Care Quality Commission

Firstsmile Limited

Kibworth Court

Inspection report

Kibworth Court Residential Care Home
Smeeton Road
Kibworth
Leicestershire
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Date of inspection visit: 8th and 9th June 2015
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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 8 and 9 June 2015 and was unannounced.

At our last inspection on 9 June 2014 the service was meeting the regulations.

Kibworth Court is a 40 bed care home located in the village of Kibworth Beauchamp in Leicestershire, and is for men and women with age related needs including dementia. Accommodation is arranged over two floors. Access to the upper floor was by stairs or lift.

There should be a registered manager at the service. 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. At the time of our inspection the manager at the service had been in post for three months and was just beginning the formal registration process.

Summary of findings

Since the new manager had been in post staff members told us that positive changes had been made. These included the introduction of staff supervision. We found that although there appeared to be a lot of work in progress and ideas in development there were a number of concerns that needed addressing urgently.

People told us they were happy at the service and that staff were nice. Staff spoke kindly to people when they supported them with tasks. However, people received little interaction from staff and there were no regular activities that took place.

Staff told us how they were in the process of reassessing people's needs and completing care plans to ensure that their care needs were met. We found that at the time of our inspection that some people were not receiving care and treatment that met their needs.

People told us that they enjoyed the food at the service, although relatives told us it appeared bland. We saw that people had access to drinks and snacks throughout the day. People were not always provided with appropriate assistance with their meals.

Decision specific mental capacity assessments had not been carried out where there had been a concern identified about a person's capacity. The service had made a decision relating to a person's care and treatment and not acted in accordance with the Mental Capacity Act.

Staff told us that they felt well supported in their roles. However, they had not received sufficient training at the service to enable them to fulfil their roles. Staff had a good understanding of how through their work they were able to respect people's privacy and dignity and promote their independence.

Quality assurance systems that were in place had failed to identify the concerns that we found and did not identify or manage risks associated with the environment. Records were not completed accurately or stored securely to ensure that information was kept safe.

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

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 consistently safe.

Staff at the service had a good understanding of safeguarding and knew how to report any concerns. Risks had not always been identified to ensure that people were protected from harm.

Requires improvement 

Is the service effective?
The service was not consistently effective.

Decision specific mental capacity assessments were not being carried out. There was sufficient food and drink made available but people were not always provided with the support that they needed during mealtimes. People told us they were able to access health professionals as they needed. The provider could not demonstrate that health professional's advice had been sought or followed.

Requires improvement 

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

People told us that staff were nice. Staff had a good understanding of how to promote people's independence and respect people's privacy. We saw that people were not always offered choices and staff engagement with them was limited to while they were carrying out tasks.

Requires improvement 

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

People's care needs had not been appropriately assessed. People's care needs were not always being met. There were very limited activities available for people to participate in. Staff meetings were used as an opportunity to discuss ways to improve the standard of care provided.

Requires improvement 

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

Records had not always been accurately completed and were not securely stored. Quality assurance audits had not always identified concerns. Staff and relatives felt that the manager was approachable. Staff felt that improvements to the service had been made.

Requires improvement 

Kibworth Court

Detailed findings

Background to this inspection

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

This inspection took place on 8 and 9 June and was unannounced.

The inspection was carried out by three inspectors and an expert-by-experience on the first day and one inspector returned to complete the inspection on the second day. 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 for older people with dementia.

We contacted the local authority who had funding responsibility for people who were using the service to obtain their feedback about the service.

We used the short observational framework for inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We completed a SOFI observation for three people who used the service.

We spoke with 15 people that used the service and five people that were visiting relatives at the service. We spoke with the provider, the manager of the service, the deputy manager, a senior staff member, three care staff and the cook. We looked at the care records of four people that used the service and other documentation about how the home was managed. This included policies and procedures, staff records and records associated with quality assurance processes.

Requires improvement

Is the service safe?

