Wingreach Limited

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

Summary of findings

Overall summary

The inspection took place on 31 October 2018. It was unannounced.

Throwleigh Lodge is a care home providing nursing care for people living with complex learning difficulties and physical disabilities. At the time of the inspection there were 13 people living at the home and up to 17 people could be accommodated.

This service was set up and registered prior to Building the Right Support and Registering the Right Support (2015) which sets out the values and standards for the size of a service for people living with a learning difficulty or autism. Although the size of this service was larger than our Registering the Right Support standards, people were being cared for in smaller group settings over two floors to enable more personalised care to be given. However, we found that more could be done to involve people, and their families and representatives, in the design of services.

People in residential care homes receive accommodation and personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

On the day of the inspection the registered manager was not present due to ill health. 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 inspection we had difficulty gathering all the information we required and the staffing records were difficult to locate. Some care and dietary records were confused and handwritten notes were not always clear. The registered manager assisted us with further information on their return to work but record keeping and organisation was an area that required improvement.

people and their relatives were not formally involved in the development of the service. Policies were a few years out of date and needed review. There was low reporting by the service to the CQC and some statutory notices had only been sent after a care professional had highlighted a concern.

The numbers of accidents and incidents were recorded but there was no evidence of any learning outcomes from these.

We discovered that some infection control measures and equipment were not at the required standard. Some aspects of the premises needed attention to ensure that a homely and uncluttered environment was provided for people.

Risks to people were being identified and staff showed awareness of the actions to take. Staff also had knowledge of safeguarding processes and an openness to report. Medicines practice and storage was safe. Staffing levels were good enough to achieve safe care. However, there had been a high turnover of staff and a reliance on bank or retired nurses.

People's needs had been assessed. Good knowledge of people's complex needs was demonstrated by the nurses. The care staff were competent and they received monthly supervision from the new registered manager. There was good daily communication between staff.

There was evidence of working with the multi-disciplinary community team for people with learning difficulties, and referrals were made to meet specific health needs. People's special dietary needs were understood and met. Environmental checks were undertaken.

People's consent was sought in line with the legal requirements of the Mental Capacity Act. Where people's liberty was restricted to keep them safe, the provider had followed the requirements of the Act, and the Deprivation of Liberty Safeguards (DoLS), to ensure the person's rights were protected.

The staff displayed a caring attitude towards people and showed patience and understanding. Care plans were person centred and demonstrated a good understanding of each person's life. There was a personalised activity plan in place for each person.

People's wishes at the end of their life were recorded, albeit separately from the person's care plan. Good care was given to people at the end of their life and those who were bereaved were remembered.

The service had a complaints procedure in place. An easy to read picture policy was also available.

In the absence of the registered manager staff had a good knowledge of the service and the people they cared for. Staff also told us they were supported and involved through regular meetings. Quality assurance and health and safety monitoring was in place and improvements had been identified. The new registered manager told us they had a vision to improve the service, the environment, and the way records and policies were organised.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also made one recommendation. The provider started to take action following the inspection.

You can see what action we told the provider to take at the back of the full version of this 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.

Infection control measures were not always in place.

Accidents and incidents were not reviewed consistently for learning.

The risks to people had been assessed and guidance was given.

People were protected from abuse.

People received their medicines safely.

There was sufficient staff available who had been recruited using safe practices.

Is the service effective?

Requires Improvement

The service was not always effective.

Improvements were needed within the home environment, to improve people's care and experience. We made a recommendation.

People's needs had been assessed. People had access to specialist equipment.

Staff were trained and supervised to deliver the care people needed.

People were supported to eat and drink enough and to stay healthy.

People had access to health care services.

People's rights were protected in line with the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring.

People were looked after by kind and compassionate staff.

People were supported and encouraged to communicate their wishes.

People's privacy, dignity and independence was protected and promoted.

Is the service responsive?

Good

The service was responsive.

People were supported by staff who knew them and gave a personalised care service.

Activities were arranged for everyone.

People's communication needs were understood and met in different ways.

People were well supported at the end of their life.

There was a complaints process in place.

Is the service well-led?

Requires Improvement

The service was not always well led.

Service organisation and record keeping needed to be improved.

People and families were not formally involved in the service or making improvements.

Quality assurance monitoring and health and safety checks were in place.

Staff felt involved and supported.

The home had good links with community services which could be developed further.

Throwleigh 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 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 31 October 2018 and was unannounced.

