

Mr Barry Potton

Asquith Hall EMI Nursing Home

Inspection report

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Ratings

Overall rating for this service

Good 

Is the service safe?

Good 

Is the service effective?

Good 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Requires improvement 

Overall summary

This inspection took place on 17 September 2015 and was unannounced. We previously carried out a comprehensive inspection in July 2014 and rated the home overall as good with a breach in regulation with regard to medicines. We inspected again in May 2015 when we looked solely at medicines to see if improvements had been made. Although we noted some improvements we found the regulation was not being met and we issued a warning notice which required improvements to be made by 3 July 2015. At this inspection we checked whether these improvements had been made.

Asquith Hall provides nursing and personal care for up to 53 people with dementia and mental health needs. The service is divided into two units – Willow Unit on the ground floor which accommodates 25 people living with dementia and Meadow View on the first floor which accommodates 28 people with mental health needs. The registered manager told us there were 53 people using the service on the day of our inspection.

The home has a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.

We found improvements had been made in the management of medicines which meant people received their medicines safely and when they needed them. There were a small number of discrepancies in the stock balances which we found was due to lapses in the auditing and recording systems.

People told us they felt safe. We found risks were managed well which meant people were kept safe and staff worked with people to ensure that any restrictions in place were lawful and the least restrictive option. Staff had a good understanding of safeguarding and knew how to report any suspected or actual abuse. Safeguarding incidents were reported to the Local Authority and the Commission as required, although there was one isolated occasion when this had not happened.

There were enough staff to meet people's needs and keep them safe. Some people had one-to-one support which was provided sensitively to support the person and keep them and other people safe from harm. Recruitment processes were followed to make sure staff were safe and suitable to work in the service.

Staff received the training and support they needed to give them the skills and competencies required to meet people's specialist needs. We found staff knew people well and good communication systems ensured they were aware of any changes in people's needs.

The registered manager had a good understanding and knowledge of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS), although we found the knowledge of the nursing staff varied. Some people had DoLS authorisations in place and for others applications had been made to the supervising authority.

Relatives were unanimous in their praise of the care and support provided and spoke highly of the staff team. Overall we found staff treated people with respect and ensured their dignity was maintained. Staff interactions were generally warm, caring and considerate.

People received the care and support they needed from staff and we saw some examples of person-centred care plans. However, other care plans were more generalised and required more specific detail to ensure people received consistent care from all staff.

There was a wide range of activities available in-house and people were supported to pursue their interests out in the community. People received a range of food and drinks and were supported by staff with their meals. We observed a difference in the dining experiences as lunchtime on Meadow View was calm and well organised which was not the case on Willow Unit. Although the registered manager told us immediate action had been taken following the inspection to address this.

There was a positive culture in the home. Staff told us they worked well together as a team and felt supported by management. There were a range of quality assurance systems in place, however these were not always effective as we found they had not identified or addressed the issues we identified in relation to the auditing of medicines, care plans and people's dining experiences. We found this was a breach of regulation 17 which relates to good governance.

Although we acknowledge the registered manager took immediate action to act upon the feedback given at the end of the inspection to put these matters right, the quality assurance systems need to be robust to ensure these or similar lapses do not re-occur.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was safe. People received their medicines when they needed them and medicines were managed safely.

People were kept safe and risks were well managed. Staff knew about safeguarding and how to report any concerns.

There were enough staff to keep people safe and meet their needs. Robust recruitment procedures ensured staff were suitable and safe to work with people. The environment was clean and well maintained.

Good



Is the service effective?

The service was effective. People were supported by staff who were inducted, trained and supervised to ensure they had the skills and competencies to meet people's needs.

People's nutritional and hydration needs were met.

The legal requirements relating to Deprivation of Liberty Safeguards (DoLS) were being met.

People had access to healthcare services and specialist advice and support was provided.

Good



Is the service caring?

The service was caring. People and their relatives praised the staff and the care provided.

People were treated with dignity and respect. Staff interactions overall were kind, caring and considerate.

People had access to advocacy services. People and their representatives were involved in decisions about their care.

Good



Is the service responsive?

The service was responsive.

People's needs were assessed and care was planned to meet individual needs.

People's social needs were met through a range of activities and interactions with staff.

