Manucourt Limited

Barton Lodge

Inspection report

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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?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We inspected Barton Lodge on 23 & 26 August 2016. This was an unannounced inspection.

Barton Lodge is a care home for older people, some of whom may live with dementia. The home is registered to provide accommodation and personal care for up to 48 people. At the time of our inspection there were 38 people living there. The home consists of a main house with a large lounge and separate smaller sitting areas and a large dining room on the ground floor. The bedrooms are accommodated over two floors with lift access to the first floor.

The service did not have a registered manager in place. 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. There had been a high turnover of registered managers in the previous four years. We discussed this with the Nominated Individual (NI). An NI is a director, manager or secretary of the company who has been delegated responsibility for supervising the way that the regulated activity is managed. The NI explained the reasons for the turnover, including a transfer of one manager to another of their homes. There was now a new manager in place who had started their application process to register with the Commission.

Staff knew how to identify some aspects of potential abuse and understood the home's safeguarding and whistle blowing procedures and who to contact if they had any concerns. However, incidents between people who lived at the home had not been identified as abuse and had not been reported appropriately to the Commission or the local authority.

Incidents and accidents were recorded, but were not always investigated appropriately. It was not always clear what, if any, action had been taken to learn from these events to minimise the risk of them happening again.

The deployment of staff required review as some people were not always supported in a timely way and in line with their preferences. People at potential risk of harm were not always adequately supervised in communal areas. The manager and provider told us they were in the process of recruiting an additional staff member which they said would address this.

There were robust systems in place to manage and store medicines safely. Staff had a good knowledge of people's medicines.

Most staff interacted positively with people and were caring and kind and respected their dignity.

The provider was in the process of updating people's care plans and transferring them on to an electronic system. However, we found some inconsistencies and inaccuracies in some people's care plans which may

have led to them receiving inappropriate care.

Staff had not all received regular supervision and appraisal in order to provide formal opportunities to discuss performance and personal development. However, the new manager had put a schedule in place and was almost up to date with this.

Staff received regular training and there was a staff training programme in place for the next year. Staff felt very well supported by the new manager who they said was approachable and proactive.

The provider followed robust recruitment practices to ensure that only people suitable to work in social care were employed.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act 2005, (MCA) which applies to care homes. The new manager understood their responsibility in relation to DoLS and MCA.

Staff knew what was important to people, their life histories and interests and had time to sit and talk them. People were supported to take part in activities within the home.

People were supported to maintain their health and wellbeing and were referred promptly for specialist treatment and advice, such as GPs, district nurses or end of life care. People living at the home were happy with the care they received and had no complaints.

People were offered a choice of drinks and home cooked meals. The chef was knowledgeable about people's dietary needs and prepared their meals in a way that met their specific needs. Staff assisted and encouraged people to eat if they needed help.

Quality assurance systems were in place to assess and monitor the quality of care and drive improvements. However, these were not always effective in identifying areas for improvement.

There was a programme of maintenance in place and regular safety checks were carried out on the fire system, fire equipment and other equipment such as hoists.

We last inspected the home in November 2013 when we found no concerns.

At this inspection we found 2 breaches of the Health and Social Care Act 2008. You can see the action we have asked the provider to take in the main report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People had not always been protected from the possibility of abuse because incidents between people living at the home had not always been identified as abuse or appropriately reported.

Staff had not always been deployed in a way that met people's needs in a timely way or to reduce the risk of harm. Staff were sometimes on call to answer phones when dispensing medicines which increased the risk of errors.

Staff were competent and had good knowledge of medicines management and administration.

The environment was well maintained and safety checks regularly carried out.

Is the service effective?

Good

The service was effective.

Staff had not all received regular supervision and appraisal. However, the registered manager had already identified this and put in place a schedule to address it. Staff felt supported with training and development.

People were supported to maintain their health and wellbeing and were provided with a variety of food and drinks sufficient and suitable for their needs.

Staff understood their responsibilities in relation to the MCA and DoLS.

Is the service caring?