The inspection was carried out by one inspector, a specialist nurse 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.

Before the inspection, we reviewed the information we held about the service. This included any notifications we had received. Notifications are changes, events and incidents that the service must inform us about. We reviewed the information in the PIR as part of this inspection. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with two people living at the home and one relative. Many people living at the home had complex communication needs and were unable to talk with us. We spent time observing the interactions between people who were living with physical and learning disabilities and the staff.

We interviewed staff working at the home, including three of the care staff, the clinical lead and a registered nurse. We also met with a service manager who represented the provider.

We looked at the care plans for five people. We checked that what was detailed in these plans matched the support and care that people received. We reviewed the recording of accident and incidents in the home. We checked how people's medicines and enteral feeding were administered. We also looked for mental capacity assessments, any applications made to deprive people of their liberty, and whether people had end of life care plans in place.

We checked whether mandatory policies and procedures were up to date, reviewed the services response to internal audits, complaints and feedback to understand how well the service was being governed and managed.

We received feedback from four health and social care professionals who have visited and worked with this home.

Requires Improvement

Is the service safe?

Our findings

People who could talk to us said they felt safe living at Throwleigh Lodge. One person said, "I'm cared for here, that's what makes me feel safe." Another said they felt safe because, "There's somebody here 24 hours a day." We observed how people were treated by staff and the care they took. For example, how a staff member checked the food temperature before giving it to one person and how people were moved with care when in their wheelchairs.

However, people were not as safe as they should be from the risk and spread of infections. The downstairs sluice room, where soiled items were dealt with, and reusable products were cleaned and disinfected, was not fit for purpose. The sink was not in use and there was no handle on the inside of the door. The door was not clean and the room was untidy. Essential space was taken up by two damaged and soiled commodes creating an infection control risk. In one of the toilets used by staff we found cleaning cloths left underneath the sink, and the light pull cord was dirty. Following the inspection, the registered manager said they had acted to clear and clean the sluice room and make sure staff could access the sink to wash their hands. Staff told us about the need for hand washing and use of gloves and aprons for personal care tasks but we did not see this in practice on the day. A nurse was observed to administer medicines prior to washing their hands. Antiseptic hand sanitiser was provided as staff could not always access a hand wash basin easily.

Where people or staff experienced a safety incident there was limited evidence to show what action was taken. There was guidance for staff when to complete an incident form and we saw some that had been completed. Accidents, incidents, and near misses, were recorded and there was a graph showing these by month. The number of incidents was not a concern, with rarely more than two a month. However, there was no analysis of these demonstrating the level of seriousness or impact. . We were told about some changes to practice that had been made because of a medicines error and following feedback from healthcare professionals. But we did not find that incidents were routinely monitored with improvements made to mitigate future risk. It was also not clear whether the low reporting was an accurate reflection of risk.

The failures to take all steps to assess and prevent the risk of the spread of infection, and to do all that is practical to mitigate risk by investigating and reviewing incidents, is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people were identified and staff understood the actions to prevent avoidable harm. There were standard risk assessments in place, which were adapted to each persons' needs. For example, risks were identified for manual handling, use of the shower room, eating at mealtimes, taking medicines and managing money. There was a specific plan in place for those who were at risk of epilepsy, those who were diabetic and where hepatitis B was a factor. A person had a positive support behaviour plan in place with an observational chart that was being completed regularly throughout the day. Another person was at risk of excessive food and fluid intake due to their condition and was also diabetic. Their keyworker told us about the risks and how they managed them, by diverting the person, supervising and providing smaller amounts of food. Where a person required a lap belt to keep them safe in their wheelchair, there was an assessment and guidelines about the risks. We observed at the mealtime that staff gave one to one supervisor and

followed professional guidance, for a person who was at high risk of choking.

People were safe from abuse as the staff had knowledge of safeguarding risks and processes. There was an openness to report any concerns to the nurses or registered manager. One staff member said, "A while ago I did report on a colleague who got angry with a person. Shouting is not acceptable." The staff member concerned was asked to leave the service. Staff also told us they had received training about the safeguarding of vulnerable adults and records supported this. There had been learning at the service about what to report as a safeguarding concern following third party allegations. One concerned an incident where a care professional was let into the home without their identification being checked and walked around the home whilst staff were in a meeting. This had resulted in raised awareness amongst all staff of the need to check visitors and safeguard individuals.

