Roseberry Care Centres GB Limited

Hylton View

Inspection report

Old Mill Road
Southwick
Sunderland
Tyne and Wear
SR5 5TP

Tel: 01915496568

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

Summary of findings

Overall summary

The inspection took place on 16 and 22 December 2016 and was unannounced. We last inspected the home on 23 and 29 June 2015. During that inspection we found the provider had breached the regulations relating to infection control, person-centred care and good governance.

The home provides nursing and residential care for up to 40 older people, some of whom are living with dementia. At the time of this inspection there were 39 people living at the home.

The home had a registered manager. 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.

During this inspection we found the provider had breached the regulation relating to safe care and treatment because the arrangements for managing medicines were not always safe. Medicines records were not always completed accurately, such as for the administration of medicines, the application of topical medicines, the application of transdermal patches and for the safe storage of medicines. We also found people were left unsupervised for prolonged periods.

The monthly medicines audits had not been effective in identifying the issues we found with medicines management. Following this inspection there had been a further two serious incidents involving medicines. We have written to the provider separately about this matter and we will closely monitor the action the provider takes to make medicines management safe.

People, relatives and care workers said the home was safe. People also told us they received good care from kind care workers.

Care workers had a good understanding of safeguarding and the provider's whistle blowing procedure. They knew how to report concerns but said they had not previously needed to use the procedures. Care workers also said the provider and registered manager would take concerns seriously and deal with them properly.

Assessments were carried out regularly to help protect people from potential risks, such as risks associated with poor nutrition, skin damage and mobility.

Although care workers confirmed there were sufficient care workers on duty, we observed there were occasions when people were left unsupervised in communal areas. The registered manager was taking action to improve the communication between care workers to ensure people were appropriately supervised.

An effective recruitment process was in place to check new care workers were suitable to work at the home.

This included carrying out a range of checks before new care workers started working at the home.

Health and safety checks were carried regularly including checks of fire safety, specialist equipment, the electrical installation, gas safety, water safety and portable appliance testing. There were also documented procedures to deal with emergency situations including personal emergency evacuation plans (PEEPs) to help keep people safe.

The provider logged, investigated and analysed incidents and accidents. Action had been taken to help prevent accidents recurring such as referrals to the 'falls team', replacing inappropriate footwear and increased observations.

Care workers received the support and training they needed to fulfil their caring role. Records showed supervisions, appraisals and training were up to date for most care workers.

The provider followed the requirements of the Mental Capacity Act 2005 (MCA), including the Deprivation of Liberty Safeguards (DoLS). DoLS authorisations had been approved for all relevant people. Care workers got people's consent before providing care. Care workers used various strategies to support people with making choices and decisions.

Care workers supported people to have enough to eat and drink in line with their needs. For example, one person required full assistance from a care worker which was provided appropriately. Other people received prompts and encouragement throughout the lunchtime. We saw one person who did not eat their full meal was not offered an alternative. Menu choices were limited with little availability of fresh fruit and vegetables. We have made a recommendation about this.

People had input from a range of external health professionals when required, such as GPs, specialist nurses, district nurses, speech and language therapists and dietitians. People's care records included the advice and guidance from health professionals.

Since our last inspection care plans had been updated to ensure they reflected people's current needs. We found they had been personalised to include information about people's care preferences.

People's needs had been assessed to identify the care they required.

People had the opportunity to participate in a range of activities, such as outings, pub meals, quizzes and parlour games.

People told us they had not needed to complain about their care. Previous complaints had been investigated and resolved in line with the provider's complaints procedure.

An annual audit plan had been developed and regular audits were taking place. Apart from medicines audits other audits were identifying areas for improvement and ensuring action was taken to address any concerns.

Care workers had opportunities to give their views and make suggestions through attending regular staff meetings or taking part in consultation.

Incidents and accidents were regularly analysed to check appropriate action had been taken and to identify trends and patterns.

The home had a long-term improvement plan with work on-going to complete the identified actions.

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.

Records did not support the safe management of medicines.

Care workers were aware of safeguarding and the whistle blowing procedure. Assessments had been carried out to help protect people from potential risks.

Care workers said there were enough care workers on duty. There were effective recruitment checks in place.

Regular health and safety checks were carried out. Incidents and accidents were logged, investigated and analysed.

Is the service effective?

Good

The service was effective.

Care workers told us they were well supported. Essential training was up to date for most care workers.

The provider acted in accordance with the Mental Capacity Act 2005 (MCA), including the Deprivation of Liberty Safeguards (DoLS).

