

Knowles Care Home Limited

The Knowles

Inspection report

6 Duggins Lane
Tile Hill
Coventry
West Midlands
CV4 9GN

Tel: 02476460148

Website: www.adeptcarehomes.co.uk

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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?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

About the service

The Knowles is a care home and was providing personal care to 33 people at the time of the inspection visit. Two people who lived there were in hospital. The majority of people who live at the home are older people living with dementia. The service can support up to 40 older people or younger adults with dementia care needs. Accommodation is in an adapted building over two floors.

People's experience of using this service and what we found

Systems to monitor the quality and safety of the service had not been fully effective in identifying areas for improvement and ensuring areas of risk were promptly acted upon. Risks associated with people's care were not always effectively recorded and managed. This included risks related to the management of falls and people's behaviours that were challenging. Some people's care plans lacked detail to support staff in keeping them safe.

People were provided with a choice of meals but gave mixed reviews of the food provided. Staff supported those people who needed assistance to eat and specialist diets were catered for. However, records did not always confirm dietary advice provided by health professionals was followed.

Staffing arrangements were not consistently effective to keep people safe. Whilst people were complimentary of staff, they felt at times support was delayed. This in particular applied to at night when staff numbers reduced, and communal areas were not always supervised. This increased the risk of people's safety not being maintained and there were people who had sustained unwitnessed falls during this time.

People received their medicines, but medicine checks showed discrepancies in medicine counts. This meant it was not possible to confirm the amount of medicine administered and remaining was correct to confirm medicines were managed safely. Medicines were stored safely.

The service had a registered manager in post but at the time of our inspection they were absent from the home and the provider had arranged for a member of the management team to support the home. People and relatives knew this staff member and spoke positively of them during our visit.

People's needs were assessed prior to them starting to use the service and were involved in making decisions about their care and how they would wish to be supported. Where appropriate family members were also involved in this assessment.

Staff understood how to recognise abuse and knew they had a responsibility to report any concerns to their manager, so these could be addressed. People told us they felt safe and felt at ease to report any concerns to staff.

People were supported to have maximum choice and control of their lives and staff supported them in the

least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Staff had been recruited safely and staff received the training they needed to support people needs. Staff felt the training they received was effective. Staff spoke kindly of people and knew people well, so they could provide care in the way people wanted.

People told us staff were kind and caring and treated them with dignity and respect. We saw staff were respectful towards people and encouraged them to maintain their independence. People had access to a range of activities which were of interest to them including some outside visits. Visitors were welcomed into the home and spoke positively of the service.

People knew who to contact if they had any concerns. The provider had a system for responding to complaints and those received had been responded to and resolved.

People spoke positively about the management team and had confidence in them. Staff felt valued which had resulted in a positive, encouraging and supportive culture which benefited all. The management team demonstrated a commitment to further improve the service.

People and staff had opportunities to comment on the service during meetings and periodic quality satisfaction surveys. Health professionals were also invited to provide their views through these surveys.

Since the last inspection, action had been taken to ensure notifiable incidents such as serious accidents and incidents were reported to us as required.

Appropriate action had been taken by the provider to display their ratings.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection (and update)

The last rating for this service was Requires Improvement (published 26 September 2018) and there were multiple breaches of the regulations. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations. The service remains rated requires improvement. This service has been rated requires improvement for the last three consecutive inspections.

Why we inspected

The inspection was prompted in part by notification of a specific incident. A person using the service sustained a serious injury. This incident is subject to an investigation. As a result, this inspection did not examine the circumstances of the incident.

The information CQC received about the incident indicated concerns about the management of falls. This inspection examined those risks.

We have found evidence that the provider needs to make improvements. Please see the Safe, Responsive and Well Led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The

Knowles on our website at www.cqc.org.uk.

Enforcement

We identified two breaches in relation to the Health and Social Care Act 2008 (Regulated Activities) Regulations. Insufficient action had been taken to mitigate risks associated with people's care to keep people safe, and systems to monitor the quality of the service, were not always effective. We have found evidence that the provider needs to make improvements across the Safe and Well led key questions.