Good

The service was caring.

Staff treated people with dignity and respect and knew them well.

Staff were friendly and helpful, and provided sensitive and

compassionate reassurance to people when they were anxious or unwell.

Relatives and friends were able to visit at any time and were made to feel welcome.

Is the service responsive?

Good

The service was responsive.

The new manager was in the process of reviewing people's care plans and risk assessments.

People were encouraged to participate in a variety of daily activities and events within the home.

People and relatives knew how to make a complaint if they needed to. Complaints had been appropriately addressed and responded to.

Is the service well-led?

Requires Improvement

The service was not always well led.

Quality assurance systems had been put in place to monitor and assess the quality of care and drive improvements but were not always effective. Records of people's care were not always up to date or consistent.

Staff had not received appropriate guidance or risk management strategies for how to support people to access the gardens in hot weather.

The culture within the home was open and there was visible leadership at all levels. Staff felt supported by the new manager.

Barton Lodge

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 they are 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.

We inspected Barton Lodge on 23 August 2016. This was an unannounced inspection and was carried out by a lead inspector who was accompanied by a second inspector. The lead inspector returned on 26 August 2016 to complete the inspection.

Before the inspection, we reviewed all the information we held about the service including previous inspection reports and notifications received by the Care Quality Commission. A notification is when the provider tells us about important issues and events which have happened at the service. The provider also completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used this information to help us decide what areas to focus on during inspection.

We spoke with eleven people, two relatives, the new manager, six care staff, a cook, a member of maintenance staff and two housekeeping staff. We also spoke with two visiting health care professionals, the NI and the registered provider. We carried out observations throughout the day and whilst lunch was served. We reviewed six people's care records and pathway tracked three people's care to check that they had received the care they needed. (We did this by looking at care documents to show what actions staff had taken, such as involving a GP or district nurses, and the outcome for the person). We looked at six staff recruitment, training, supervision and appraisal records, and other records relating to the management of the service, such as medication records, health and safety checks and policies and procedures. Following the inspection we spoke with a third health professional to obtain their views of the service provided by Barton Lodge.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at Barton Lodge and most said there seemed to be enough staff. One person told us "I like it here. I feel safe." A healthcare professional told us they had "No concerns" about the safety of people at Barton Lodge.

Although people told us they felt safe, we identified some concerns and found that procedures for safeguarding people from abuse required improvement. Staff and managers had not always recognised incidents of abuse. For example, records showed two separate incidents where people had hit each other during an altercation. Incident forms had been completed by staff who witnessed the incidents and these had been reported to senior staff but no other action had been taken. These incidents had placed people at risk of harm but had not been reported to the local authority safeguarding team, or to the commission, as required by law.

Unexplained injuries had not always been appropriately recorded, reported or investigated. For example, body maps in one person's care plan recorded two unexplained bruises. There was no incident form relating to these injuries. There had been no investigation to determine the possible cause of the bruises. Another person had a large bruise on their arm which they told us had been caused when they had been pushed by staff through a doorway in their wheelchair. This had been recorded on a body map in their care plan but there was no record of an investigation or what action had been taken to prevent similar incidents happening again. We spoke with the new manager who was unaware of the incident. They spoke to staff about it. They told us the person was prone to "Flinging" their arms out when being moved in their wheelchair. Whilst it appears this was an accident, this should have been appropriately investigated and recorded, and staff briefed as to how to reduce the risk of this happening again.

People had not been adequately protected from abuse or improper treatment. This is a breach of Regulation 13 of the HSCA 2008 (Regulated Activities) Regulations 2014.

Other incidents had been appropriately shared with the local authority and investigated. Staff were able to explain to us about other types of abuse and what they would do to report it. For example, they had identified one person's behaviour had put others at risk of abuse. The provider put an additional twelve hours of one to one support in place at night time, at their own cost, reported it to the Local Authority and investigated appropriately. Staff understood the whistleblowing policy and told us they would not hesitate to use it if they had to.