Staffing levels were good enough to achieve safe care. One person told us, "The staff are reliable and available when I need them." There was one registered nurse always on duty and a supernumerary clinical lead was available some days. This meant that people's complex health needs were managed and the care staff had access to good clinical support. There were six care staff working, three upstairs and three downstairs to care for 13 people. At night time this reduced to two care staff across the home with the registered nurse. There was a three-shift pattern in use making the night shift shorter. However, there was a high turnover of care staff and recruitment was difficult. The service depended on bank nursing staff, who have been previously employed in the home or had retired. Some of the extra supernumerary time for clinical support and administration tasks had been reduced since the new registered manager started.

People were cared for by staff who had undergone appropriate checks before they began working at the service. Information provided showed that staff were required to submit an application form. The provider had obtained two references, proof of identity and a Disclosure and Barring Service (DBS) certificate before staff started work. DBS checks identify if prospective staff have a criminal record or were barred from working with people who use care and support services. The nurses were registered with their professional body; the Nursing and Midwifery Council.

People's medicines were managed in a safe way. Medicines administration records (MAR) were up to date, accurate and included people's photographs for clear identification. Any 'as required (PRN) medicine was recorded and this included the reason for it being required. However, the medicines folder had some old information in it. When this was pointed out it was removed and we were told it was being updated. People's epilepsy care plans and seizure records were kept in the medicines folder. We observed the lunchtime medicines being administered safely. Some people had tablets crushed and added to water. One concern was that this procedure was undertaken in the main kitchen which was busy with food preparation and the pestle and mortar used was left in the sink with any residue in it. Although there was only a small risk of this affecting anyone it should have been removed from the kitchen.

The storage of medicines was safe. There were two lockable rooms used, one on each floor. One of these was a dedicated small room, but the other was the activity room, which had a locked cabinet for the medicines. The clinical lead had implemented a new system for storing and checking any specialist medicines, following an error earlier this year. This was working well and we saw that the records tallied up.

Requires Improvement

Is the service effective?

Our findings

The premises were meeting the needs of the people who lived there and the building was kept clean. However, we found that that there was a need for some updating and improvement with the environment. The shared bath and shower rooms, although spacious, needed redecorating as the paintwork was marked and drab and the bare walls appeared cold and stark. There was no adapted bath on the premises and the showers looked basic with just a simple rail and plastic chair. Staff told us that they did not always use the shower rooms and gave personal care in people's own rooms.

There were also areas of the home that looked cluttered. On the ground floor there was a large chair in the corridor blocking a door to a room. The activity room on the first floor was used as a store room, where desks with chairs and two large hoists were kept, as well as the medicines cupboard. Staff told us they could use this room to do a one to one session with a person but we found it was not a comfortable environment to be in. On some walls of the home there were notices which read, "Zone 2" or "Zone 3" with a large arrow. These were to assist staff for fire safety drills, but as there were few photos or pictures on the walls this gave an institutional feel rather than being homely.

Staff told us that a redecoration plan was underway. One person's room had recently been repainted and new flooring and white furniture was in place. More furniture was already ordered for another room. Following the inspection, the registered manager sent us their action plan for the home improvements. They told us they would, "Address the environmental issues. I want this to be a beautiful home. I will make it better."

We recommend that improvements to the home are prioritised and carried out in a timely way to improve the décor and home environment.

People had access to specialist equipment. There was a massage chair in one lounge and some people had specially adapted chairs to meet their specific needs. There were sufficient hoists available to support care giving and transfers. Some people's bedrooms were bright and spacious and decorated according to individual choice and interests. There was also a sensory room which had been specially designed to help people relax and enjoy different sights and sounds. This could be modified to suit the person who was spending time in there.

People's needs had been assessed and a monthly review was undertaken. Needs assessments and plans were comprehensive. However, any updates had been handwritten on people's plans and it was not always easy to read and out of date information was not always removed. There was a good awareness of people's clinical and care needs and nursing staff were familiar with NICE standards and guidance, for example in relation to specialist nutritional and dietary requirements.

The staff had received training to carry out their roles. One staff member said, "I had an induction and now have refresher training which is yearly for manual handling, infection control, first aid and fire safety." They had also recently had training on positive behaviour support and said that this had helped them, "To

understand people's behaviour and work in a positive way… to distract people and deal with any challenges." The records confirmed that staff were up to date with their training and that this was monitored by the provider. The care staff undertook the national care certificate and are then encouraged to secure another nationally recognised qualification (NVQ) in care up to level three.