Complaint procedures were in place to make sure any complaints were dealt with effectively

Good



Is the service well-led?

The service was well led, though further improvements were identified.

Requires improvement



Summary of findings

Staff told us they felt well supported by the management and we found there was a positive culture which meant staff worked well together as a team.

Quality assurance systems were in place. However, these were not always effective as we found the systems had not picked up or addressed the issues we identified during the inspection.

Asquith Hall EMI Nursing Home

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 17 September 2015 and was unannounced. The inspection team consisted of four inspectors, a specialist professional advisor in mental health and an expert by experience with experience in dementia. 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 home. This included looking at information we

had received about the service and statutory notifications we had received from the home. We also contacted commissioners from the local authority and the local authority safeguarding team.

We usually send the provider a Provider Information Return (PIR) before the inspection. 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 did not send a PIR to the provider before this inspection.

We spoke with five people who were living in the home, three relatives, three nurses, five care staff, the cook, the activity co-ordinator, the registered manager and the director of nursing.

We looked at nine people's care records some in detail and others to follow up on specific information, six staff files, medicine records and the training matrix as well as records relating to the management of the service. We looked round the building and saw people's bedrooms (with their permission), bathrooms and communal areas.

Is the service safe?

Our findings

At the previous inspection in May 2015 we found a regulatory breach in relation to medicines which included gaps in recording, medicines running out of stock and a lack of guidance for staff in how to administer 'when required' medicines. At this inspection, we found improvements had been made.

We looked at people's medicine administration records (MAR) and reviewed records for the receipt, administration and disposal of medicines and conducted a sample audit of medicines to account for them. We found records were complete and people had received the medication they had been prescribed.

We found all medicines, including controlled drugs, were stored appropriately and securely. Medicine fridge temperatures were monitored to ensure the correct temperatures were maintained. Some people were prescribed controlled drugs and we found these were accurately recorded and accounted for.

The home had a medicines policy based on the National Institute for Health and Care Excellence (NICE) document 'Managing medicines in care homes', which included guidance on covert medication. We looked at the records for four people who received their medicines covertly. We saw mental capacity assessments and best interest meetings had been conducted with the registered manager, the person's family and a GP or psychiatrist and a pharmacist had been consulted to ensure a safe and effective method of disguising the medicines was used. We saw guidance notes were kept with the MARs for each person which contained information on how people liked to take their medicines and any nursing interventions for safe administration such as taking people's pulse prior to administering digoxin, and possible side-effects. Arrangements for the administration of 'as required' medicines protected people from the unnecessary use of medicines and records showed under what circumstances these medicines should be given. The nurse we spoke with demonstrated a good understanding of the protocol and during our inspection we observed protocols were strictly adhered to.

Our discussion with a nurse indicated all medicines were under constant review and this was confirmed in care records we reviewed. In particular we saw a number of

instances in the recent past where the nurse's observations of people's mood, sleep patterns and general mobility had resulted in the reduction in dose or stopping of anxiolytic and antipsychotic medicines. At the time of our inspection a person had recently returned from hospital following an unexplained fall. The nurse was aware one of the common side effects of Risperidone was loss of balance control and had requested a review of the person's Risperidone to ensure this was not a contributing factor to the fall.

We stock checked a sample of medicines on both units and found a small number of discrepancies in stock balances which related to 'as required' medicines. These discrepancies had not resulted in any harm to people but indicated auditing and recording systems for checking medicine stock required improvement. Following the inspection the registered manager provided us with evidence to show that action had been taken to address these issues.

People who used the service told us they felt safe and this was confirmed by relatives. One person said, "I feel very safe here, and I can go where I like, but I like to stay in here with my friends." A relative told us, "I visit every day for two hours and I feel that (my relative) is as safe as they could possibly be." Another relative said, "I am very pleased with (my relative's) care and how safe they are. In fact I feel that they are very safe."

Safeguarding policies were in place and a local flow chart had been developed showing the action staff were required to take which included reporting to the local authority and the Commission. Staff we spoke with confirmed they had received safeguarding training and showed a good understanding of safeguarding procedures. Staff were able to describe the different types of abuse and knew the signs and symptoms to look for such as unexplained bruising or changes in mood and behaviour which may suggest abuse was occurring. They were confident about the reporting systems and were aware of whistleblowing procedures.