Staff were not always deployed effectively to meet people's needs. At 10.30am of the morning on the first day of our inspection, we observed one person being pushed along a corridor in their wheelchair. They told us they were "Very late." We asked them if they had had breakfast and they said "No. And I'm hungry." We checked the person's care plan which stated they liked to get up between 8am and 9am and have breakfast. At 11.22am we observed the person in the dining room with four other people. They had just finished their breakfast and were about to be taken to the lounge along with the others. We spoke with a staff member who said lunch would be served at approximately 12.30pm but people who had a late breakfast could have

a later lunch.

Staff did not always communicate people's changing needs. We returned to the dining room at 12.25pm and saw that the people who had finished their breakfast at 11.22am were back in the dining room awaiting lunch. The person we had spoken with earlier had a full lunch meal in front of them and was not eating anything. Staff offered them another choice, but we informed them they had only left breakfast an hour before. Staff seemed unaware of this and the person's lunch meal had not been put back as had been described to us.

Communal areas were not being adequately supervised or monitored by staff who were deployed elsewhere attending to people's needs. We had been informed by staff to be aware of one person's behaviour, who could be pinchy and grabby towards others. The person's care plan for mood and capacity stated the person 'Is showing continuous challenging behaviour such as moving furniture, walking with cutlery in their hand, such as knives and forks and refuses to let them go, often grabs other residents clothing.' There was nothing in the person's care plan to guide staff in how to manage this. We observed the person in the lounge taking other people's drinks and moving them around while unsupervised.

We saw from accident records that the person had also had a number of recent falls. Their mobility care plan had been evaluated, but made no mention of the increase in falls. It stated they were required to be monitored and assisted by one care worker when mobilising. We observed the person getting up on their own and on one occasion we had to intervene as there were no staff present to assist them when they got into difficulty. On another occasion, the person was at risk of falling on the floor from their chair. We had to intervene again and found a staff member to assist the person. We looked at other incident and accident forms which recorded other people had had a number of unwitnessed falls in the dining room and lounge. These had not been appropriately reviewed and there was nothing recorded to say what action was to be taken to try to minimise the risk of this happening again.

No link had been made between falls and lack of supervision. We discussed this with the new manager and NI who told us they did not think they had to have staff supervising the communal areas at all times. They said they would review this following our observations. We later heard staff discussing who would stay in the lounge to "keep an eye" on people which demonstrated they had been given this guidance. We will check to ensure this has been embedded when we return to re-inspect.

Staff were distracted when dispensing medicines to people. We observed a senior staff member on their medicines round. They wore a tabard saying they were not to be disturbed but we saw they were answering the phone, forwarding calls and writing down messages, which interrupted them dispensing people's medicines. They said they had to cover this when the head of care was on a day off, or at weekends when the Head of Care didn't work. They told us it was "Dreadful" and "Distracting" and explained how they had to "keep going back to check" where they had got to. We discussed this with the new manager and NI who said they would review this but didn't think it happened very often, although they confirmed the Head of Care did not work at weekends. We were concerned, however, that this practice could contribute to the occurrence of medicines errors. The new manager said they would review the practice and address this immediately. However, we noted it still happened during medicines rounds on the next day of our inspection.

We spoke to staff about staffing and workloads. A staff member told us they had difficulty getting everyone up in time for their breakfast because there were a lot of people who required two members of staff to get them up and ready in the mornings. They told us each day could vary. Some days they could manage, but other days were more difficult. Some people needed different levels of support from day to day, depending on how they were feeling. They said the number of agency staff on duty also impacted on how smoothly a

shift would run. Another staff member also commented that the night staff had not got anyone up in the morning so this had impacted on the number of people the day staff had needed to support at the start of the day shift. We asked people if staff attended to them promptly when called for and received a mixed response. One person said staff came quickly most of the time "Depending how busy they are." Another person told us the staff "Could come more quickly."