Our findings

One person that we spoke with told us that they did not feel safe at the service. They said that this was because they did not have bed rails in place and we found this to be the case. They had been discharged from hospital with a risk assessment that identified they required bed rails but they had been at the service for three nights without them. The service had not responded to the hospital's risk assessment and had not undertaken a risk assessment of their own. Rather they had responded to the person's concerns by placing a wheelchair against the bed to provide psychological support. This was not a safe alternative. This person had sustained a previous fracture and had been discharged before it had healed on a 'non-weight bearing pathway'. There was a high risk that this person may have fallen out of bed and they could have sustained a serious compounding or new injury. The manager assured us that the situation would be rectified urgently.

We also found that this person's allergies to certain types of medicines had not been identified by the provider and so there was a risk that they person could have been provided with medicines which may have had harmed them.

These and other maters referred to later in this report constituted a breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 9: Person-centred care

Other people who we spoke with told us that they felt safe at the service. Relatives also told us that they felt that people at the service were safe. One relative told us, "Whilst I think the place itself looks a bit jaded and in need of repair in places, for instance the paper is coming away in [my relatives] room, I do feel [my relative] is completely safe in here." A person who used the service told us, "I think in places it could do with a good fettle [meaning a thorough clean-out] but generally it is OK in here."

We saw that there was some ongoing refurbishment work in the reception area of the service being carried out. We discussed this with the provider who told us about the plans that were place for the rest of the year. These included new flooring throughout bedrooms and corridors within the service and new boilers and hot water cylinders.

The manager told us how they were working on making the environment at the service more dementia friendly. We saw that one corridor had been decorated with a seaside theme with a sensory wall for people to touch.

We found checks had been carried out on equipment that was used and that portable appliance testing had taken place. We saw that where required window restrictors and hot surface protection was in place and although one radiator had the top of the protection missing, this had been addressed by the end of the day. We found some areas of the environment that posed a risk without sufficient assessments being in place. For example there were several places where the floor covering was missing particularly around the fire exits, some toilets did not have seat covers and some did not have a seat. All these areas were accessible to and used by people who used the service. Also, all stairwells were open to people that used the service and there were no assessments around the risks to people that this posed.

We found that checks on the hot water taps were carried out on a monthly basis but we were concerned that water out of hot taps did not appear to be hot. Records showed that hot water taps were between 21 and 26 degrees. This meant that staff were required to carry very hot water from the kitchen to assist to wash people in their rooms. This was also an issue in relation to infection control. The provider's legionella risk assessment stated that all hot water temperatures should be maintained above 46 degrees and that this should be monitored and recorded monthly. Water temperatures were being recorded monthly but they were not at the recommended temperatures. We discussed this with the provider who told us that this would immediately be addressed.

We saw that there was a progression evacuation procedure in place for staff to follow in the event of an emergency. However this did not contain information about people's individual needs in the event of an emergency. The manager told us they were in the process of introducing personal emergency evacuation plans and that at the time of our inspection they had completed them for two people.

Staff had a good understanding of the various types of abuse and knew how to report it. There was a safeguarding policy in place that contained some good descriptions of different types of abuse. It contained reference to CQC, but provided no contact details. There was also no reference to the local safeguarding authority or the police. This is where

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Is the service safe?

safeguarding concerns are reported to externally as the local safeguarding authority have the responsibility to investigate safeguarding concerns. There was a whistleblowing procedure in place that provided advice to staff about the protection that was available to whistle-blowers and how to report issues internally. However there was no advice about reporting issues externally or how concerns could be escalated.

We received mixed feedback from relatives about if they were informed following any incidents at the service that had occurred. One relative told us, "The home was very quick in informing me when [my relative] had a fall and they seemed to do everything right, getting [my relative] to hospital and that." Another relative told us, "They didn't ring when [my relative] had a fall but they did when they had a bleed."