We looked at the incident records and found in most cases, where there had been aggression between people, this had been correctly identified as safeguarding and appropriate referrals had been made to the Local Authority and the Commission had been notified. There was a high number of these incidents mostly due to the needs and behaviours of people living on the Meadow View Unit. These incidents were appropriately investigated in conjunction with the safeguarding authority. The registered manager

Is the service safe?

understood the different types of abuse and that aggression between service users constituted abuse and said all instances of this nature would be reported to the local authority and the Commission. However, we found one incident where there was no evidence recorded to show it had been reported to the local authority or notified to the Commission. Following the inspection we checked the notifications we had received and this incident was not included. In the context of the number of incidents, we found this to be an isolated case and the registered manager assured us this would be looked into further.

Our observations throughout the inspection concluded there were sufficient staff on duty to meet people's needs. Staff were present in communal areas and on the Meadow View Unit we saw staff intervened promptly, yet sensitively and calmly, to distract and de-escalate potential areas of conflict between people. On Willow Unit, although there were sufficient numbers of staff, we saw a lack of direction and leadership at lunchtime meant the support provided to people was disjointed. Staff we spoke with said they felt the staffing levels were sufficient to meet people's needs and told us bank or agency staff were used to cover any absences. Staff told us they took on different roles throughout their shift which they felt benefitted them and the people who used the service. For example, one staff member explained when they were providing one-to-one support to people the staff changed on an hourly basis. They felt this had a positive impact on the individual and acted as a de-escalation technique if the person was getting frustrated with the staff member.

We found risks to people living in the service were well managed. Staff we spoke with told us they had received training in the management of anger or potential aggression (MAPA) and one of the nurses was a MAPA trainer. We saw staff adopted preventative and de-escalating approaches by way of on-going risk management as opposed to a reactive approach to risk management. We saw when intervention techniques were used staff did this calmly and sensitively. For example, we observed staff escorting a person using an arm hold out of the dining room and along the corridor following an incident. Both staff remained calm and the senior care staff

member continued to speak to the person explaining where they were going. The arm hold was not excessive and the person was not in any discomfort as they were still able to walk and move about. Staff needed to increase the intensity of the arm hold and this was done discretely and the person's safety was maintained. When staff returned to the dining room they simply continued with the tasks they were doing before and everything continued 'as was'.

Effective recruitment, retention and selection processes were in place. We looked at six staff files which showed robust recruitment procedures were followed and relevant checks were carried out before an offer of employment was made. These included full employment history, proof of identity and two references. We saw evidence all staff had secured Disclosure and Barring Service (DBS) clearance before commencing employment. All applicants completed an application form and were interviewed by the registered manager. We spoke with two new staff who confirmed this recruitment process had been followed. There was an effective system in place to monitor the periodic registration of nurses with the Nursing and Midwifery Council. The registered manager told us people who used the service took part in the staff recruitment and selection process and their views were taken into account when appointing new staff.

We looked round the home and some people showed us their bedrooms. We found all areas were clean and the environment was well maintained. We detected isolated odours in two lounges. The registered manager assured us this would be addressed straightaway and following the inspection confirmed both lounges had been deep cleaned. Maintenance workers were employed and a system was in place for staff to report issues to them via maintenance books on each unit. Regular checks were undertaken on safety related items which included water temperatures, nurse call system, emergency lighting, fire alarm, gas and lifting equipment. The electrical hard wiring certificate was due for renewal and we received confirmation from the electrical contractor that this work was being undertaken. Regular room checks were also carried out by staff. These looked at a range of areas including furniture, bed rails and window restrictors.

Is the service effective?

