the inspection. People had a range of needs with fourteen people requiring residential care and ten people requiring nursing care. Some people were independent, other people were being nursed in bed, and five people were living with dementia.

The service was last inspected on 20 August 2014 where we identified the provider was not meeting the regulations in relation to records. The provider sent us an

Summary of findings

action plan and confirmed in July 2015 they had completed the required actions to meet the regulations. At this inspection, we found sufficient action had not been taken in relation to the concerns identified at the previous inspection.

Prior to this inspection, we received safeguarding concerns from the local authority. Concerns included a lack of monitoring of blood sugar levels for people with diabetes, weight loss, skin care, records in place for monitoring people's health and wellbeing not being completed, and referrals to healthcare professionals not being made in a timely way.

Shortfalls in the assessment, planning and delivery of care and treatment meant people may not always be kept safe. There was no system for ensuring that people at risk had been checked on regularly. People's fluid intake was not recorded in a way that ensured people were having enough to drink and could place people at risk of dehydration. Weights were not being monitored and recorded in a way that addressed the risk of people losing weight. Where people were at risk of pressure sores, there were no records to evidence they were repositioned in line with their care plan. Records relating to pressure sores were unclear. One person's diabetes was not well managed. We have made safeguarding alerts to the local authority about these concerns.

Prior to the inspection, a visiting healthcare professional raised concerns about staffing levels. The building layout is over four floors with long corridors. When a staff member needed assistance they said it could take some time to find another staff member, which meant people had to wait. People, relatives, healthcare professionals, and staff told us there were not enough staff at times. One person said the staff did not always assist them to the toilet in time. We observed staff were very busy during our inspection. Although the registered manager had carried out an assessment of staffing in April 2015, there had been some changes and they said this needed to be reviewed.

People's needs had been assessed and care plans were reviewed monthly and updated when their needs changed. Where updates had been added, these were not always clear and dated which meant it was difficult to follow. This meant people's care plans did not always accurately reflect people's needs. The registered manager told us they had recently introduced a new care plan format.

People's social and emotional needs had not been fully assessed and care plans had not been developed to ensure people's needs were met. Some people spent most or all of the day in their bedroom. There was no evidence that activities or engagement had been designed to address issues such as preventing isolation. One person said "I have tried going downstairs but I found it depressing as they all seem to go to sleep or outside to smoke". People living with dementia did not benefit from individual activity plans to ensure they had meaningful activities to promote their wellbeing. Staff told us the activities co-ordinator was in the home and provided activities every Saturday from 1.00pm to 5.00pm. The Provider Information Return said the provider was looking to link care planning and the activities provided.

People spoke highly of the care they received. They said "Everything is good here… the staff are lovely and so patient" and "I love it and if I didn't I'd go somewhere else.' Staff talked about the people in their care affectionately. They demonstrated they knew the people they supported. People were clean, looked well cared for and well dressed. People were supported to make choices about the clothes they wore. One relative told us staff always made sure their husband's clothes were colour co-ordinated which was important to them.

People enjoyed the food in the home. One person said "There's a very good chef…we get two choices daily…I've enjoyed all the meals here…he's very nice to talk to, he comes and has a chat with me". The chef had been trained to cater for people with specific dietary needs.

There were systems in place to assess, monitor, and improve the quality and safety of care. The director visited the service every two to three weeks. The registered manager had identified records were still not being completed accurately and was taking action to make improvements.

There was an open and supportive culture. People were comfortable when speaking with the registered manager and smiled at them. One person commented "They are so efficient". A visiting healthcare professional said they

Summary of findings

found the registered manager acted professionally, was genuine, listened to them, and cared about people. Staff found the registered manager to be very approachable. Comments included “They’re brilliant, a good manager” and “I can approach the manager whenever I want to”. However, two relatives told us they were not happy with the registered manager’s attitude and response to their comments and concerns. We discussed this with the registered manager who was disappointed to hear that people felt this way. They told us they would follow this up by speaking with everyone involved in the home.

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?
The service was not always safe.

Poor monitoring and record keeping placed people at potential risk of harm.

Staff were not deployed in a way that ensure people always received care when they needed it.

People said they felt safe and secure at the home but concerns were raised about the lack of security at the home.

Requires improvement

Is the service effective?
The service was effective.

People were asked to give consent before care was carried out. Where people lacked capacity to make decisions, meetings had been held to ensure decisions were made in their best interests.