Care workers supported people to meet their nutritional needs.

People received input from external health professionals to meet their health care needs.

Is the service caring?

Requires Improvement

The service was not always caring.

We saw people were sometimes left unsupervised in communal areas.

People were happy with their care.

People were usually treated with dignity and respect.

Is the service responsive?

Good

The service was responsive.

Care plans had been updated to reflect people's current needs and to include information about people's care preferences.

People's needs had been assessed to identify the care they required.

People had the opportunity to participate in a range of activities.

People did not have any complaints about their care. Previous complaints had been investigated and resolved.

Is the service well-led?

Requires Improvement

The service was not always well led.

Medicines audits were ineffective.

An annual audit plan had been developed. Other audits were taking place regularly.

Care workers had opportunities to give their views and make suggestions about the home.

The home had a long-term improvement plan.

Hylton View

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 19 and 22 December 2016 and was unannounced.

The inspection team was carried out by one adult social care inspector, a pharmacist inspector 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 home. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about. We also contacted the local authority commissioners of the service, the clinical commissioning group (CCG) and the local Health Watch. Health watch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

The provider completed a provider information return (PIR) prior to 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.

During the inspection we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with eight people who used the service and three relatives. We also spoke with the registered manager, the deputy manager, a senior care worker and two care workers. We looked at a range of records which included the care records for four people, medicines records, recruitment records for five care workers and other records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

During our inspection, we looked at the arrangements for the management of medicines and found that the arrangements were not always safe.

The majority of Medication Administration Records (MARs) contained photographs of people to reduce the risk of medicines being given to the wrong person however their allergies were not consistently recorded.

Records relating to medication were not always completed correctly placing people at risk of medicines errors. We checked a sample of medicines alongside the records for people and found varying accuracies between upstairs and downstairs. For example, downstairs we found all medicines we checked matched up, whilst upstairs we were unable to reconcile any medicines due to overstocking and no carried forward balances. For example, staff upstairs had not carried forward figures for one medicine resulting in over 1000ml surplus stock. This is necessary so accurate records of medication are available and care workers can monitor when further medication would need to be ordered.

We looked at how the home managed application of patches to people and found they were not using transdermal patch body charts as detailed in their current medicines policy. We looked at one person's record who was prescribed two different strength controlled drug patches every seven days as a combined dose for pain. We found that the prescriber's instructions had not been accurately followed. For example, the two different strengths of patches had been applied on different days which did not reflect the current instructions on the MAR. For the same person we found that on one occasion both patches had been applied one day late then subsequently one day early and on one occasion one strength had not been applied at all.

We saw how the care home managed the application of creams and gels. Although the home had a policy stating there should be a topical body chart in place, with information on where to apply and the frequency of application, there was no guidance in place for any person who was prescribed topical medicines. For example, we looked at one record where the person was prescribed a gel with directions of 'as directed'. There was no guidance or information in the care records to show where or how often this gel should be applied.

We looked at two people with medicine prescribed at a variable dose. The records showed that staff were not always recording the dose administered therefore we could not accurately identify the dose the person had received. This was not in line with the home's current medicines policy.

We looked at the guidance information kept about medicines to be administered 'when required'. Arrangements for recording this information were in place for some people however some of these records were not accurate. For example, we looked at one record for a person who had 'when required' medicine prescribed for agitation. This person had 'when required' guidance in place but the dose to be administered was not accurate in relation to their current prescription. We looked at another record where no 'when required' guidance was in place for a person requiring pain relief. This information would help to ensure

people were given their medicines in a safe, consistent and appropriate way.

Several people were being given medicines covertly (disguised in food or drink) however we found care workers were not following the home's medicine policy or national guidance. For example, the home's medicine policy stated there should be a specific form in place to record any decision making to administer covert medicine but this could not be found for any person we looked at. We looked at one record where no guidance was in place to inform staff which medicines should be given covertly or how they should be administered. For the same person we found on some occasions most medicines were given covertly but for other regular medicines the person had been allowed to refuse.

Medicines which required cold storage were kept securely in two fridges within the medicines store rooms. Processes for the checking of fridge temperatures across both floors were not consistent. For example, upstairs actual temperatures were being recorded daily but over the last three months no temperature had been recorded on 18 occasions. We found this fridge to have a maximum reading of 21°C on the day of inspection. Minimum and maximum temperatures only were recorded daily on the fridge downstairs however on 36 occasions over the past month the temperatures recorded were outside the recommended range and no action had been taken or documented. This means the home could not confirm that medicines stored in these fridges were safe to use.