We looked at the records of accidents and incidents that had taken place. We found that accidents and incidents had been recorded and initial action taken by staff had been documented. We saw that within the incident forms body maps were available to record people's injuries. These had not always been used. The manager told us that the completion of accidents and incidents forms was something that they had been working with staff on. We saw evidence that the importance of the completion of incident/accident forms had been discussed with staff in a meeting. We also saw that the provider had introduced a monthly analysis audit of incidents and accidents to gain a better understanding of when and why incidents had occurred.

People told us they didn't have to wait long for staff to respond when they needed them. A relative told us, "There are not enough staff as many of the residents have high needs and can be quite challenging and therefore you need more staff to cope. I think they just about manage." Staff told us they were very busy and at times there were not enough staff on to duty to meet people's needs. Throughout our inspection we observed times when there were not sufficient staff around and people had to wait for support. We saw one person who was left alone at a dining table with an apron on until 2.50pm after being assisted into the dining room at 12 noon. The person was unable to move independently. We saw that another person was sitting in their wheelchair from 9.30am until 3pm when staff assisted them into an armchair. We spoke with the senior staff member about this who confirmed that they should not have been sitting in their wheelchair. We discussed staffing levels with the manager and the provider. They told us they had identified a need to increase the staffing levels and this was something they were currently looking to do.

The provider had a recruitment policy and procedure in place to ensure that safe recruitment of staff took place. We looked at the recruitment records of five staff members. We found that relevant pre-employment checks had been carried out, however we identified that a gap in a person's working history had not been explained and that three people had started prior to the their disclosure and barring service (DBS) check being carried out. We discussed this with the manager who told us that they had risk assessed the situation and that they were satisfied that this did not pose a risk to people that used the service. This was still a concern as pre-employment checks had not been fully completed prior to people commencing their employment at the service.

We saw that there was a medication policy in place for staff to follow to ensure that people's medicines were managed safely. However, the policy referred to regular competency assessments for staff who administered medicines and these were not being carried out. It also stated that controlled drugs would be administered by first level nurses and there were no nurses at the service.

We saw that medicines were supplied from the pharmacy in a bio dose system. This is a system that reduces the risks associated with the administration of medicines. We found that medicines were not always being stored appropriately. We saw that the medication room was kept locked but we were concerned about the room temperature. We saw recordings of 25.6, 27.4 and 25.4 degrees. These are all above the acceptable limits for the storage of medicines. We saw that the fridge that was used to store medicines was being maintained at a temperature lower than the acceptable limits. We discussed this with the manager who took immediate action and amended this during our inspection.

There were processes in place to ensure that where people had time critical medicines that they were effectively managed. Appropriate processes were in place for the receipt and disposal of medicines. It was clearly marked on medication administration record (MAR) charts when a medicine had been stopped. Where medicines were prescribed as PRN [as required] and labelled as such, protocols were not in place to advise staff when to

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Is the service safe?

administer it. Where medicines were prescribed in variable doses, for example 'take one or two tablets', variable dose protocols were not in place. There was a risk that people may not receive these medicines as they needed them as there was no clear guidance in place for staff to follow.

Requires improvement

Is the service effective?

Our findings

We found there were door alarm sensors fitted on all bedroom doors at the service that could be turned on or off when they were needed. These were used as a monitoring mechanism to alert staff to people leaving their bedroom. As these were a restriction of people's freedom consent for them being used should have been sought. If people do not have the capacity to understand the use of them then a Mental Capacity Act (MCA) assessment should be carried out, a best interest decision made and consideration given to if a Deprivation of Liberty Safeguards (DoLS) referral needs to be made. The MCA provides a system of assessment and decision making to protect people who do not have capacity to give consent themselves. The DoLS are a law that require assessment and authorisation if a person lacks mental capacity and needs to have their freedom restricted to keep them safe.

Since our inspection the quality assurance manager of the service has confirmed that decision specific MCA assessments relating to the use of these door sensors have been carried out and they are in the process of completing DoLS referrals to the local authority.