The manager told us they deployed one Head of Care and two care team managers supervising during the day, one care worker deployed to supervise the dining room from 7am to 1pm, five care staff from 8am to 8pm, and one care staff member from 7am to 7 pm. They also used agency staff when permanent staff were unable to cover shifts. We spoke with the new manager and the NI about staffing and how staff were deployed in light of the size and layout of the home, which had been extended since our last inspection. The new manager told us they had recently discussed staffing levels with the NI. They had completed a dependency tool to help identify staffing needs and told us that although this showed they had more staff than were needed, they had also listened to staff feedback. As a result of this they were recruiting an additional team member for the mornings which they thought would resolve this problem.

Following our inspection, the provider confirmed the dependency tool was used in conjunction with a staffing policy. They told us "Both the policy and the tool form the staff dependency tool. The policy clearly states that when determining the number of staff on duty, we need to consider the environmental layout, the types of needs residents have and how some of these needs may need to be met at any one time by more than one person. The policy also clearly states that the proprietors, Manager, Head of Care and Care Team would be involved in deciding the best course of action."
Whilst the provider had identified a need for an additional care staff member in the mornings, there was a moderate impact on people due to staffing at the time of inspection. We will check to see that the additional staffing has been embedded when we return to re-inspect.

The provider had not deployed sufficient numbers of suitably experienced staff to meet people's needs at all times. This is a breach of regulation 18 of the HSCA 2008 (Regulated Activities) Regulations 2014; Staffing.

Other aspects of medicines were well managed. Only senior staff who had been trained in giving medicines were allowed to do so and were regularly assessed for on-going competency. Staff dispensed medicines to people patiently and at a pace that suited them. Staff asked people for consent and gave them an explanation about their medicine and what is was for before they gave it. Medicine administration records (MARs) were signed after each medicine was successfully dispensed. Stocks of medicines were well controlled. Medicines were stored in medicines trolleys which were well organised and secured. Controlled drugs (CDs) are covered by specific regulations called the Misuse of Drugs Act. We found that CDs were stored, managed and dispensed in accordance with the Act. A spot check showed all CDs, other tablets and liquid medicines were all accounted for.

The provider had ensured that only staff who were suitable to work in a social care setting were employed. Recruitment records showed staff had been recruited safely and their files contained two references, employment histories and confirmed that full checks had been carried out with the Disclosure and Barring Service (DBS). The DBS checks assist employers in making safer recruitment decisions by checking prospective care workers are not barred from working with people who need social care support.

We saw people's rooms were risk assessed and equipment was in place to keep people safe where required, such as alarm mats and bed rails. The provider employed maintenance staff to ensure the upkeep of the premises and equipment. There was a planned schedule of maintenance. Care staff recorded any issues identified in a book which was checked and actioned daily by maintenance staff. They carried out regular

safety checks such as fire alarm tests, emergency lighting and fire extinguisher checks. Regular servicing and testing of equipment, such as hoists and baths was documented.

The home had a business continuity plan which outlined who staff should contact and the action to take in the event of an unforeseen emergency. This included personal emergency evacuation plans to guide staff in how to support people to evacuate the home in the event of an emergency.

Good

Is the service effective?

Our findings

People told us staff asked for their consent before providing any care or support. For example, one person said "They always knock and ask if they can come in to my room." A health professional told us the home contacted them promptly when best interest decisions or advice was needed for a person who was being cared for at the end of their life.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We noted staff had a good understanding of their responsibilities under the MCA 2005. Assessments had been completed where required.

The Care Quality Commission (CQC) monitors the operation of DoLS which applies to care homes. These safeguards protect the rights of people using services by ensuring that if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. The new manager understood their responsibilities in relation to DoLS. Applications for authorisation of DoLS were submitted when required and a list of everyone on a DoLS was available to all staff.