Staff knew the required procedures for managing controlled drugs. We saw that controlled drugs were appropriately stored and signed for when they were administered. However, care workers were not completing weekly controlled drug stock checks or receiving spot checks from their regional manager as detailed in their medicines policy.

Eye drops and specific liquids, which have a short shelf life once opened, were not marked with the date of opening. This meant care workers could not confirm that they were safe to use.

We looked at how the registered manager monitored and checked medicines to make sure they were being handled properly and that systems were safe. We were shown the medication audit completed in November 2016 which scored the home as 100% compliant. This did not reflect the issues we found on the day of the inspection. The questions on this audit did also not reflect the guidance given to staff in their medicines policy.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

During our last inspection in June 2015 we found the provider had breached the regulation relating to safe care and treatment. This was due to a number of cleanliness shortfalls that compromised the control of infection within the home. Following our inspection the provider sent us a report of the actions they planned to take to become compliant with these breaches. These included a manager's daily walk around to check cleanliness of the building, staff training in infection control and monthly infection control audits. The provider told us they would meet the requirements of the regulations by 29 February 2016. We found the provider had made progress towards completing the actions identified in the action plan.

The registered manager told us infection control had been a priority when they took over management of the home. Due to the concerns identified during the last inspection, we carried a full walk around of the home when we first arrived. This involved inspecting all of the communal areas, including toilets, bathrooms and wet rooms. Generally cleanliness within the home was to a good standard. However, we found some toilets and wet rooms hadn't been cleaned properly. When we checked again later in the day we found this

had been addressed.

People and relatives told us they felt safe living at the home. One person said, "You need to use buttons to get in and out, so you know no one can come in if they don't know the buttons." One relative said, "They are well cared for and it's a safe environment.....there's no restriction on visiting."

Care workers also told us they were confident people were safe living in the home. One care worker commented, "Yes I do think they are safe." Another care worker told us, "I definitely think they are safe. The doors are locked and alarmed. Any issues get sorted."

Care workers showed a good understanding of safeguarding, including how to recognise the potential signs of abuse and how to raise concerns. One care worker commented, "I would report concerns to the manager straightaway." The provider had been pro-active in responding to previous safeguarding concerns. We saw from viewing the safeguarding log concerns had been referred appropriately to the local authority safeguarding team. Action had been taken to help keep people safe including invoking disciplinary procedures where required.

Care workers had been made aware of the provider's whistle blowing procedure. They told us there had been no reason to use the procedure but wouldn't hesitate if they had concerns about people's safety. One care worker said, "Any issues would be quickly addressed. The correct procedure would be followed." Another care worker commented, "I have not seen anything bad. They would definitely take things seriously, they are firm but fair."

The provider carried out a range of assessments to help protect people from potential risks. These included the risk of poor nutrition, skin damage and risks associated with mobility. Where people were identified as being at risk of harm measures were put in place to help keep them safe. For example, monitoring people's food and fluid intake and regularly checking their weight to identify any significant weight loss.

Care workers confirmed there were sufficient care workers to ensure people received appropriate and timely care. One care worker told us, "Staffing is generally quite good. (If we need cover) they ring around, staff are good and will pick up extra shifts." Another care worker said staffing levels were "quite good at the moment". We discussed staffing levels with the registered manager. They told us recruiting new staff had been a priority and there was now a full team of care workers. A dependency tool was used to monitor and analyse staffing levels. This was used as a guide as the tool showed more care workers were usually deployed than the tool recommended.

There was an effective recruitment process in place to check new care workers were suitable to work with people using the service. Pre-employment checks had been completed prior to new care workers commencing their employment at the home. This included requesting and receiving two references and Disclosure and Barring Service (DBS) checks. These checks were carried out to ensure prospective staff did not have any criminal convictions that may prevent them from working with people.

A range of health and safety checks were carried out to help keep the premises and equipment safe for people to use. This included checks of fire safety, specialist equipment, the electrical installation, gas safety, water safety and portable appliance testing. All checks were up to date when we visited the home. The provider had procedures to help ensure people were kept safe in an emergency situation and continued to receive the care they needed.

Incidents and accidents were logged, investigated and analysed to help reduce the risk of accidents

happening again. The analysis was completed to identify trends and patterns so that appropriate action could be taken to respond to each accident. The latest analysis showed there had been three accidents caused by a person losing balance, a slip and a person rolling out of bed, with no particular trends identified. Action taken included referrals to the 'falls team' for additional advice and guidance, replacing inappropriate footwear and increased observations.