Staff had a thorough induction and regular training to make sure they knew how to meet people's needs.

People spoke highly of the food at the home. The chef knew how to cater for specific dietary needs.

Good

Is the service caring?
The service was not always caring.

Staff were not able to provide care in a way that ensured people's dignity and treated them with respect at all times.

People were positive about the caring attitude of the staff.

Staff talked about the people in their care affectionately. They demonstrated they knew the people they supported and were able to tell us about people's preferences and personal histories.

Requires improvement

Is the service responsive?
The service was not always responsive.

People's changing needs were not always clearly identified in the care plan.

People were not always protected from the risks of social isolation.

People were not always enabled to carry out person centred activities that encouraged them to maintain their hobbies and interests.

Requires improvement

Is the service well-led?
The service was not always well-led.

Requires improvement

Summary of findings

People were not always protected from unsafe care because accurate and up-to-date records were not maintained.

The provider had systems in place to assess and monitor the quality of the service.

Staff spoke highly of the manager and confirmed they were approachable. Staff placed trust in the management and described it as supportive.

Mr 'C's

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

This inspection visit took place on 19 and 25 August 2015 and was unannounced. The team included one adult social care inspector, a specialist advisor, 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. Their area of expertise was care for older people living with dementia.

Before the inspection, the provider completed a Provider Information Return (PIR). This was a form that asked the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We contacted the local authority to ask for their feedback about this service.

On the day of our visit, 24 people were using the service. We used a range of different methods to help us understand people's experience. We spoke with eight people and seven relatives. We spoke with the registered manager, deputy manager, nurse, and nine staff. We received feedback from three visiting health professionals.

We looked at six care plans, medication records, staff files, audits, policies and records relating to the management of the service.

Requires improvement

Is the service safe?

Our findings

We found people were not always receiving safe care. Prior to this inspection, we received safeguarding concerns from the local authority and the ambulance service. Concerns related to a lack of monitoring of blood sugar levels for people with diabetes, weight loss, skin care, records in place for monitoring people's health and wellbeing not being completed, and referrals to healthcare professionals not being made in a timely way. The concerns had been closed to safeguarding. Concerns relating to one person's weight loss were partially substantiated because the service had not kept appropriate records.

During our inspection we looked at these types of care and treatment to see if people were receiving safe care.

Risk assessments were in place for people who needed regular checks as they could not use the call bell. However, there was no evidence these checks had been carried out. For example, one person was assessed as needing hourly checks due to a risk of choking and falls. The nurse told us they checked people on their rounds and staff were responsible for a group of people. Staff said they checked people when they passed bedrooms, provided care, or when food or drink was served but not at specific times. This meant checks were not carried out consistently, there was no system for ensuring that people at risk had been checked on, and people may have been placed at risk.

Fluid charts did not show people were being supported to have enough to drink. For example, one person's care plan told staff to offer two litres a day. The fluid charts did not show that two litres of fluid had been offered. Two charts had been added up with the wrong total. Charts did not always show when people had been offered drinks. One drink was given to a person at 11.00am but this was not added to the chart until 3.00pm. This means people's fluid intake was not always recorded accurately. Staff could not assure themselves that people were having enough to drink.

Some people had been assessed as being at risk of losing weight. In order to identify weight loss, these people were being weighed. For example, one person had lost weight. Staff had made a referral to the person's GP in July 2015. The GP's advice was to encourage food. The person had been weighed the day before our second inspection visit and had lost a further 2.3 kg. We discussed this with the nurse who told us they would contact the GP and ask for a referral to a dietician. This had not been done prior to our discussion in spite of the continuing weight loss. Another person had lost weight and their care plan said to check their weight weekly. In July 2015, this person's weight was not recorded for 15 days. Their weight had increased. However, the lack of monitoring, and lack of timeliness in taking appropriate action may have put people at risk.

Risk assessments identified people who were at risk of pressure sores. One person had pressure sores this year. At the time of our inspection this person's pressure sores had healed. This person's care plan said to reposition them every two hours and carry out daily visual checks of their skin. There were no records to evidence this person was repositioned every two hours. Records did not show daily skin checks were being done. The pressure sores had healed in June 2015. However, in July 2015 records showed the wound had reopened. It was difficult to follow when pressure sores had developed. For example, records were unclear; one record said it reopened on one date, another record indicated it had developed before this date. The body maps were cluttered and unclear. For example, one body map showed four different skin problems. Poor records meant that staff could not reassure themselves that risks to this person's skin were being monitored and managed appropriately. The poor documentation, and lack of daily skin checks, leading to delays in treatment placed people at risk of pressure sores in the future. Another person was prescribed topical creams for their skin. Charts were in place for staff to sign when they applied the creams. However, these had not been consistently signed. This meant staff could not be sure that creams had been applied regularly and could place people at risk of skin breakdown.