People were supported to maintain their health and wellbeing. People told us they received the health care and support they needed. Staff monitored people's health and identified any changes quickly. Staff knew people and their health conditions well, and were up to date with changes in people's wellbeing. A health professional told us "Any changes, deterioration or concerns and they'll call. If I ring, they're knowledgeable about the situation." Detailed handover records were produced and discussed at each shift change, which included the carry-over of important on-going information so it wasn't missed by staff who did not work every day. For example, recent changes to medication or concerns about pressure areas. People were referred promptly to health professionals, such as district nurses, GPs or a speech and language therapist (SALT) when necessary, for specialist advice or treatment.

Staff understood people's particular dietary needs, such as preparing food to a specific consistency for a person with a swallowing difficulty. The cook explained how they pureed each food item individually so that the flavour of each food could be tasted. They knew who required other special diets, such as a gluten free or diabetic diet and explained how they purchased special ingredients to meet their needs, such as gluten free gravy and cereals, and sugar free ice cream. A health professional told us about a person being cared for at the end of their life. They told us "The chef has met with [the person] and [their family member]. They have gone out of their way to find things they like, a list of favourite foods, special things, even if they only take a spoonful." People's care plans contained information about their food preferences, likes and dislikes and any allergies, which the cook was also knowledgeable about.

People were happy with the choice of food provided. One person told us "The food is good. Any requests

you can put it in and there is plenty of choice." There was a four weekly menu with several choices of breakfast, lunch and evening meal. For example, on the first day of inspection the lunch choices were cod mornay, Cornish pasty or vegetarian sausages, all served with potatoes, peas and carrots. A choice of homemade desserts, such as trifle, fruit salad, apple pie or crumble, was available from a trolley.

People could choose where they ate. Some people remained in their own rooms. One person told us they weren't feeling very well and had declined their lunch, but they had been given plenty to drink. Two people took their lunch in the Turret room. Their meals arrived with covers on them to keep them hot, and condiments were available. We observed the lunch meal in the dining room which was colourful, bright, and nicely laid out with table cloths and flowers. Staff offered encouragement and assistance to people who needed it which ensured they ate and drank to reduce any risk of malnourishment.

Staff had not all received regular supervision and appraisal. However, this had been identified by the new manager who was working through a supervision and appraisal schedule with staff which was nearly up to date. The new manager explained they wanted to carry out intital superversions with all staff as this would give them an opportunity to get to know their staff. These were now planned on the electronic system and would flag up to the new manager when they were due. Although they had not received regular supervision and appraisal, staff told us they now felt well supported and were able to discuss any issues, concerns or training requirements when they wanted to.

New staff had completed an in depth induction which included work shadowing, on-line and DVD training as well as face to face training, such as moving handling. There was an on-going programme which included key topics such as fire safety, medication, MCA 2005 and dignity and respect. Staff had opportunities to learn about specific conditions such as dementia awareness and dysphasia which helped them to better understand some people's individual conditions.

The design of the building and gardens promoted people's independence and provided visual recognition to aid orientation. For example, corridors had names such as London Road or Buckingham Palace Road. Walls were decorated with old movie stars or Penguin books in different areas of the home and some people's doors had been personalised with pictures. Handrails were in place around the home to assist people with their mobility. The landscaped gardens were fully accessible to people with mobility difficulties or wheelchair users. There was a large raised patio area with tables and chairs, and a lovely view of the sea. A gently sloping ramp led down to the lawned area with a wide pathway giving access around the whole garden, including to three brightly coloured beach huts.

Good

Is the service caring?

Our findings

People told us they were happy living at Barton Lodge. One person said "Staff are all kind and caring." Another person told us "They [staff] are very nice, very genuine." A health professional told us staff always welcomed them and were friendly. They said relatives came in and had lunch with a family member and they "Had family dos here."

Staff knew people well, including their life history, family and hobbies. People made choices about their day to day lives, such as what activities they wanted to do, where they ate their meals or what they wanted to wear. We observed staff chatting, joking and listening to people and showing an interest in what they had to say. Staff interacted with people in a friendly way and there was banter and humour throughout the home. Although staff were busy, they were relaxed and calm.