Good

Is the service effective?

Our findings

Records showed care workers received regular supervision and an annual appraisal. For example, all care workers employed for over a year had received at least four supervisions. Care workers also told us they were well supported in their role. One care worker said, "I do feel supported. I feel I can speak to any of them." Another care worker commented, "Yes (I do feel supported), I can approach them anytime (registered manager and deputy manager)."

Care workers had completed training relevant to their job role in the home. The provider had identified certain training courses as essential for care staff to complete. This included fire safety, moving and handling, safeguarding, health and safety and infection control. Records showed essential training was up to date for most care workers. The registered manager maintained a training matrix to monitor when care workers needed to update their training.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are 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 were being met. People had been assessed and applications for DoLS authorisation submitted to the local authority for all relevant people. At the time of this inspection DoLS authorisations had been approved for 30 out of 39 people. This was following a MCA assessment and best interest decision having been made on behalf of each person. Within people's care records we viewed other examples of MCA assessments and best interest decisions made on behalf of people. For example, where they did not have the capacity to consent to their admission to the home.

Care workers understood the importance of seeking consent and respecting people's decisions before providing care. One care worker told us they respected people's choices and their right to refuse. One care worker commented, "It's their right to refuse (if they want to)." Where people lacked capacity, care workers described the strategies they used to support people with decision making. These included showing people pictures to enable meal choices and showing people items of clothing to choose from.

Care workers described the strategies they used to support people with behaviours that challenged. These included using distraction, reassurance and having a cup of tea. We observed during the inspection occasions when care workers adopted these strategies to good effect. For example, at one point one person was displaying repetitive behaviour. A care worker noticed this and quickly intervened. They said, "[Person] are you going to have a cup of tea?" The person nodded to show consent and went willingly and happily

with the care worker holding their hand.

We observed over the lunchtime to help us assess whether people were appropriately supported with eating and drinking. We observed the tables were set with a Christmas theme before people arrived in the dining room. One person commented, "That's lovely isn't it." Care workers were attentive to people's needs. For example by helping people to sit down at a table or pushing people's chairs closer to the table if they were too far away. Care workers offered prompts to encourage some people to eat.

Care workers supported people to have enough to eat and drink. People were offered a choice of drinks. Care workers encouraged people to point out which drink they would like. We saw one person needed full support with their meal and was assisted by the team leader. Other people were independent with eating or required minimal assistance from care workers. For instance, care workers helped some people by cutting up their food for them. Care workers always asked people for their consent before providing any assistance. We overheard one care worker say, "Is it okay if I cut up your food up or you?" Another care worker said (to another person), "Are you done [person's name], is it alright to take it (the person's empty plate)?" In both cases the care worker only proceeded to help when the person agreed to receive the help.

Where people had been assessed as being at risk of poor nutrition, food and fluid charts were in place to record people's nutritional intake. These were usually completed consistently. However, we did find a small number of gaps where meals or fluid had not been recorded. We raised this with the registered manager during the inspection in order to take immediate action.

Following our last inspection we reported the menus were repetitive, and did not include many options for vegetables, salads or fruit. We also reported many meals were accompanied with chips. We observed a similar situation during this inspection. People were offered a choice of meal but both were served with chips as there were no other options available. For example, the lunch options were either scotch egg and chips or corned beef, beans and chips. There were no fresh vegetables or salad for people to choose from. We noted following the most recent mealtime audit that menus were 'being looked at'.

We recommend as part of this review the provider researches best practice in relation to the planning and provision of a nutritious, balanced and varied menu and updates its practice accordingly.

Two people had a pureed diet due to specific needs they had. The cook took time over how this was presented by piping the food. Some people gave positive feedback about their meal. We overheard one person saying, "Oh I really enjoyed my dinner." However, one person also commented, "I don't like the food in here". We saw one person did not eat their meal apart from a few chips. They told a care worker they didn't want it. We noted no alternatives were offered to the person.

People had regular input from a range of external health professionals in line with their needs. This included GPs, specialist nurses, district nurses, speech and language therapists and dietitians. Care records incorporated the advice and guidance health professional had given. For example, one person had received input from SALT. They had given specific guidance to care workers about the most effective method to communicate with the person. This guidance had been incorporated into the person's communication care plan to help care staff provide care in a consistent way.

Requires Improvement

Is the service caring?