One person's diabetes was not well managed. On one occasion, they had a very low blood sugar level. The nurse telephoned the GP who told them to check blood sugar levels more often that day. Records showed the blood sugar level was not checked again for over six hours. The nurse told us they had checked the levels more often than this but there was no evidence this had been done as they had not made a record. If low blood sugar is untreated there is a risk of the person losing consciousness and/or having a seizure. After supper, the person vomited. There

Is the service safe?

was no record of their blood sugar level after this event. During the evening, records showed staff found the person "fitting on bed, unconscious, rolling eyes". Paramedics were called and the person was admitted to hospital.

Where risks had been identified, action had not been taken to reduce or remove the risks. For example, after the incident where a person's diabetes was not well managed, there continued to be a lack of monitoring of the person's blood sugar. There was no clear guidance in the care plan for the management of high or low blood sugar levels. The care plan stated this person's bloods sugar levels were to be checked twice a week or more often if required. Records showed this did not always happen.

Daily care records were kept for each person. One record was blank for the three days before our inspection visit. Later that day we saw the record had been signed as completed. The staff member who had signed for the previous three days had not been in work on one of those days. This showed records did not accurately reflect the care given.

Shortfalls in the assessment, planning and delivery of care and treatment meant people may not be kept safe. We have made safeguarding alerts to the local authority about these concerns.

This was a breach of Regulation 12 (1)(2)(a)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Prior to the inspection, a visiting healthcare professional raised concerns about staffing levels as it had taken them some time to find staff in the building. People were concerned about the length of time it took for call bells to be answered and for care to be provided. The building layout is over four floors with long corridors. Two staff told us when they needed assistance, it could take some time to find another staff member, which meant people had to wait. One of these staff members commented "It is such a big building, you can't always find someone".

People told us they often had to wait for assistance. One person said the staff did not always assist them to the toilet in time. Comments included "There's not enough staff for the number of people" and "They have to work very hard and they're always in a rush and off like a whirlwind and no-one ever has the time to sit down and talk". We saw staff, after attending one person in their bedroom, left their call bell out of reach. This person was being nursed in bed, and spoke very quietly. The person would not have been able to get help if they needed to.

Four staff told us they had time to meet people's physical needs. Two staff told us more staff were needed. Comments included "There aren't enough staff on duty" and "Call bells aren't necessarily being answered". Another, two staff said they felt people would benefit from another member of staff in the morning. We observed staff were very busy during our inspection. For example, two people were served their lunch in the dining room and began to eat. Then, one person needed the assistance of two care staff to go to the toilet. This meant the delivery of meals to the dining tables stopped until other staff came to the dining room five minutes later.

We observed the nurse who was the person in charge on the first day of inspection was very busy. They were speaking with people, relatives, staff, and visiting healthcare professionals. They made and received phone calls including calls to the GP about one person who was unwell. They administered people's medicines and attended to people's needs. This meant they were not able to plan their day and were reacting to things as they happened.

We spoke with the registered manager about staffing levels and the skill mix. The registered manager is at this home two and a half days a week, and supports another home on two and a half days a week. They told us they had carried out an assessment of staffing levels in April 2015, and had assessed peak times during the day when staff were needed in July 2015. They said this needed to be reviewed because a number of staff had left and the needs of people living in the home had also changed. New staff had been employed, and the registered manager said they always ensured they worked with more experienced senior staff. The rota confirmed the nurse was on duty with four care staff during the day and there was a mix of experienced staff with new staff. Care staff provided care and support, delivered meals and drinks to people in the dining room and their rooms. They were responsible for organising activities and helping people to engage socially. In addition there was a receptionist, chef, and two housekeepers. Two care staff were on duty overnight and were supported by the nurse who covered three homes in the local area.

Requires improvement

Is the service safe?

Although the registered manager had assessed staffing levels, people did not always receive assistance at the times they needed it. It was not clear whether the delays were due to a lack of staff or the building layout and deployment of staff.