Staff supported people with compassion and reassurance when they became upset, anxious or unwell. Two people had recently been bereaved and were especially tearful. We observed one person in their room, sitting in their easy chair calling out for help. Staff responded quickly, knelt down to their level to make eye contact, held their hand and used gentle touch to reassure them. Another person had become confused and was wandering around upstairs unable to remember how to get to the dining room. A staff member spoke to the person kindly, reassured them and accompanied them downstairs to the dining room to make sure they arrived safely and without getting further distressed.

People were supported to stay at the home, if they wished, when nearing the end of their life. A health professional was involved in one person's end of life care and told us the communication with the home was very effective and everything was in place to enable the person to be supported to remain at the home, which was their wish. They told us the person was comfortable and safe and said "The staff always provide a thorough handover. Confidence is an important part of their role."

Staff were kind and thoughtful and treated people with dignity and respect. For example, personal care was provided discretely by staff who ensured people's privacy and dignity were respected. We saw a staff member place a cushion behind one person's back and ask them if they were cold. They got a blanket which they left on their chair and checked they were comfortable before leaving them. People were encouraged to retain their independence where possible. For example when washing and dressing in the morning. Staff were also aware of the need for confidentiality, which we saw in practice throughout our inspection. We also noted staff used people's preferred names when addressing them.

There was a relaxed and welcoming atmosphere at Barton Lodge. Friends and family were welcome to visit and there was no restriction on when they could do so. People's bedrooms were homely and personalised with things that were important to them, such as family photographs, pictures and ornaments.

Good

Is the service responsive?

Our findings

Our findings

People who were able to, told us they were involved in planning and reviewing their care. One person told us they were happy with the way staff looked after them and would say something if they weren't. Another person said they were very old and had everything done for them. They told us "I'm happy not to do anything."

The new manager told us they were re-writing people's care plans which were gradually being transferred on to a new electronic care planning system. A new system of daily recording had also recently been introduced and staff now used hand held devices to provide updates about the care and support people had received throughout the day and night. They told us this would help give a more accurate, immediate and complete record of how people had been supported. For example, their mood, what they had eaten, what activities they had done and all other aspects of their day to day lives.

The current care plans we looked at included an initial assessment of people's needs and basic guidance for staff in how to support people with, for example, their skin care, mobility, nutrition and personal care needs. Care plans included people's preferences, their likes and dislikes, their life histories, social needs and hobbies and interests. We identified a number of discrepancies and omissions within care plans which we have referred to in the "Well led" section of our report.

Although people's care plans were basic, staff knew people well and remained up to date with their needs which enabled them to deliver appropriate care. Care plans were reviewed regularly and people, or sometimes their family members, were involved in reviews. Care plans and reviews had been signed where this was the case.

People were encouraged to take part in activities within the home. Staff provided games and quizzes for people to take part in if they wished to. We observed people being encouraged to do some gentle seated exercises with a therapist which most people seemed to enjoy. People pursued their own interests as well such as reading newspapers and books.

People told us they knew how to make a complaint but most people said they had not had cause to do so. One person told us "If I ever complain, they do generally get it sorted." Most complaints or issues raised by people were dealt with there and then, reducing the need to escalate them within the formal process. We looked at the provider's complaint procedure and complaint log and saw the most recent formal complaint had been investigated appropriately and responded to in a timely way. Staff were aware of the complaints procedures and confirmed they would support people with any concerns they might have, or would report them to the new manager on their behalf.

Requires Improvement

Is the service well-led?

Our findings

The new manager was visible in the home and it was apparent that most people knew who they were. One person told us "She was introduced to me." The new manager had also contacted us at the Commission to introduce themselves to our inspector when they took over management of Barton Lodge.

Although people told us they were happy with the management of the home, we identified some issues where improvements were required.