Our findings

We observed occasions when people were left unsupervised for long periods in communal areas. One person told us, "We come in here and no one comes to see if we need anything." For some people this meant they did not always have their needs addressed quickly. For example, one person asked us to alert care workers they needed assistance with personal care. When we relayed this information to the care workers, they assisted the person immediately. Other people did not have meaningful interaction with care workers during this time or were sitting in uncomfortable positions. We noted another person was having difficulty standing up. As care workers were often busy elsewhere these needs were not addressed quickly enough.

On another occasion we observed two people arguing. We saw there were no care workers present to intervene. We raised our concerns with the registered manager. They advised that at the time two care workers were in a person's bedroom supporting them with personal care. The care workers had not communicated this information to the nurse and team lead who were working in the nurse's office. The registered manager advised they would deal with these issues to ensure people were supervised appropriately in future.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Most people we spoke with told us they were happy care workers met their needs appropriately. People and relatives also gave us positive views about their care more generally. One person commented, "I have been in a lot of worse places, and they're very nice to us here." Another person said, "They are very good to us." A third person told us, "I like living here, as the nurses are very kind." A fourth person said, "I like being here." One relative said "I took [my family member] to see the manager as she didn't believe this was going to be her home. When [my family member] was told (that it was their home), [my family member] was very happy, as [my family member] really likes living here." Another relative, "I'm happy if [my family member] is happy."

Most interactions we saw between people and care workers were kind and caring. For example, we noted one person wanted to walk around. A care worker walked with them and chatted whilst they held the person's hand for reassurance. Another care worker supported a person to transfer from their wheelchair to a dining chair. The care worker allowed the person to go at their own pace and explained to the person what was happening at all times. A third care worker discreetly approached a person who was showing signs of agitation to check they were alright and then engaged them in an activity. However, we observed one person being supported to transfer from their wheelchair with little interaction from a care worker.

People were cared for by care workers who knew their needs well. Care workers told us they took time the time to get information from family and friends. One care worker said, "We build up a picture of each person, we get to know their likes and dislikes. How they like to do certain things." We viewed in care records that care workers had access to information about people's care preferences. This included information about such things as food likes and dislikes, whether the person preferred a bath or shower and other daily

routines. Care workers also supported people to meet their choices and preferences. For instance one person had got up late. Care workers ensured they were offered breakfast in the dining room.

Care workers told us they actively promoted dignity and respect. They gave us examples of how they maintained people's dignity when providing care. For example, talking to people throughout when providing personal care and offering reassurance. We observed examples of this during our inspection. For example, one person spilled their drink. A care worker spoke with the person with compassion and reassurance, telling them it was an accident. The care worker took the person for a walk whilst another care worker cleaned the area.

Good

Is the service responsive?

Our findings

During our last inspection in June 2015 we found the provider had breached the regulation relating to person-centred care. This was because care plans did not always fully reflect the specific needs and support people required. Following our inspection the provider sent us a report of the actions they planned to take to become compliant with these breaches. This included implementing care plan audits and an evaluation matrix, care plan training for relevant staff and re-writing care plans. The provider told us they would meet the requirements of the regulations by 31 December 2015. We found the provider had completed all of actions in line with the timescales set in the action plan.

Care plans had been updated and re-written since our last inspection. The care plans we viewed now contained personalised information about the care and support each person needed. For example, one person had difficulty with communication. The person's communication care plan provided details about the most effective strategies for care workers to use to promote choice and independence. For instance, this included the use of pointing, gesture and showing objects. The care plan also clearly described the best communication style for the person, such as speaking slowly and offering one piece of information at a time. Care plans had been evaluated regularly to help keep them up to date and reflective of people's current needs. None of the people we spoke with had been involved in their care planning or reviews. However, they told us this was their choice and they were happy with that situation.

One relative told us about a time when the provider had been particularly proactive in responding to their family member's needs. They said, "[My relative] needed new shoes and when the activities co-ordinator heard this, [activity co-ordinator] organised to take [my family member] out to buy them. You can't ask for anything better than that, as when [my family member] was at home they never got out only if I took them."

People's needs had been assessed to identify the care and support they needed. This information was used when developing care plans. Care records contained background information about each person, such as their next of kin, allergies and other professionals involved in their care.

We observed the activity co-ordinator going round the home to inform people about the planned activities for the day and to encourage them to join in. People were very comfortable around the activities co-ordinator who was attentive to people's individual needs. We also saw relatives were given the opportunity to join in.