This was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People said they felt safe and secure at the home and they trusted the home to care for them. However, relatives and healthcare professionals raised concerns about the lack of security at the home. The front door was unlocked at times and one healthcare professional told us how they entered the home and were able to walk freely around the premises, without being challenged by staff. There was a keypad on the door which meant it was locked when shut properly. The registered manager told us people did not always close the door after they had been out. During our visit, the registered manager put a sign up asking people to close the door. Letters were also prepared to go out to people. Since the inspection, the registered manager told us they had arranged for the maintenance team to visit the home and see if the door could be adjusted to close automatically.

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines. People had locked storage in their bedrooms for their prescribed medicines. The nurse on duty gave people their medicines. Records of medicines administered confirmed people had received their medicines as they had been prescribed by their doctor to promote good health. The local authority trust carried out a medicines audit on 29 July 2015. They told us they were happy with the improvements made.

People were protected from the risk of abuse as staff had received training in safeguarding people. Staff understood the signs of abuse, and how to report concerns within the service and to other agencies. Staff told us they felt confident the registered manager would respond and take appropriate action if they raised concerns.

Safe staff recruitment procedures were in place. Staff files showed the relevant checks had been completed. This helped reduce the risk of the provider employing a person who may be a risk to vulnerable people.

Where accidents and incidents had taken place, the registered manager reviewed these to ensure the risk to people was minimised. For example, falls were recorded on a chart each month. This was monitored to identify any trends. Where two falls had taken place at the same time of day, the registered manager had followed this up with staff to see if there was a reason for this.

There were arrangements in place to deal with foreseeable emergencies. For example, a fire box was stored by the front door. This contained blankets, torches, water, and contact numbers. Each person had a personal emergency evacuation plan that told staff how to safely assist them. The registered manager had arranged for people to be moved to alternative accommodation in the event of a fire.

Good

Is the service effective?

Our findings

Most people who lived in the home had capacity. Staff asked people for consent before delivering care. General mental capacity assessments were in place but had not been made for specific decisions. The Mental Capacity Act (2005) (MCA) provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. The registered manager had some understanding of the MCA and told us they had booked to attend further training to make sure they were following the MCA appropriately. Where one person lacked capacity and there were concerns about them, the registered manager had met with family and healthcare professionals to discuss how to proceed in their best interests.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. This includes decisions about depriving people of their liberty so that they get the care and treatment they need, where there is no less restrictive way of achieving this. The registered manager had made the appropriate DoLS applications to the local authority. One person was being monitored to keep them safe whilst the DoLS application was in progress.

Staff told us they were happy with the training they had received and felt skilled to meet the needs of the people in their care. Comments included "There's lots of training" and "You only have to ask and it's arranged". Staff received regular training to make sure they knew how to meet people's needs. Each staff member had an individual plan to identify their training needs.

Additional training was completed in relation to end of life care, bereavement, and medical conditions to meet people's specific needs. The registered manager had recently recruited new staff. They carried out a review of staff's skills and knowledge on their first day so they could identify their training needs. There was a comprehensive induction programme for these staff which included face to face training and observations. Staff were encouraged to complete diplomas in social care.

Staff had received regular supervision. During supervision, staff had the opportunity to sit down in a one-to-one session with their line manager to talk about their job role and discuss any issues. One staff member commented "We have good support".

People spoke highly of the food at the home. Pictures of food were available to assist those who had communication difficulties. One person said "There's a very good chef…we get two choices daily…I've enjoyed all the meals here…he's very nice to talk to, he comes and has a chat with me". The chef had spoken with people about their food preferences.

Some people had specific dietary needs. The chef had been trained to cater for those needs. For example, where people had a pureed diet, the different elements of the meal were separately set out with separate spoons. Staff who assisted people to eat explained what the foods were and enabled the person to communicate a choice about which foods they would like. The speech and language therapist (SALT) told us staff followed their guidelines in relation to food and drink. The service was quick to react when they had concerns about one person's swallow. They sought advice from the SALT and ensured the person received appropriate medical treatment.

People we spoke with told us they got prompt medical attention and relatives said they were kept informed. During our inspection, one person had a raised temperature. The nurse arranged for the GP to carry out a home visit. The GP attended later that day. After the visit, the nurse told staff the GP's advice and asked staff to check this person regularly.

Requires improvement

Is the service caring?