There were inconsistent responses from care staff about how many people had door sensors that were in use. Records showed that two people's door sensors were being turned on at night. This was a concern as there were no records to evidence that people's consent to the use of these had been obtained. We discussed this with the quality assurance manager who told us that these people would not have the capacity to understand the use and give consent to the door sensor being used. There was no MCA assessment relating to this decision that had been carried out.

A number of people that used the service were living with dementia and not able to provide their verbal consent to all aspects of their care and support. As decision specific MCA assessments were not being carried out there was a risk that decisions were being made about people's care and support that were not in accordance with the MCA legislation.

We spoke with a senior staff member about their understanding of the MCA legislation. They told us, "We've had very basic training about MCA and DoLS. It's about whether someone can make a decision and if you don't think they can, contact DoLS. Everyone has a capacity assessment in their care plans. At the moment we don't have any best interest decisions." This was a concern as it is the responsibility of the person directly concerned with the individual at the time that a decision needs to be made that should assess their capacity to make that specific decision. Other care staff members that we spoke with did not have an understanding of the MCA or DoLS legislation. We saw that training on MCA and DoLS had been arranged for later in the year.

We saw that MCA assessments were in place in people's care records but they were not decision specific. Where it had been identified in the MCA assessment that there was a concern around a person's capacity no further action had been taken.

A staff member told us, "We have quite a few people with sensor mats by their beds." These had not always been recorded in people's care plans and there was no evidence to demonstrate that people had provided their consent to these being in place.

These matters constituted a breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 11: Need for consent.

One staff member told us, "'The training was very basic with the previous manager but [the new manager] has some really good ideas. I haven't had any training recently." They also told us, "New staff do training like fire, moving and handling and safeguarding. They have an induction booklet and a dedicated senior for support. They do some shadowing before working on their own, about three to four days depending on the person." However we spoke with a new member of staff who had never worked in care before. They had been at the service for four months and had been given induction documentation to complete. They had carried out some shadowing as part of their induction to the role. They had not received any moving and handling or hoist training and this was a task that they were being asked to carry out. We immediately discussed this with the provider who told us that they would not be carrying out any further hoisting until they had been sufficiently trained.

Another member of staff that was administering medication had not received any form of medication training since working at the service. They had worked at

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Is the service effective?

the service for three years. The manager advised us during the inspection that they had arranged medication training with the pharmacy and it was to take place before the end of the month.

Staff told us that they felt well supported in their roles and that they received supervision in both a meeting and observational form. One staff member told us, "We didn't use to have supervision but now it's about three monthly." The manager told us how they had recently worked alongside cleaning staff to demonstrate the standards that they expected staff to meet.

People told us that they enjoyed their lunch, the food was warm enough and they had sufficient to eat. We saw that there were positive comments from people that used the service made about the food during a recent meeting. Relatives told us that the food was bland. One relative told us, "The food is bland, like school dinners." A tea trolley was taken around in the morning and during the afternoon. In addition to tea and coffee it also included a choice of milkshakes, biscuits and peeled fresh oranges. Light snacks were also available for people in the lounges at other times.

A staff member told us that people completed a food preferences form when they first started to use the service but they told us these had not been updated since. We spoke with the cook who told us that when they did new menus they tried them out for about a month to see if people liked them. Then they make amendments to the menus if needed. Some people were unable to recall being offered a choice of meals. We saw that a verbal choice of food was offered.

Kitchen staff had access to a nutritional needs folder. The folder contained dietetic advice for one person and incomplete advice about thickeners for another person. However care staff had advised us that a different person required thickeners in their fluids and the kitchen staff were not aware of this. This was a concern as the information that staff gave to us about people's nutritional needs was inconsistent and they could not be certain that people's nutritional needs were being adequately met.

We saw that the dining room was newly decorated and during lunchtime there was general chatter between people that used the service and with staff. Jugs of juice were on tables along with salt and pepper and a flower arrangement. Some people were given the choice of where to sit. We saw that where staff gave assistance to people to eat, this was done sensitively and people were not over paced.