Please see the action we have told the provider to take at the end of this report.

Follow up

We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe.	Requires Improvement ●
Is the service effective? The service was effective.	Good ●
Is the service caring? The service was caring.	Good ●
Is the service responsive? The service was not always responsive.	Requires Improvement ●
Is the service well-led? The service was not always well led.	Requires Improvement ●

The Knowles

Detailed findings

Background to this inspection

The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team

The inspection was carried out by two inspectors and one assistant inspector.

Service and service type

The Knowles is a 'care home'. People in care homes receive accommodation and nursing or 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.

Notice of inspection

This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

During the inspection-

We spoke with six people who used the service and four relatives about their experience of the care provided. We spoke with four care staff, the maintenance person, the cook, a housekeeper, two health professionals (one that was happy with everything and another who felt communication and training could be improved), the deputy manager, the compliance manager, and two directors.

Some people living at the home were not able to tell us about their experiences of living at the home due to their complex health conditions. We therefore spent a period of time observing people in the communal areas. This helped us judge whether people's needs were appropriately met and to identify if people experienced good standards of care.

We reviewed a range of records. This included a review of three people's care plan records plus other care records related to people's care and multiple medicine records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including complaints, accidents and incidents, quality monitoring, health and safety, and safeguarding people records.

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- Risks to people's health and safety were not always managed safely. The inspection was prompted in part by notification of a specific incident. A person using the service sustained a serious injury as a result of a fall during the night. This incident is subject to an investigation. As a result, this inspection did not examine the circumstances of the incident. The information CQC received about the incident indicated concerns about the management of falls. This inspection examined those risks.

Following the incident, the provider reviewed falls training with staff and was taking action to investigate the root cause of this, so they could identify if any actions were needed to prevent this type of incident from happening again.

- At this inspection we found two people assessed as being at very high risk of falling did not have detailed management plans to inform staff what actions they needed to take to minimise the risks of them falling. Although pressure mats and crash mattresses were used to reduce the risk of injury in people's bedrooms, it was not clear how risks were managed in the lounges when there was reduced staff on duty.
- A person assessed at high risk of falls had a sensor mat which was to be positioned by the side of their bed to alert staff if the person tried to get out of bed unsupported. We saw when the person was in bed the sensor mat had not been placed in position beside the bed despite staff knowing this was required.
- Staff told us a staff member should be in each lounge "to keep an eye" on people however this had not always happened at night. One person told us, "At night time when everybody is going to bed there aren't many staff. They come as soon as they can... but of course it can be difficult with some people."
- A person at risk of seizures who had been discharged from hospital following a seizure did not have a seizures risk assessment to identify and manage risks associated with these. This was raised with the management team to ensure clear plans were in place for staff on the management of risks.
- A person assessed as being at high risk of skin damage had a care plan that stated they should be sat on a pressure relieving cushion. We saw the person sat in the lounge without their pressure relieving cushion.

- Improvements were still required to ensure staff had the information they needed to support people with behaviours that could challenge the service. Whilst staff understood about using distraction techniques, information to support staff about these techniques lacked detail.
- Care records showed one person became "upset" and was agitated on a regular basis. Records were not always detailed enough to identify potential triggers to show why this may be. Actions taken by staff were not sufficiently detailed to show how they kept the person and others around them safe.
- One person had a fan beside their bed and a bedside light. The cables went across the head of the bed, so they could be plugged into a socket on the other side. The wires trailed between the headboard and the mattress which presented a potential entanglement risk to the person. We raised this with the management team so that immediate actions could be taken to address this. We have subsequently been advised this had been moved.
- Incidents and accidents were recorded but the level of detail was not consistent to demonstrate they were appropriately managed. For example, details of investigations undertaken into the potential cause and action taken to reduce the risk of reoccurrence.
- There was inconsistency in the recording of accident and incidents to show risks were identified and minimised. For example, one person's daily records detailed behaviour that could have caused them harm, this had not been recorded on an incident form. However, when the behaviour for the same person had occurred on a different date, this had been recorded on an incident form.
- Recording of falls was not consistent on the electronic system which meant the true number of falls people had experienced may not be identified. For example, a "falls tracker report" showed an ambulance had been called following a person falling, this was recorded as 'ambulance' rather than 'fall'. Another person's records showed they had attended hospital following a fall, this was recorded as 'hospital' rather than 'fall' so did not show on the falls report.