Our findings

People were very complimentary about the staff working at this home. However, staff were not always able to provide care in a way that ensured people's dignity and treated them with respect. For example, one person had been left in pain because staff were not available to meet their needs in a timely manner, and other people did not have their needs met because staff were not available to do this. Some people had to wait for their meals because staff were not available to deliver their meals to them.

People spoke highly of the care they receive. They said "Everything is good here… the staff are lovely and so patient" and "I love it and if I didn't I'd go somewhere else.' Relatives said "The staff are lovely…she has a very good rapport with them", "She loves it here…she wants it all settled that she's staying here" and "The staff are all friends, they're brilliant. It's a happy atmosphere when I walk in".

A visiting healthcare professional told us staff were really helpful and genuinely cared about people.

Letters and cards received from relatives thanked the staff for the care provided. Comments included "Excellent, caring and friendly" and "Lovely, attentive staff". Several cards thanked staff for the end of life care they had provided. Comments included "Thank you for your sensitivity... We were made to feel at home and it was a great privilege to have that special time at the end" and "Thank you for your support at a difficult time".

Staff were pleasant and friendly. They treated people with respect and kindness. For example, staff addressed people with their preferred name and spoke with respect. People responded to this by smiling and engaging with staff in a friendly way.

Staff talked about the people in their care affectionately. They demonstrated they knew the people they supported. They were able to tell us about people's preferences and personal histories.

Interactions showed staff were patient when meeting people's needs. For example, when staff assisted one person to eat their lunch, they spent time sitting next to the person and encouraged them to eat independently. They gave assistance when requested. All of this was done at the person's pace, without rushing them.

Staff listened to people and talked to people in a way they understood. For example, one person was not able to communicate well verbally. Staff knew this person well and understood them. They spoke kindly and used some humour to engage the person, who responded positively.

People were able to maintain their privacy. For example, people who were able to move around the home independently had a key to their bedroom. They chose whether to remain in their rooms or join others in the lounge. Staff were careful to close doors when carrying out personal care to respect people's privacy.

One staff member had completed the National Dignity Council's "Dignity Champion" course. Their role in the home was to listen to people and be a voice for them. For example, one person wanted to move to a different bedroom as they didn't want their window to face the church. The champion listened to them and showed respect for this person's wishes. They were offered a different room which they accepted.

People were encouraged to do be as independent as possible. One person said "I do everything I can but if you can't they do it all for you".

People were clean, looked well cared for and well dressed. People were supported to make choices about the clothes they wore. One relative told us staff always made sure their husband's clothes were colour co-ordinated which was important to them. The hairdresser visited regularly and there was a hairdressing and beauty treatment room in the home.

People and their relatives told us they had not been involved in planning their care. They did not seem concerned about this. One person said "I know I have a care plan but I can't remember ever seeing it or signing it". A relative said "I haven't been involved but I'm happy that they get on with it and know what to do". Care plans were not signed by people or their representatives. Staff told us they spoke with people and carried out observations to determine the care needed. The registered manager told us they would ensure people and their representatives were involved in future as they had introduced a new care plan format.

Relatives and friends were welcome at any time. Some families spent up to seven or eight hours a day at the

Requires improvement

Is the service caring?

home. They could have privacy in individual bedrooms or in the lounge or dining areas on the ground floor. One relative told us they enjoyed having lunch with their spouse at the home, at the weekend.

Requires improvement

Is the service responsive?

Our findings

People's needs had been assessed and care plans developed. People's care plans were reviewed monthly and updated when their needs changed. However, where updates had been added, these were not always dated which meant it was difficult to follow. The information in the monthly reviews had not always been used to update the main section in the care plan. This meant people's care plans did not always accurately reflect people's needs. For example, one person's spouse had passed away five months ago. There was no reference to this in the main care plan which frequently mentioned the spouse's involvement in this person's life. There was no detailed information so that staff knew how to support and respond to this person or consider their feelings. We discussed this with the registered manager who told us they had recently introduced a new care plan format which would be updated on the computer and printed out if there were any changes.

People's social and emotional needs had not been fully assessed and care plans had not been developed to ensure people's needs were met. Some people spent most or all of the day in their bedroom. There was no evidence that activities or engagement had been designed to address issues such as preventing isolation. One person said "I have tried going downstairs but I found it depressing as they all seem to go to sleep or outside to smoke". Staff told us they would have a chat with people in the afternoons when it was not so busy.