One person told us, "I prefer eating on my own because there is too much commotion in there [the dining room]." Another person told us it could be quite hectic in the dining room at times. We saw that there were not sufficient staff to give an appropriate level of assistance to two people. These two people sat on tables alone, struggled with their meals and received little social interaction during lunchtime. On the second day of our inspection the dining experience for these two people had improved.

People told us that they had access to GP's district nurses and chiropodists as they required. We saw some evidence of health professionals involvement in people's care. However we were concerned that the provider was not able to show that appropriate referrals had been made, and health professionals advice followed. For example we saw that the speech and language therapy team had advised that a person required moderately thick fluids to drink and a pureed diet and if there were any changes that they should be contacted. We found that the person was being provided a normal diet and this was what was documented in their care plan. We saw that another person had lost weight and the action stated to refer to dietician but there was no evidence that this had been done and staff were unable to confirm that it had.

Requires improvement

Is the service caring?

Our findings

People told us the staff were nice and spoke very highly of a particular care staff member. One person told us, "[staff member] you've got a good one there." Another person told us, "[staff member] is absolutely lovely. [Staff member] will do anything for you." A relative told us, "Whilst it is quite institutionalised, I thought and still think, the staff do a good job." Another relative told us, "I can't fault the care workers at all." When asked specifically about the staff another relative told us, "They all seem to have a nice attitude."

We saw that staff member's engagement with people while carrying out tasks was positive. However, interactions with staff were limited to when tasks were being carried out. We saw that where people were being supported to eat staff didn't rush them and they provided people with plenty of encouragement throughout their meals. Staff also knew these people's needs.

There had recently been a large change to the staff team at the service. A number of staff had been at the service for just over three months. We were concerned that not all of the staff team knew the names of people using the service.

We saw that one person who was usually supported by their relative to eat was left sitting in the dining room at the side of a table without any lunch for a period of time while everybody else in the dining room had their meals. This was until an inspector asked why the person was not provided with food at which point they were provided with a meal. The person then started to eat with their knife. Staff did not acknowledge or offer any support to this person.

The person then dropped their knife on the floor, which made a loud noise but was not acknowledged by any staff members. They then leant out of their wheelchair to try and reach it. An inspector had to intervene as there was a risk that this person would overreach and fall.

Some people told us that they had choices. One person told us, "I stay in bed, it's my choice." We saw that staff respected this and provided this person's care in bed. However we saw people that were left sitting in their wheelchairs throughout the day without being offered the choice of sitting in an alternate chair. This was seen in the lounge area and when people were assisted into the dining room. We spoke with staff about this who confirmed that there was no reason why these people were not assisted into alternate chairs.

Staff had a good understanding of how they were able to promote people's independence. They told us how they were able to do so while assisting them with their personal care. For example they told us how they encouraged people to do as much for themselves as possible such as by washing and drying areas of their body that they were able to.

Staff had a good understanding of how they were able to respect people's privacy and dignity while providing their care. We observed a staff member assist a person to the bathroom, they spoke with them discreetly so that their privacy and dignity was maintained.

Relatives told us that there were no restrictions on visiting times to people that used the service. This was confirmed by staff members.

Requires improvement

Is the service responsive?

Our findings

Apart from the person who had recently arrived at the service, people that were able to speak with us told us they'd been involved in the planning of their care. One person told us, "They asked what my preferences were regarding the time I get up." When we discussed the involvement in care plans with relatives their responses were more vague. One relative told us, "I suppose I was involved at the very beginning."

We looked at the plans of care for four people that used the service. We found that they did not sufficiently represent people's individual needs and did not support good responsive care practice.