Care workers told us the availability of activities had improved. One care worker commented, "People do a lot more lately than they have done. They like to go out to town, have pub meals and once a week (person) goes to the local club." Each person had a personalised activity plan with details of their preferred activities. Detailed activity records were kept to show the group and individual activities people had participated in. Group activities included reminiscence, quizzes, cookery classes, sing a longs, parlour games and arts and crafts. Individual activities included chatting about current affairs, listening to music, food tasting and dominoes.

People and relatives had opportunities to give their views about the home. There were regular meetings for people to attend if they wished. We viewed the minutes from the last meeting held in December 2016. Topics discussed included activities, menus and people's views about safety in the home. During 2016 the provider, as well as an external organisation, had carried out consultation with people. The report of the findings from these consultation exercises were in the reception area for people to view. Six people had provided positive feedback about the experience of the home. For example, six people said they felt either very safe or quite safe and said they were involved in activities to meet their needs. An action plan had been developed following the consultation. Actions identified included increasing the frequency of meetings with the activity co-ordinator, new menus to be introduced and sensory signage purchased to aid orientation around the home.

People told us they had not previously needed to make a complaint about their care. They told us if they had a problem they would speak to the registered manager or a senior care worker. We viewed the complaints log for the home which confirmed there had been six complaints received since January 2016. These had all been fully investigated with action taken to address any concerns. Action included changes to menus and disciplinary action.

Requires Improvement

Is the service well-led?

Our findings

During our last inspection we found the provider had breached the regulations relating to good governance. This was because quality assurance systems at the home had not been effective in making sure improvements were made to address identified shortfalls. Following our inspection the provider sent us a report of the actions they planned to take to become compliant with these breaches. These included monthly provider visits, implementing an audit matrix and carrying out monthly audits. The provider told us they would meet the requirements of the regulations by 30 September 2015. We found the provider had completed all of these actions in line with the timescales set out in the action plan.

An annual audit plan was in place which identified the audits that were required to be completed each month. For example, in November the expected audits included infection control, medicines, catering, the mealtime experience, hand hygiene and maintenance. We checked the supporting records which confirmed these had all been completed. Where required, action plans had been developed and monitored until complete. For example, action had been taken following a mealtime audit to improve people's dining experience through introducing pictorial menus and soft background music.

However, we found the medicines audit, although done consistently each month, had not been effective in promoting the safe administration of medicines as we identified the provider had breached this regulation. We were also notified separately following this inspection that there had been two serious incidents at the home involving medicines. In particular, on the evening of 17 January 2017 people living on the ground floor did not receive the medicines they needed. The provider told us this was due to a lack of communication between care workers and was being fully investigated. The matter had also been referred to the local safeguarding team for investigation. We have written to the provider separately about this matter to register our concerns about medicines management and to instruct the provider to take robust action to improve the management of medicines within the home. We will closely monitor this situation until we confirm people are receiving their medicines safely.

The home had a registered manager. The registered manager had been proactive in submitting statutory notifications when needed. Care workers told us the registered manager was supportive and approachable. They also told us the home had a positive and welcoming atmosphere. One care worker described the home as a "friendly and welcoming place".

Care workers had opportunities to give their views and make suggestions to improve people's care. They told us staff meetings were held regularly. One care worker commented, "I speak my mind." Regular staff meetings were held. We viewed the minutes from a recent meeting. The meeting was used to reinforce important areas relating to people's care, such as confidentiality, infection control and quality assurance. An external organisation had recently carried out consultation with care workers. The report produced from the feedback given was available to view in the reception area. All seven staff gave positive feedback about the home. For example, all seven staff described the home as having good relationships with people using the service and their relatives.

The registered manager effectively carried out care plan audits. We found all care plans we viewed had been audited. These had been successful in identifying areas for improvement and ensuring action had been taken to address any issues. For example, audits had identified some care plans needed updating whilst other documents needed signing or amending. We saw from viewing people's care records these actions had been completed. The care plan audit also specifically checked whether there was evidence of any diversity or cultural needs having been taken into account when planning people's care.

The home had a long-term integrated action plan which covered all aspects of the home and people's care. Work was on-going to complete the action plan with some actions identified into 2018. For example, to develop a sensory, therapeutic garden for people to enjoy.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to adequately assess and mitigate risks to the health and safety of people using the service because people were sometimes left unsupervised for prolonged periods. Records did not support the safe and proper management of medicines. Regulation 12(2)(a), 12(2)(b) and 12(2)(g).