Our findings

Our discussions with staff and review of the training matrix showed all staff received mandatory training and this was monitored by the director of nursing who arranged the refresher dates. They told us an electronic training record system had been purchased which would automatically trigger expiry dates and this was to be implemented in the near future. Some staff members were appointed as a 'link' which meant they had an area of practice which they were responsible for. For example, one of the senior care staff was responsible for moving and handling and provided in-house training as well as monitoring and addressing any poor practice. This 'link' approach encouraged participation and responsibility amongst the staff. The director of nursing explained that training was responsive to the needs of people using the service and this was evident as we saw staff had completed the Dementia Care Mapping course, another staff member had an alternative therapy qualification which they offered within the home and a staff member who was trained in physical therapy which they provided within the home. Furthermore the director of nursing told us they were looking at a core bundle of skills across all the qualified nurses. Staff told us they received regular supervision and this was confirmed in the staff records we reviewed.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes are looked after in a way that does not inappropriately restrict their freedom. The registered manager told us some people were subject to DoLS authorisations and further applications for DoLS had been made to the supervisory body with no outcome as yet. We reviewed the policy, assessment and operational procedures regarding the Mental Capacity Act 2005 (MCA) and DoLS within the home and found these were well structured and easy to follow. They included flow charts to assist assessors in how to arrive at a decision of capacity / lacks capacity and the subsequent best interest decision making process. They included a DoLS assessment tool which included a clear 'Pre-admission, Assessment and Planning' section. The registered manager told us the home had a waiting list which meant when people were referred staff from Asquith Hall carried out a pre-admission assessment which included a decision about the person's

capacity to consent to the move and identified whether a DoLS authorisation was required. Staff told us usually standard authorisation requests were sent to the authorising authority in advance of the person being admitted to the home which ensured authorisations were in place when people moved in. They said occasionally urgent authorisations had to be requested on the day of the move and that sometimes this process was delayed. This was discussed with the registered manager and director of nursing who said they would ensure all DoLS applications were submitted in a timely way.

We spoke with two of the nurses about MCA and DoLS. Their responses showed a variation in their levels of understanding about assessing capacity, best interest decision making and the application of this in practice. One nurse told us they had not received any training in MCA and DoLS and there was no evidence of this training in their training file. We reviewed the care records of two people who had DoLS authorisations in place and looked at capacity assessments. Records showed the decision to manage one person's smoking was clearly explored and evidenced by the Best Interest Assessor from the person's local authority and was authorised within the DoLS. We looked at the capacity assessments for five people in relation to safe access to their bedrooms through provision of an electronic key fob and found the assessments required updating and reviewing. We discussed our findings with the director of nursing and the registered manager who stated the assessments would be reviewed and they would arrange more in depth training on MCA and DoLS for senior staff.

We observed breakfast being served on both units. We saw staff offered people a range of food and hot and cold drinks. We saw breakfast was served to people throughout the morning as they got up and staff showed us a list they kept which recorded when people had received breakfast so that no one was missed. We saw where people required assistance with their meals this was provided on a one-to-one basis.

At lunchtime there was one main meal served. Staff told us people could have an alternative if they wanted however this relied upon people asking for something different. There were no alternatives recorded on the menus and when we spoke with the cook they told us they had not prepared any alternative meals that day. The cook knew about people different dietary needs and there was

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information about this displayed in the kitchen. The menus were displayed on the units but were not in an accessible format for people living with dementia as there were no pictures and the print was very small. We saw visual aids were available to help people living with dementia choose what they wanted, but these were not used by staff on the day of our inspection, although the director of nursing told us these were usually used by staff.

On Meadow View Unit we found the lunchtime meal ran smoothly with senior staff in attendance and staff provided support to people where needed. People told us they enjoyed the food and we saw people were offered something different if they did not want the meal. On Willow Unit it was not as well organised. There was no senior staff member present and we saw for the first 20 minutes two junior staff members were left to serve meals and assist people without any support or direction from more senior staff. The “dignity bibs” which were used did not arrive in the dining room until 15 minutes after the meal service had started and one person who had already started to eat their meal was interrupted to have a bib put on. About 20 minutes after the meal service had started two additional members of staff came to provide support.

By 12.50 four staff were supporting people to eat, however, we saw one person had not touched their meal and it was going cold in front of them, one person had not been offered a meal and another person’s meal had been taken away untouched because they appeared to be asleep.

Care records we looked at showed people’s weight was monitored by staff and specialist nutritional advice from dieticians and speech and language therapists (SALT) was recorded in the care plans. We looked at the food and fluid charts for two people. Although the care records for both people showed they were maintaining weight we found the charts were incomplete and the information recorded was not being monitored or reviewed by the nursing staff. Following the inspection the registered manager informed us new food and fluid charts had been put in place and the care co-ordinator had been given additional supernumerary time to support staff on Willow Unit.