The provider had failed to ensure that care was provided in a safe way to service users. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following our visit, we were told of actions taken to reduce the frequency of people falling. The management team had looked closer at the reasons why people were falling. This included reviewing people's medicines, checking how many times people had fallen before, looking at people's sleeping patterns and health conditions. Staff had been re-educated about the actions needed to reduce the risk of falls. Records provided showed these actions had been effective in reducing the number of falls.
- A relative told us staff were responsive to their family member who "fell over quite a bit". They said, "They're always on top of it [Name] has an infection or if anything's wrong. [Name] has a walking frame with wheels... they need assistance getting up and help with their balance... they just hold them for a few seconds and reassure them."
- Risk assessments had been revisited following our visit to check they contained all of the required information to ensure people were supported safely. This included looking at the details of a person's medical diagnosis that had contributed to their seizures and updating records, so staff would know what to expect if the person was to have a seizure and what to do.
- The provider's new quality director had identified improvements were needed in the standard of information recorded in accident and incident forms and the overall analysis to more effectively identify any trends or patterns.
- People had a personal emergency evacuation plan (PEEP) which detailed what assistance and equipment they would need to evacuate the building in the event of an emergency.
- Safety checks of the building and equipment were completed to make sure the premises remained safe for people, visitors and staff. This included checks of water, gas, electricity and equipment people used.
- A member of the management team confirmed that people's dependency levels were considered to

determine staffing levels required at the home. We saw staff hours had been increased or decreased in accordance with occupancy and fluctuating dependency levels.

Systems and processes to safeguard people from the risk of abuse

- Improvements had been made since the last inspection in the reporting of accident and incidents that reached the safeguarding threshold to ensure these were appropriately managed.
- Staff knew how to identify signs of potential abuse and said they would report any concerns to their manager. One staff member told us, "I would go and report it to the senior in charge and then I would write a statement of what I had seen. If the senior didn't do anything, I would go to the manager. I would phone CQC."

Staffing and recruitment

- People and relatives had mixed views about whether there were enough staff available. One person told us, "No (not enough staff)... They do their very best... A relative told us, "The managers often help out, this is actually the norm, I have not seen people have to wait a long time for things."
- Staff told us they sometimes felt pressured particularly in the morning. One said, "No (not enough staff). I do what I have to do to make the residents comfortable, but I do not have time to sit and chat with them. Sometimes it can get really, really hectic. When they have an extra member of staff. Those are the best days." A second member of staff told us, "No, I think we could do with one extra staff. That would make a difference in the morning when we come on and the senior has to go and do the 7.30am round. If someone has to stay in the lounge you are short of assistance to get people up in the morning."
- On the day of inspection, we saw staffing arrangements were sometimes not effective. For example, at breakfast time staff were task orientated with little time to spend with people. Two people were assisted to eat by one staff member at the same which was not dignified. One person who repeatedly called out was ignored and not acknowledged by staff in a timely way. However, for the remainder of the day when more staff were around, people were responded to and staff had more time to spend with people.
- Safe recruitment practices were followed to ensure staff were suitable to work with people who lived at the home.

Using medicines safely

- People received their medicines from suitably trained staff when they needed them. Staff competencies were regularly checked to make sure they continued to manage medicines safely.
- The electronic medication system enabled staff to identify which medicines people needed and the correct time to give them. However, there were discrepancies in the amount of medicine the system said was available and the actual amount available. Staff were not aware of why the counts were different to rule out any medicine errors but told us the necessary checks would be completed.
- Staff wore "do not disturb" tabards to help them administer medicines safely with minimal interruptions.