One person's records that we looked at detailed that they should be weighed regularly and that they required between two and two and a half litres of fluid each day. We found three food and fluid charts for this person. The amounts had not been totalled but we found that on each of the three days recorded the person had received less than one litre of fluids. We saw that the person's care records said that they should have "a normal diet – nothing that requires too much chewing, has small portions". We also found a speech and language therapy review of swallowing that recommended the person had a soft moist diet. This information was not in the persons care plan. We saw that the person was served a normal size portion of chicken nuggets, mashed potato, lettuce and tomato for lunch. This was not in accordance with their assessed needs and was potentially harmful to them.

We also saw that this person was not eating their meal. They told us, "'I can't see it, I don't want it if I can't see it." We found that they had a diagnosis of age related macular degeneration [a condition that results in severe vision loss] in 2012 and evidence that their sight was very poor. This person did sit next to the window during their lunch which would have helped them slightly but there was no care plan or risk assessment for their sight related needs and no advice about what living with severe sight loss meant to the person or to people supporting him. This person was not receiving appropriate care and treatment to meet their needs. There was not an appropriate assessment of their needs.

We looked at the care records for another person at the service. The person required dentures to eat. We saw that they were provided with chicken nuggets, mashed potato, lettuce and tomato for their lunch. The way that they ate this meal indicated to us that they had a distinct preference for soft foods. For example they ate the mash first and then picked the nuggets and salad out of their mouth and discarded them. They were then provided with a second plate of the same food which they treated in the same way. Staff did not enquire whether this person was wearing their dentures or if there was any other reason why they were eating only the mashed potato and so their diet was severely restricted.

This person's care plan also regularly referred to them becoming aggressive towards staff. There was no monitoring of this and no specific information in the persons care plan about any triggers, calming or diversionary techniques to use. This person was not receiving care and treatment that was appropriate to meet their needs. There was not an appropriate assessment of their needs.

The care records for another person did not reflect their current needs. They contained no details about their personal care. We only found one recording within the daily records that were provided, from approximately the last two months of the person being assisted to have a shower. We saw records in the daily notes that confirmed that the person's door alarm was being used. There was no reference to this in the persons care plan. There was confusion between staff members about whether or not this was being used. A full assessment of this person's needs had not been carried out.

We discussed the care plans with the manager who advised us that they were in the process of reviewing and updating care plans for everyone that used the service. We were concerned as the information that staff had to work from and use at the time of inspection was not adequate to ensure that people's needs were being met. We discussed our concerns with the provider and quality assurance manager who advised us that the completion of care plans would be a priority.

These and the other matters described earlier in this report constituted a breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 9: Person-centred care.

One person told us, "There's no activities anymore." A staff member told us, "We've got a new activity coordinator

Requires improvement

Is the service responsive?

coming tomorrow. At the moment it's just what we're doing things like chatting, 1:1, TV, music." The manager told us that the care staff were trying to do activities when they had time. They told us how one staff member had carried out a session of armchair Zumba three or four weeks ago. We saw that a big picnic event was advertised at the service that was due to take place in June. During our inspection we did not see any activities being carried out.

We saw that there was an activities room at the service where there was a goldfish, foot massager and art and craft resources. The manager told us that they were working on making the environment more dementia friendly. We saw that one corridor of the service had been decorated with a seaside theme and had a sensory wall. The manager told us that the next corridor at the service was going to be decorated with a garden theme and contain another sensory wall.

We received mixed responses from people about how their concerns and complaints had been addressed. One relative told us that they'd only had to complain once when their relative had been wearing the same clothes two days in a row. The home responded and it had never happened since. Another relative told us they had repeatedly raised an issue with the service and it had still not been addressed. We saw that the service had received one formal complaint within the last six months. They investigated the complaint and provided a written response. The issue was discussed with staff to prevent it from happening again.

The complaints procedure included advice to staff on general and serious complaints. There were timescales for responses detailed. However there were no details provided for people of where their concerns could be escalated to for investigation should they not be satisfied with the provider's response.