We found people had good access to healthcare services. People’s care records showed input from GPs, quest matrons, Speech and Language Therapist (SALT) teams, community mental health teams, pharmacists, opticians and dentists.

Is the service caring?

Our findings

People who used the service and their relatives were unanimous in their praise of the staff. One person, on seeing a staff member across the lounge, pointed and said, "He's good him. I like him."

One relative said, "I visit my (relative) every day and staff welcome me at all times. In fact you could say we have all become good friends through the shared interests of my (relative). The staff work very closely with us and keep me well informed." Another relative said, "I have always been involved with my (relative's) care, in fact it is constant involvement, and I am extremely happy with the level of care they receive." A third relative said, "I am always involved with my (relative's) care. In fact I know when I come for the two hours daily, that staff work around me, and give (my relative) one to one care when I go home until I return the next day."

We observed staff practices throughout the day on both units. In the main we found staff were kind, caring and compassionate in their interactions with people. When we went to speak with one person the staff member who was providing one to one support asked us to keep the questions short as they said the person would become anxious after a few minutes. We saw the staff member worked closely with the person and when we spoke to the person they had nothing but praise for the staff member. We saw when people became agitated staff were quick to offer reassurance and were very aware of people's needs, quickly intercepting any distress or potential conflict between people.

On Meadow View Unit there was a calm atmosphere. We saw staff engaged with people at every opportunity and when offering assistance did so sensitively and with reassurance. For example, we saw one staff member offered a person a drink and assistance. We saw the staff member repeatedly reassured the person and when they appeared to be struggling tried an alternative approach. The staff member was patient and showed the person the cup each time before putting it to their mouth ensuring support was provided in a dignified way. On Willow unit we heard a staff member who was supporting a person to drink encouraging them and explaining, "I am putting the

cup to your lips now". On another occasion we observed staff helping someone to move with the aid of a hoist and saw that staff spoke with the person throughout and explained what was happening.

We observed on Willow Unit that staff interacted more with some people than with others, for example we saw one person had no interaction with staff over a 40 minute period. On another occasion we observed staff approached a person, asked them to sit forward and put a handling belt in place without explaining what they were doing or why they were doing it. During our time in the lounge we saw three people with whom staff did not engage. One person was making the same loud noise constantly, yet staff ignored them and there was no attempt to distract, reassure or engage the person. We observed these continuous loud sounds agitated the other people in the lounge resulting in another person shouting out in response, yet staff did not intervene. We discussed this with the registered manager and director of nursing at the end of the inspection and they said they would look into these matters and speak with staff. Following the inspection the registered manager told us the care co-ordinator's supernumerary hours had been increased and they were providing additional support to staff on Willow Unit.

We saw staff treated people with respect and maintained their dignity. One person said, "Staff here are okay, they treat me with respect and call me a gentleman." The language used by staff demonstrated their respect for people, such as calling people "Sir", asking "Would you like some help?" and "Shall I shut this [bathroom] door for you?" People were well groomed and dressed in appropriate and clean clothes. We saw one person whose trousers were slipping down and staff quietly and discreetly took the person to one side to adjust their clothing. We saw staff knocking on doors and asking if they could enter before going in.

People had access to advocacy services and we saw people, their representatives and/or advocates were involved in the decisions about their care. This was confirmed in our discussions with relatives. One relative said, "I have constant involvement in my (relative's) care and all their needs." Another relative said "When my (relative) first arrived here, they couldn't stand water or any

Is the service caring?

invasion of their space and I feel the staff have worked very hard to help them settle. They now appear much more calm. The staff keep me in the circle of everything to do with my (relative's) care."

Is the service responsive?