The nursing staff could describe how they kept up to date with clinical practice which is required for their professional registration, although we did not see evidence of clinical development or use of reflective practice within the organisation. The clinical lead and registered nurse said they had both undertaken their NVQ Level 5 in Leadership and Management.

Supervision of all care staff was undertaken by the registered manager. Staff told us this happened every other month as well as an annual appraisal. We saw that a schedule was in place. Bank staff were also supervised but this was a little less frequently. As the registered manager was not a trained nurse, the nurses received their clinical and professional supervision from another home manager every two months.

The home relied on good daily communication between care staff and nurses to meet people's needs. One staff member spoke of the, "Handover every time we start work." Each registered nurse was responsible as a named nurse for several people and care staff worked as keyworkers for individuals. There was a daily communication book in place, used by the nurses which recorded anything significant with people's care. This included any changes in care and referrals to the GP or another agency. The home worked with the multi-disciplinary community team for people with learning difficulties and referrals were made to meet specific health needs. For example, one person's behaviour was currently being monitored following a change to their medicines which had been advised by the community team.

People were supported to stay as healthy as possible. There was evidence of referrals to healthcare professionals, the GP and secondary hospital care, to address people's specific health problems. The service used health action plans, a recognised pictorial tool for people who have a learning disability that explains what needs to be done to keep them healthy. Staff knew the health needs of each person and had a good understanding of what to do for them. One person described this as, "They are always thinking ahead of me."

People were supported to eat and drink enough and any special dietary needs were understood and acted on. One person told us they had a choice about food and drink. They said, "If I don't want what is on the menu for that day I just tell the staff, and they give me something else." There were menus with pictures available to help people choose their meal. At the meal time, there was a good atmosphere and the dining areas were clean and comfortable. The food was homemade and looked appetising. The care staff who supported people with their meals wore aprons, and made sure that people's appearance was maintained whilst eating. Some people had specialist needs with their diet, for example swallowing problems or diabetes. There were guidelines in place from the dietitian or speech and language therapist that were being followed. The nursing staff displayed a good awareness of the needs of a person who had a gastric tube in place due to low oral intake and poor swallowing. The person had put on weight since being at the home. Peoples' fluid and food intake was monitored.

People's consent was sought in line with the legal requirements of the Mental Capacity Act. Where people's liberty was restricted to keep them safe, the provider had followed the requirements of the Act, and the Deprivation of Liberty Safeguards (DoLS), to ensure the person's rights were protected. A staff member told us, "We always ask people and inform them, and they will communicate their needs to us. We work with them." Where DoLS had been asked for, there were mental capacity assessments and best interests decisions documented for each person. A person who needed a lap belt when in their wheelchair for safety

reasons had a decision specific capacity assessment in place. A person who liked to go into other bedrooms and collect items was not restricted unnecessarily but was supported and supervised to ensure the safety of other people's possessions. A person who had the mental capacity to agree to care had signed their own consent form.

Good

Is the service caring?

Our findings

People were looked after by staff who displayed a caring attitude towards people and demonstrated patience and understanding. A relative told us, "The staff members are very caring and polite. My relative is really looked after …and the staff are very welcoming." One person also said, "They anticipate my problems, they take care of me and have the patience to do it." A professional wrote to praise the, "Care and commitment" of staff.

We observed the staff talking and working with people in a gentle manner, at mealtimes and during the day when people needed support and guidance. Staff demonstrated compassion and empathy in the way they spoke about people, their background and their needs. One person was still settling into the home after living in a poor environment. Staff told us what they did to help the person to stay calm and they were gradually seeing changes and improvements. One person had recently died and as they had no immediate family the staff had planned the funeral and taken the trouble to search out any relatives. We saw the order of service and flowers in their memory displayed. Staff had also made a big effort to decorate the home for Halloween and were planning a party for everyone that day. The staff created a happy and relaxed atmosphere, engaging with people and being appropriately affectionate.

People were asked by staff about their wishes and the care they were given. People's care plans gave guidance to staff to consult people who were able and wanted to make their own choices day to day. One person said that, "Staff listen and understand me." Some people were not able to verbalise their needs and views and staff had to get to know their non-verbal signs and their communication in different ways. One staff member said, "We do get to know them and what they want, we learn to understand them." New staff were helped by shadowing and watching existing staff and people's care plans contained advice on communication. For example, one person used specific hand movements and actions if they did or did not want to do something. Another person used their eyes and head and smiled if they agreed with the choice. Professional advice was being given to the home about one person who had been communicating they were unhappy, following a change in their medicines.