People's care plans lacked detail and there were a number of discrepancies and contradictions in the guidance for staff which had not been identified during reviews. An example of this was one person's skincare risk assessment stated they were at severe risk of pressure sores. Their care plan for skincare made no mention about skin fragility or how staff should care for the person to help prevent pressure sores. Their mobility care plan stated the person had deteriorated and now required "A hoist for all transfers and a wheelchair for mobilising." The objectives section remained unchanged and stated " Staff are to assist her if it is required and offer the use of a wheelchair if she is tired." Their hospital passport was also out of date. This is a record of important information that goes with the person should they be admitted to hospital. It stated the person was independent and used a stick. It also said they had no special care requirements such as a pressure cushion, which they now used. The person's records had three different room numbers recorded as they had moved rooms. Documents had not been updated accordingly.

We discussed a number of examples of out of date and contradictory information with the new manager. They told us care plans were a work in progress and that there was still work to do. They confirmed that this would be addressed as part of the review and gradual transfer of care plans on to the electronic system. They made a commitment to review all the paper records in the meantime.

Policies and procedures had been reviewed. This included the provider's 'Heatwave' policy which stated to discourage people from going outside between 11am and 3pm when it was very hot. It did not give guidance to staff about how to support people to go out if they wished to do so by managing the risks of exposure to the sun. The first day of inspection had been very hot and upon our arrival, the new manager had told us "We don't let them [people] out between 11am and 3pm. We try to encourage them to go out later." Before lunchtime, we also heard a staff member telling a person, with capacity to make the decision for themselves, that they could not go out as it was too hot. This was against the person's wishes and did not support them to make informed choices. We discussed this with the new manager and NI and said they should assess the risks and look at how they could enable people to go out, such as providing a sun shade and plenty of fluids, and encouraging them to use sun cream and a hat. They told us they would review their policy to ensure staff had appropriate guidance.

Systems in place were not always effective in picking up areas which required action and improvement. Service audits had been carried out by external auditors. These were aligned to the Health and Social Care Act 2008 regulations. However, these were not always effective as they had not identified the issues we had found during the inspection. For example, we found several inaccuracies, contradictions and errors in

people's care plans which had not been accurately up dated. Incident and accident forms had not always been appropriately reviewed to determine a cause, or to identify learning. We saw there was a range of other audits which were carried out by senior staff to assess and monitor the service and drive improvements, which included, for example, medicines audits and people's weights. These audits were effective as they had identified where action was needed.

Quality assurance systems were in place to monitor and assess the quality of the service. For example, surveys were sent out to care professionals involved with the home in April 2016 which were all positive. Other surveys for staff, people and families had been delayed until September 2016 which meant the provider did not have up to date feedback on their views of the service. However, the new manager wanted to include questions that would obtain people's feedback on their performance as the new manager. A number of compliments had been received which included an email from a family who thanked the staff for arranging a family picnic for their parents and thirteen relatives.

The culture within the home seemed open, transparent and well organised. Most staff seemed happy, relaxed and at ease when carrying out their duties. One member of staff told us "[The new manager] is very good, approachable, takes things on board." Another told us "[The new manager] is working on everything. I've noticed improvements already. She's very approachable and straight with me. We've already had two staff meetings which have been useful."

Other staff confirmed they found the staff meetings helpful, and could take their ideas and any concerns to staff meetings and they would be listened to. We saw that regular staff meetings took place which enabled staff to be kept up to date with issues and discuss any concerns. Minutes of the most recent meeting in August showed that staff had been updated about training for pressure care, diabetes and improvements to equipment. The new manager told us they used to have separate staff meetings for different teams within the home. For example, kitchen staff, housekeeping staff and care team management. They told us they might re-instate these to make meetings more focussed and relevant to staff roles.

The new manager was responsive in providing information to us during the inspection. They were supported by the NI and the provider who both attended the home to support the inspection process. The management team were enthusiastic and proactive in their approach to developing the service and were keen to make further improvements. The provider explained how they felt lucky to have recruited the new manager who they said was excellent. They had invested in extending the home and landscaping the gardens for people to enjoy. The NI confirmed they were supporting the new manager to ensure they settled in to their role and understood their responsibilities.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People had not been adequately protected from abuse or improper treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not deployed sufficient numbers of suitably experienced staff to meet people's needs at all times