Our findings

Relatives we spoke with were very satisfied with the care provided to their family members. One relative said, "Prior to my (relative) coming here, we were finding it very difficult to find a place where they were able to take young afflicted people. (My relative) has now been here for four years, two years of this was spent on the other unit, but there were changes in their health issues and they were moved down here, where I am very pleased with their care and how safe they are." Another relative said, "My (relative) has been here since this place was just opened, that is five years ago. Before that, we tried three different places which were safe and suitable enough to take them. There were none. After the last time in hospital, (my relative) came here for respite care and has remained ever since. I know that they are safe here." A further relative said, "My (relative) came here directly from a hospital after being sectioned twice, twelve months ago. I visit every day for two hours. The staff are very good and (my relative) has one to one care when I am not here, to ensure they stay safe."

We saw staff were responsive to people's needs. For example we looked at the behavioural charts for one person and found the approaches taken by staff were sensitive, clear, firm and proportionate. The charts showed after physically intervening and ensuring safety, staff engaged the person in a verbal discussion around boundaries. Following review of the person's behaviour, one-to-one support was provided by staff which enabled the person to be supported in the community so that they could continue to engage with activities of their choosing. Another person had a smoking management plan as part of their DoLS authorisation. All staff were aware of this plan and knew the next smoke time when asked by the person which ensured consistently. Staff we spoke with had a good understanding of people's needs and told us they were kept informed of any changes through the handover meetings at each shift change.

We found variations in the care records we reviewed in that some care plans were personalised and gave specific details about the support and care required, whereas others lacked detail and were generalised. For example, one person's care plan described how the person would pouch food in their mouth and were at risk of choking and would sometimes take food from other people's plates and

throw crockery. There were clear actions for staff to follow to ensure the person ate their meal safely and that other people were also protected from the actions of this person. We saw this person having their breakfast and these actions were followed. Yet another person's care records were less specific and advised staff to manage the person's continence needs by toileting 'regularly', 'encouraging fluids' and 'using prescribed products'. The care records showed this person was prone to urinary tract infections yet there was no information to guide staff on the target fluid intake. The registered manager provided us with information after the inspection to show that these issues had been addressed with staff and the care records were being reviewed to ensure they all reflected a person-centred approach.

Information about activities was displayed in pictorial format and showed a range of activities and events taking place including the use of the home's hydrotherapy pool. The home produced a newsletter for people using the service and their friends and relatives. We saw evidence which showed people were supported to go out into the community as well as joining in with activities in the home. One person had been out with staff to a football match and another regularly attended a 'mens club'. We saw detailed information in some people's records about their personal history which included social interests and hobbies. We saw the activities organiser engaged with small groups and on a one-to-one basis on Meadow View Unit during the morning and afternoon providing a variety of different activities to suit individual tastes. We saw on the downstairs unit some people were not involved in any activities although in some cases this was through choice. One relative told us, "I realise that my (relative) really cannot join in any activities and in any case, they likes to spend the afternoon in their room enjoying their own space."

A complaints policy was in place with agreed timescales for acknowledging and responding to complaints. Two complaints had been received in 2015 and we saw both of these had been appropriately responded to within the timescales of the policy. The complaints were partially substantiated and the complainants had been informed in detail of changes made to reduce the likelihood of a reoccurrence and improve the quality of the service.

Is the service well-led?

Our findings

The home has a registered manager who registered with the Commission two months ago. Staff spoke highly of the management team and said they felt well supported in their roles. One staff member told us the registered manager had made lots of improvements since taking on the role. Our discussions with staff and managers showed respect for people who used the service as well as each other. Staff were clear about their responsibilities in addressing poor practice and this culture was embedded within the staff team.

We found improvements had been made to the management of medicines which addressed the regulatory breach found at the previous inspection in May 2015. However, as identified in other sections of the report we found some issues which indicated the auditing and recording systems in relation to medicines, care plans and the dining experience required improvement. Following the inspection the registered manager provided us with information to show that they had taken action to address the issues we raised, yet these issues should have been proactively identified and addressed by the home's own auditing processes.

We found systems were in place to assess, monitor and review the quality of service provided. Many of the audits and checks focussed on the two units separately and there was no overall analysis. For example, analysis of accidents, medication audits and room checks were all done by unit. There was no evidence that the provider checked these audits as part of their monthly provider checks as a tool to monitor overall performance. This meant there was a missed opportunity to identify common themes throughout the home and share any learning and this had been identified in the previous inspection report. The registered manager had a good understanding of the audits and checks undertaken.