Families and visitors were welcomed in the home. There was good communication between staff and relatives. A relative told us they were very involved since the person they cared for became unwell, "They are wonderful, I get updated daily even if it's late at night the staff call me to tell me how my relative is doing."

People's privacy and dignity was protected. People received any personal care behind closed doors in a private way. One person told us what dignity meant for them. "Every time a member of staff comes to my room they knock on the door. I'm always addressed by my name." One person found it difficult to wear clothes all day. The staff were exploring different items to see what worked for this person to maintain their dignity.

People were encouraged to be independent. One person said, "I get on with what I can and staff help me when needed." One person, we observed, liked to stay in their room a great deal. Staff checked on them but allowed them the space they needed and provided one to one activities in their room.

Good

Is the service responsive?

Our findings

People were helped by staff who knew their needs and how they preferred to be supported. The care plans demonstrated there was a good understanding of each person's life and what they wanted to achieve and do. They included people's wishes, their social and family relationships, the activities and they enjoyed, and any religious background or beliefs. There were pages entitled, "What are your hopes?" and, "Our plan to support you achieve your hopes." There was evidence that this was reviewed with people over time. One person had expressed a hope to go out and visit a friend and this had recently been achieved. Another hope was to visit London and a timeframe for this was added. People's ideas in their care plans were represented in picture format, making them more personal and more accessible. Pictures had been used for a person's diet plan to highlight what food they should eat.

Each person had their own staff key worker who was familiar with them and took an interest in them and their care. One of the care staff said, "We value each person and sit with them, and ensure they are all treated well." There was also a communication book and handover to ensure individual support is known about and given as staff change shift. People's rooms were personalised to them, reflecting their personalities, their interests and family. For example, one person had pictures of the sports and teams they followed and a shelf of their favourite films. Another person's room looked quite bare, but we learnt that the person was still settling in and had initially been distressed by items on the wall. Some photos and items and pictures were out of reach and staff were working with the person to gradually introduce things they might accept.

People could take part in activities they enjoyed and there was an activity plan in place for each person. This identified something for them to do every morning and afternoon as well as ideas for special outings. One person told us, "I do puzzles, watch T.V, listen to music, and play games." A member of staff was seen playing a game with this person in the lounge. Staff told us that another person, "Likes the magazines, being in the sensory room, music in her room, and going for walk." These activities required staff being able to give one to one time. We were also told that some people joined in with a group cooking session that took place weekly led by the home's chef.

People had some opportunities to go out of the home, to the shops or town. One person enjoyed going for drives but this was dependent on staff and driver availability. One staff member said, "We could do more, especially outside of the home, and taking people out more. If we have the driver, we might try a couple of times each week." There were external providers who came into the home to provide specialist activities that were tailored for people with sensory and learning needs. We saw this happening on the day of inspection and five people had been involved in the social interaction group. The provider of the activity said, "We've been coming in once a week for several years. The home is good at giving people appropriate stimulation."

People were cared for at the end of their life in a person-centred way. One person was currently receiving palliative care and their wish was to stay at the home. Their relative told us, "[name] has deteriorated and the staff are doing everything they can to help them feel as comfortable as possible." There were easy to

read versions of a persons' wishes for the end of their life which, where possible, had been clarified with the person's family. There were also funeral plans in place for each person.

There was a complaints policy in place. The service also had an easy to read policy with pictures available. One person said they would, "Go to the person in charge," if they had a complaint. Another person said, "I don't know how to make an official complaint. I haven't been given a reason." They said they would be able to," Voice their opinion," if they weren't happy about anything. There was a folder for complaints but none had been made this year.

Requires Improvement

Is the service well-led?

Our findings

People told us they knew who the manager was. One person said, the service was, "Generally good, very good in fact." Although there was no registered manager present for the inspection, the nurses demonstrated a good knowledge of the needs of the people they cared for. The regional manager attended to provide support to staff and told us they knew there were organisational areas they intended to improve. They said, "We want to hear what you have to say and will pick things up and deal with them."