Preventing and controlling infection

- Staff had completed training, so they had a good understanding of infection control procedures. They had access to personal protective equipment such as disposable gloves and aprons to help them reduce the risk of the spread of infection.
- There were specific staff employed to clean the home every day and staff told us this included a "deep" clean when needed.

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Good. At this inspection this key question has remained the same. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs were assessed before they moved into the home to identify their needs and preferences for care to ensure these could be met.
- Summary care plans contained basic information on how people liked to receive their care and the support they required to assist staff in delivering care in accordance with their preferences.

Staff support: induction, training, skills and experience

- People and relatives felt the staff knew how to support people effectively. We saw safe practices were followed when supporting people such as transferring them from a wheelchair to a comfortable chair.
- Staff completed an induction to the home, and completed ongoing training the provider considered essential, to support them in meeting the needs of people effectively. New staff completed the Care Certificate, a learning programme to help them provide safe and compassionate support to people.
- Staff completed training linked to people's needs such as dementia. A staff member told us, "I can put myself into their situation now and I do understand how they feel. And that is the reason I always talk to them and let them know what is happening around them because it must be really hard if you just do things to them and they don't know what is happening."

Supporting people to eat and drink enough to maintain a balanced diet

- People continued to have mixed opinions about the quality of the food. One person told us, "I'm being quite honest here... it's edible. There are some nicer than others (main meals). Another said, "Lovely... the food is beautiful in here."
- Most main meals were obtained frozen and pre-prepared and were cooked at the home. The cook checked the choice of meals was based on people's known preferences. 'Taster sessions' enabled people to offer their opinion of the meals before they were added to the menu.
- At breakfast time people were not routinely offered choices but despite this, some people knew choices were available. One person told us, "There's three cereals plus the porridge. On Wednesday and Saturday, they have a full English breakfast. They (people) really do enjoy it."
- Specialist dietary needs were catered for, for example, one person had a reduced sugar diet because they had diabetes, this included diabetic desserts and sugar free snacks were available.
- Coloured plates of different sizes were used to assist people to see their food clearly and encourage them to eat their meals.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- Managers worked in partnership with health and social care professionals such as GPs, mental health teams and relevant others, such as family members to ensure people's needs were met.
- People told us they could access healthcare professionals when needed. One person told us, "The doctor comes every Tuesday... people get used to her. The staff usually prepare a list of people who need to see the doctor. They call the paramedics in emergencies."

Adapting service, design, decoration to meet people's needs

- Consideration had been given to ensuring the environment met people's needs. Bedroom doors contained memory boxes with items such as photos to help people recognise the doors to their bedrooms. There was clear signage around the home.
- A relative told us, "I think the money the group has been spending in here is out of this world. We have had new flooring and they have redecorated the lounge. We can't complain about the upkeep of the place, they have a maintenance man who is on hand."
- There was a lift to assist people to easily access the upper floor and doors were code locked where it was felt necessary (such as on stairwells) to minimise the risk of people falling.
- People had access to the garden and one relative told us, "The garden outside is lovely, I think it is a really good feature."

Ensuring consent to care and treatment in line with law and guidance

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. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- Staff demonstrated they understood the principles of the MCA and sought consent from people before providing care. Staff respected people's right to refuse support.
- People's MCA records contained details of what prompted the MCA assessment and what the specific decision was that needed to be taken. Records included details of who had been consulted and details of any best interest decision that needed to be made.
- DoLS applications had been made where appropriate and there was a system to check DoLS were reapplied for when needed to ensure any conditions were complied with.

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Good. At this inspection this key question has now remained the same. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- People told us the staff were kind and caring to them. One person said, "Everybody is so kind, not only to be me but to everybody."
- Relatives felt staff were caring towards people. One relative told us, "They can't do enough for you and the residents. They do little things like they do her nails, they'll talk to them, they'll get people involved (in activities) if they want to but they never push people."
- Staff communication with people was warm and friendly, showing a caring attitude.
- Staff demonstrated a detailed knowledge of people as individuals and offered words of encouragement when they recognised people needed support.
- Staff were positive about the people they cared for and what the role meant to them. One member of staff told us, "We all love them, and the residents make you happy and laugh. They make you feel your job is rewarding however hard your day has been."