Incidents and accidents were analysed monthly to determine the number of each type of incident/accident and these were analysed per unit. It was sometimes unclear what preventative action had been put in place following incidents, as the space on the incident/accident form was limited. For example, it was noted on 9 July 2015 one person head butted another person in the face and the person hit their head on the wall as they went down. There was no injury evident. The 'action taken' section stated,

“No treatment required, no evident injury, staff to monitor”. There was no further information to show what action had been taken to prevent a reoccurrence or share learning about this incident. The analysis showed another person had sustained two falls in June, five falls in July and none were recorded in August 2015. However, when we looked at this person's care records they showed the person had fallen three times in August 2015 but this was not included on the incident analysis. This showed that in this case the analysis was not an accurate representation of all the incidents/accidents.

We saw internal audits which monitored people's health care including weight and nutrition and a traffic light system was used to risk score any changes in weight. Mattress audits and pressure area equipment audits were also completed.

We looked at medication audits. An external audit had been conducted by a pharmacist on 5 February 2015, which identified some minor issues but was mostly very positive. We saw internal medication audits were regularly undertaken and highlighted issues including missing signatures and stock balances not being correct. Recent medication audits showed consistently that recorded totals of medicines did not match with stock balances. This indicated a widespread problem, particularly given our findings on the day of inspection. Although there were action plans in place to address these issues, these were not 'signed off' and there was no evidence to show these issues had been adequately addressed with nursing staff. The fact that we identified anomalies in stock balances during our inspection showed the quality assurance systems were not sufficiently robust in reducing risk and driving improvement.

The registered manager showed us a new care plan audit document which had been introduced in June 2015 to try and improve the quality of care plans. This looked at a range of areas of care documentation/care quality, including DoLS, risk assessments, care plans, pre-admission assessments and daily entries. We found the care plan audits had not identified many issues, yet our inspection identified several shortfalls in the care records we reviewed. For example, one person's BMI score had been calculated inaccurately giving a score of 30 when it should have been 25. After discussing this with the nurse it was then identified the wrong height had been recorded and the BMI was calculated to be 28. The falls risk

Is the service well-led?

assessment for the same person had been updated on 28 August 2015 and stated there had been no falls, yet an accident report showed the person had fallen in the shower on 2 August 2015. Similarly the falls risk assessment for another person had been reviewed in August 2015 and stated there were no changes, yet the accident records showed this person had sustained six falls since the previous review in July 2015. The falls diary for this person did not reflect the full history as only two falls were recorded in July and August, yet accident records showed seven had occurred and there was no up to date falls management plan. This showed that the audit systems in place were not effective in identifying and addressing these issues. This was a breach of the Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw internal audits which monitored people's health care including weight and nutrition and a traffic light system was used to risk score any changes in weight. Mattress audits and pressure area equipment audits were also completed.

The provider carried out monthly visits to the home where they did an overall audit on the quality of the service. This focused on speaking with staff and people, premises, complaints. There was evidence that improvements were

discussed with staff and their ideas were listened to. Staff's views were sought through an annual staff survey. The results of this had just been analysed and showed that staff morale was good and staff were generally happy in their role. The information was collated and the results were displayed in the home. Staff and management meetings were undertaken, there was evidence these were used to improve quality with a range of topics discussed including medication, DoLS and mental capacity.

A range of policies and procedures were in place including a CCTV policy. A privacy impact assessment had been carried out to ensure that the benefits and risks of CCTV were considered prior to approving CCTV on the unit.

Systems were in place to seek people's feedback on the quality of the service. This included quarterly service user questionnaires and these showed most people were very happy with the service. Carers and relatives were also asked for their views on the service. However, there was no overall collation of the findings, unlike with the staff survey, which was a missed opportunity to feedback the results to relatives and people who used the service about the findings and what had been done to address any negative comments recorded. We saw resident meetings were held and agenda items included food and activities.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance
Diagnostic and screening procedures	Systems and processes were not established or operated effectively to assess, monitor and improve the quality of the services provided or to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. Accurate, complete and contemporaneous records were not maintained in respect of each service user, including a record of the care and treatment provided to the service user and decisions taken in relation to the care and treatment provided. Regulation 17 (1) (2) (a) (b) (c).
Treatment of disease, disorder or injury	