People could not recall there being any meetings. We saw the minutes from a meeting held in May. There had been general discussion about the service and about the big picnic event that was coming up. Relatives told us that they hadn't been invited to any meetings or received any form of feedback questionnaire but they felt happy to raise any concerns with staff.

Staff told us they had attended regular meetings. We saw minutes of meetings that had taken place since the new manager had been in post. These were used as an opportunity to discuss ways to improve the standard of care provided and other issues that were important such as the completion of records.

Requires improvement

Is the service well-led?

Our findings

Quality assurance audits that had been carried out had failed to identify concerns around the environment that we found. There were a number of areas around the general environment of the service that were not included in the audit, such as the broken ceiling tiles and floor coverings. The systems that were in place to mitigate risks associated with water temperatures and legionnaire's disease had failed to protect people. Systems that were in place to ensure that people's medication was stored appropriately had failed to identify that temperatures were outside of acceptable limits. There was no quality assurance system in place to identify the concerns with care and care records that we found.

Records relating to people's care and treatment were not fully completed and decisions relating to people's care and treatment were not evidenced. Accident and incident forms had not always been fully completed to enable staff to monitor injuries that occurred. There was a risk that if people sustained injuries there were not adequate records to ensure that these were monitored effectively. We found that two people had information relating to their dietary needs from a health professional that was not incorporated into their care plan. Staff told us that they had received a verbal update in relation to one of these people but this was not recorded anywhere. There was a risk that these people would not receive care and treatment to meet their dietary needs as an accurate record relating to decisions that had been made had not been kept. We saw that where there had been a need identified for staff to complete food and fluid charts to monitor people's nutritional intake, these records had not always been completed. There was a risk that people were not receiving adequate food and drink and control measures that had been put in place to monitor this were failing as records were not being completed.

We asked to look at daily records for four people and the records of people's weights that the service kept. Daily records were not provided for two of the people requested as they could not be found. These records had not been stored securely. The records of people's weights were not available between February and May. Appropriate records had not been kept. We saw that a carers station had been put in place to allow staff space to complete notes as required. We were concerned that information kept in this area contained people's personal information and it was not secured in anyway. This information was not being maintained securely.

This constituted a breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17: Good Governance

Relatives told us that the manager was approachable but they did not always get the opportunity to talk to her. One relative told us, "She's just too busy to pin down." Staff spoke highly of the manager and told us that she was approachable, they felt listened to and felt that the manager acted on any issues raised. One staff member told us how they had raised some concerns around another staff members practice. They went on to tell us how the manager had acted on them without delay and the situation had been resolved. Another staff member told us, "There's been lots of home improvements. The providers are brill. If we ever run out of anything they'll get it straight away."

The manager told us how they liked to work alongside staff so they had a 'uniform' day every so often where they work as a carer on the shift. This enabled them to keep in touch with the day to day running of the service. A staff member told us, "'The care was poor and [the manager] has changed the paperwork to ensure personal care is carried out, care has improved. I don't have any concerns." Another staff member told us, "We try to ensure that we look after everyone equally and we do our best."

CQC notifications had not been received as required. We found that the death of a person that used the service and one incident of a fall resulting in a hospital admission had not been reported to CQC as it should have been. This was prior to the current manager's employment with the service. We discussed this with the provider who apologised and explained how this had been an oversight. They told us that they were aware of their legal responsibilities and would ensure that this situation did not arise again. We have since received some further notifications from the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent How the regulation was not being met: Decision specific mental capacity assessments had not been carried out where there were concerns identified about people's capacity to consent. Where a person was unable to give consent to a specific decision the service had failed to act in accordance with the MCA. Regulation 11 (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: People did not receive care and treatment that met their needs. A full assessment of people's needs had not been carried out. Regulation 9 (1) (3)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: Quality assurance systems that were in place were failing to assess, monitor and mitigate risk to people that used the service. Accurate records for each person that used the service were not being securely kept. Regulation 17 (2)(b) & (c)