The approach to record keeping and service organisation needed improvement. People's written care records were kept up to date but, following a review or any change in care, the notes had been handwritten and these were not always clear. Changes had also been made in pen to one person's feeding regime and to dietary guidelines in another. The form used for recording people's monthly weight was also not fit for purpose as additional dates and columns had been added making the records unclear. We were informed that there was work underway to review and archive documents and move to electronic care records.

There was one person's care record where risks assessments were still in draft. We were informed that the person had moved to the home about four months ago and the registered manager was still updating this care plan. We considered the impact on this person and the delivery of safe care. The nurses could describe to us in detail the person's health and nutritional needs and there was evidence from their communication book of a good handover. However, not ensuring that accurate care records were available for all staff, after this period, demonstrated to us a lack of organisation and leadership.

Whilst policies and procedures were in place, a number were over three years old and needed review. For example, the safeguarding policy needed to reflect the most recent local authority guidelines. Safety checks on the staff, equipment, beds, the building and water flushes were being done but the evidence and latest reports were not in the right folder or easily located. These were sent to us after the inspection.

There had been low reporting by the service to the CQC of incidents and some statutory notices had only been sent after a care professional had highlighted a concern or given feedback. We raised this at the inspection to be sure that the service had correctly identified incidents. The clinical lead said there had not been any other notifiable incidents in the last year. The regional manager said they "Listened and responded to professional feedback," However, we also heard from healthcare professionals that the home could do more to take on board their views. The provider told us, after the inspection, that they have set up monthly meetings with professionals to improve communication.

People and their relatives were not formally involved in the development of the service. There were no regular meetings held where people and their representatives were asked their views of the service. Instead, families were welcomed into the home and we were told of informal feedback, but this was not being recorded or used to support service improvements.

The failure to maintain accurate records, and to seek and act on feedback from people and those acting on their behalf is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

Staff told us they were supported and felt involved in the service. They spoke well of the registered manager and the way they worked with everyone. One staff member said, "The new manager wants to do the right things for people, and is trying to make changes to improve people's rooms and upgrade furniture. We can tell the manager if we have ideas."

Staff meetings were held monthly and staff were encouraged to attend and were paid to do so. In the minutes of the last meeting communication between the staff was an item as well as a review of how they could improve the meal support for people. Staff put forward ideas and they were also reminded of some good practice issues by the registered manager. For example, how meals were not to be rushed and that staff must communicate with people about what they are eating. There was a reminder to read the guidance for one person and to ensure all staff wore the correct aprons.

There were various means of ensuring communication with staff, which we saw in practice. The regional manager said, "We are working hard to bring everything up to date and to the same standard." There were new computers on order and a plan to implement a new system for electronic record keeping. The registered manager, who had been in post four months, later told us they wanted to make improvements to the organisation of the office and recognised there was work to do.

There was a quality assurance process in place. We were told of quarterly internal audit system by the care provider and evidence of this was sent to us after the inspection. A health and safety report covered areas such as the number of reportable incidents, any maintenance or breakdown of equipment, any visits from health and safety contractors and any first aid, fire or health and safety related training attended. There was also a quarterly review of care and good governance within the home, including staffing levels, training and supervision, medicines, people's care and the management of some people's finances. Observational checks on staff practices were part of the audit. There was an action plan in place which was monitored.

The service had made good connections with the local GP, the community learning disability team and the acute hospital. They had consulted professionals and sought advice over some care issues. People and staff were encouraged to go out and access local shops and resources. The service was well placed to offer placements for nursing students, as there was expertise within the nursing staff group, but this had not been developed yet. This could be of benefit and a positive influence for the home as well as provide a good experience for the students.

Following the inspection, the registered manager told us they had the passion and vision to improve the service. They sent us a plan of actions they had identified, for home improvements, re-organisation and to work on the new systems and records. We will check that these improvements are made and sustained at the next inspection.

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 12 HSCA RA Regulations 2014 Safe care and treatment (b) Incidents that affect the health and safety and welfare of people must be reviewed and thoroughly investigated by competent staff, and monitored to make sure that action is taken to remedy and prevent future occurrences and make improvements. (h) People who use the services must be protected sufficiently against the risk of spread of infections. Providers must act to assess, prevent and control the spread of infections.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance (c) Records relating to the care of people must be completed, legible, indelible, accurate and up to date. (e) Providers should actively encourage and act on feedback about the quality of care and involvement from people using the service, those lawfully acting on their behalf, carers and other relevant bodies.