Five people were living with dementia. They did not benefit from individual activity plans to ensure they had meaningful activities to promote their wellbeing. Care plans contained information about the person's life, the work they had done, and their interests. However, this information had not been used in their day to day lives to develop individual ways of stimulating and occupying people.

The television was on all day in the shared lounge but not everyone was watching it. One person told us "There's not enough to do. I watch television all day but some days it's too loud". They went on to tell us they liked to paint. We asked a staff member if they had enabled this person to do some painting. They told us they didn't do painting and the activities co-ordinator would be in on Saturday. Activities were available every Saturday from 1.00pm to 5.00pm.

A newsletter called "Mr. C's Express" was produced every month. The August edition gave information about the visiting hairdresser and two visiting musical entertainers. People had put their name on the lists if they wanted to attend. The service had recently held a Summer party which people had enjoyed.

Some people were more independent and able to come and go as they wished. They enjoyed spending time with each other, were comfortable in each other's company, and chatted together.

We discussed activities and isolation with the registered manager. They told us they had met with people in May 2015. People had said they didn't want activities every day but would like to have themed events. However, new people with a range of different needs had moved into the home since this time. The Provider Information Return said the provider was looking to link care planning and the activities provided.

People knew how to raise concerns or complaints. There were large notices in the entrance and around the home inviting comments or concerns. There were also contact details for an independent person within the company who would discuss concerns. Records showed formal complaints had been investigated and responded to. There was one complaint which was on-going and yet to be resolved.

Requires improvement

Is the service well-led?

Our findings

At the previous inspection carried out in August 2014, we identified the provider was not meeting the regulations in relation to records. The provider sent us an action plan and confirmed in July 2015 they had completed the required actions to meet the regulations. At this inspection, we found sufficient action had not been taken in relation to the concerns identified at the previous inspection. We discussed this with the registered manager who told us the improvement work was on-going.

People were not always protected from unsafe care because accurate and up-to-date records were not maintained.

This was a breach of Regulation 17(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us they had faced significant challenges over the past year which included opening the home as a new service, caring for people with complex needs, and trying to recruit and retain the right staff. They were keen to provide a good service and committed to making the required improvements.

The registered manager managed two nursing homes owned by this provider. They split their time between the two homes, spending two and half days a week at Mr C's. The nurse on duty was the person in charge in their absence.

There were systems in place to assess, monitor, and improve the quality and safety of care. The director visited the service every two to three weeks. Audits were carried out by a manager from another home within the group. The local authority had recently carried out a quality audit and sampled two care plans and medicines. However, the provider had not identified the issues with staffing we found during our inspection.

The provider's system had identified records were not being completed accurately. Records for the staff meeting held in July 2015, showed the registered manager had spoken with staff about the importance of recording what they had done. They told us they planned to hold training workshops for staff to make sure records were completed correctly. If improvements were not made, they said they would address this individually with the staff concerned.

People's individual charts and records were stored in a central locked cabinet. Following our inspection, the registered manager told us they had placed all records and charts into people's bedrooms so that staff recorded what they had done straight away. The registered manager told us they would monitor these records with support from the nurse.

People were comfortable when speaking with the registered manager and smiled at them. One person commented "They are so efficient". A visiting healthcare professional said they found the registered manager acted professionally and was very appropriate with them. They added that the registered manager was very genuine, listened to them, and cared about people. However, two relatives told us they were not happy with the registered manager's attitude and response to their comments and concerns. We discussed this with the registered manager who was disappointed to hear that people felt this way. They told us they would follow this up by speaking with everyone involved in the home.

Staff found the registered manager to be very approachable. Comments included "They're brilliant, a good manager" and "I can approach the manager whenever I want to". Staff said the team worked well together. Comments included "We all get on with one another" and "We offer support to each other". At the end of their shift, a staff member said goodbye and the registered manager thanked them for their support that day.

The registered manager wanted to develop and improve the service. They accessed resources to learn about research and current best practice. For example, they had obtained latest research and information from recognised societies and associations about people's medical conditions. They received the monthly updates from the CQC and had subscribed to a monthly care magazine. They attended care conferences and forums with other providers to share good practice.

The registered manager had notified the Care Quality Commission of all significant events which had occurred in line with their legal responsibilities.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not provided to people in a safe way. Regulation 12 (1)(2)(a)(b)(c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Records relating to the care and treatment for each person were not accurate and up to date. Regulation 17 (2)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Sufficient numbers of staff had not been deployed to make sure people's care and treatment needs were met. Regulation 18 (1)