Supporting people to express their views and be involved in making decisions about their care

- People felt staff listened to them and said they were encouraged to express their views. One person told us, "The senior staff are very, very approachable... they ask you if everything is ok."
- Care plans contained information about how to involve people in decisions about their care. For example, one care plan said, "Can make informed decisions re clothes and choosing meals. Staff to give [Name] the time and patience to express any concerns or care needs." We saw this happened.
- People and their relatives had opportunities to share their views and opinions during reviews of their care. Relatives confirmed they were also able to approach staff to discuss people's care, where appropriate so they felt involved in their care. One person told us, "I have a care plan... I get to see it, they ask you every now and then if it's still ok."

Respecting and promoting people's privacy, dignity and independence

- People and their relatives told us staff treated people with dignity and we observed staff maintained people's dignity when supporting them.
- Staff understood the importance of respecting people's privacy and dignity. Staff knocked people's doors and identified themselves before entering. Staff ensured doors were closed and people were covered when supporting people with personal care.
- People were encouraged to be independent where this was possible. Care staff knew the level of support each person needed and what aspects of their care they could complete themselves.

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Overall, people spoke positively about their care, but we found sometimes they did not receive personalised care due to risk management not being consistently effective. One person who had fallen three times in a seven-day period had been referred to the 'falls clinic'. Health professional advice was to check the person's blood pressure weekly. A member of the management team was unable to demonstrate this was being done to help identify a possible cause of the falls.
- Summary care plans provided staff with basic information about people's needs. Some people did not have detailed care plans to help ensure they received personalised care although the provider knew care plans needed further work and was working to ensure this was addressed.
- Care plan records showed people's preferences for sleeping but these did not always reflect what happened in practice to support people's sleeping routines. There were people sleeping in chairs, sometimes in communal areas, as opposed to their beds. It was not always clear why this was.
- People were able to independently help themselves to jugs of juice on tables at lunchtime if they wished.
- One person chose to apply their own moisturiser on their legs but staff had noted a deterioration in the person's health and asked if staff could apply this for them until they were better.
- A relative told us staff knew how to respond to their family member's needs. They said, "[Name] can be quite difficult ... they won't let them (staff) do personal care on them but they have learnt to go back in half an hour and try again, it's the same with their medicines."

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- People's communication needs were identified, assessed and recorded in their care plans.
- Staff knew people's communication needs and supported people where needed. Staff recognised where people may benefit from documents being read out aloud or explained.
- At lunchtime staff showed people sample plates of the menu choices available to help them choose what they wanted as they recognised people may not be able to make choices from menus or from being asked.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- Information about people's interests and hobbies was assessed when people started to use the service. People had access to a variety of social activities and were prompted to join in, so they could choose

whether to participate.

- Since the last inspection new equipment had been purchased to support people's social care needs and interests. This included an interactive touch board in one of the lounges for people to use, ration books, memory games, and doll therapy.
- Visits from family members and visitors were encouraged so that people could maintain contact with people important to them. One relative told us, "The immediate thing I noticed here is the number of staff and the fact they have time to stop and talk to you."
- Links with the community had been established including local places of worship. Since the last inspection more outside trips had been organised including, a trip to a garden centre and a picnic in the park. Entertainers were also arranged to visit the home.

Improving care quality in response to complaints or concerns

- Systems were in place to manage and respond to complaints or concerns received by the service and people felt at ease to raise these if needed.
- Records showed the provider had responded and resolved complaints raised with them.
- People and relatives spoken with did not have any complaints about the service. One person said, "I've no complaints. The staff are lovely here... kind and understanding with all of the residents here." A relative told us, "I think it is good, I have got no complaints."

End of life care and support

- Care plans contained some end of life information to support staff in understanding people's wishes at this time
- Staff had been comforting and compassionate when a person had passed away at the home. A family member told us, "The staff who helped and supported both [Name] and myself during [Name] last few days, were extremely sensitive, kind and helpful."
- Staff responded to people's needs when approaching the end of their life. A care staff member told us high calorie homemade milkshakes were being provided to person at the end of their life who had lost a lot of weight as they knew the person liked them.

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At our last inspection the provider had failed to ensure systems and processes to monitor and assess the quality and safety of the service were effective. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had not been made at this inspection and the provider was still in breach of regulation 17.

- Established systems in place to review the quality of the care provided were not fully effective to ensure the quality and safety of people who used the service.
- Monitoring systems had not identified the lack of clear records relating to risk management. For example, potential triggers for behaviours and actions taken in response to them. This meant it was not possible to evaluate these were managed effectively.
- Food and drink records did not always show specialist diets such as diabetic alternatives or fortified foods, as advised, were provided to maintain people's health.
- Auditing of medicine records had not been effective in identifying the amount of medicines available did not tally with the amount recorded.
- We found the standard of completion of accident and incident forms was variable with some not being clear about what action had been taken to minimise risk or identify the cause. However, the new quality director had started to review records and they had identified themselves that improvements were needed.

The provider continued not to have effective arrangements in place to monitor, improve and sustain the quality, safety and welfare of people using the service. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Continuous learning and improving care

At the last inspection the provider had not complied with their legal responsibilities to tell us about notifiable incidents such as all safeguarding incidents that occurred in the home. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

At this inspection enough improvement had been made and the provider was no longer in breach of Regulation 18.

- Accidents and incidents that compromised people's safety had been reported to the relevant agencies as required.
- The service demonstrated they continually sought feedback and suggestions via surveys and meetings with people and staff, and monitored the service, to further improve care delivery.
- Issues raised in quality surveys such as activities, catering and complaints procedures were discussed during meetings to demonstrate people's views were listened to.
- Staff told us any poor practice was discussed at meetings, but they also had a responsibility to report it. One staff member said, for example, if they did not like the way a staff member spoke to a person they would tell their manager.
- A staff member told us, "There's been a lot of improvements including activities, more support, better staff attitudes, more teamworking."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- People and staff told us they felt the registered manager and the management team were approachable and communicated with them well.
- A relative told us staff contacted them as agreed when something had happened that impacted on their family member's care. They told us, "[Name] falls over quite a bit... I tell them to give me a ring... they always do."
- Feedback from quality satisfaction surveys was positive. A relative stated, "Lovely home, carers are wonderful, extremely hardworking. All staff are very caring, efficient and an asset to the home."
- Professional visitors had completed a quality survey and were positive in their comments of the home. This included comments that staff were knowledgeable and had supported a person they were visiting a dignified way.
- Staff spoke positively of working at the home. They described the management team as, "Good, they are fair, easy to talk to. If you have got any problems, they help you out." Another told us, "There's been a lot of improvements "including activities," "more support, better staff attitudes, more teamworking."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People and relatives were encouraged to contribute their views both formally and informally through questionnaires, meetings and one to one discussion. A relative told us, "We have family meetings; this was about 'explaining the difference between Alzheimer's and dementia... and how to interact with people', this was very helpful."
- A second relative who had attended a meeting told us, "The senior staff are very, very approachable... they ask you if everything is ok."

Working in partnership with others

- Staff worked with other health professionals and agencies to ensure people's needs were met.
- People at the home had the opportunity to participate in organised events across the provider's other homes. For example, all homes were provided with sunflower seeds for people to grow. The provider's hospitality manager went around homes to judge them. Photos showed people had enjoyed this activity.

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 Risks associated with people's care had not always been effectively acted upon to reduce the risk of them happening again, and records were not always clear, to support staff in managing risks.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's systems and processes had not been consistently effective in identifying and swiftly acting upon areas of risk that impacted on the quality and/or safety of the service.