Lunan House Limited

Warmley House Care Home

Inspection report

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Date of inspection visit:
12 May 2016
13 May 2016

Date of publication:
06 July 2016

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Warmley House Care Home is part of the Four Seasons Brand and is situated on the outskirts of Warmley, South Gloucestershire. The home can accommodate up to 58 people who require nursing care. The service also provides care for people who have a diagnosis of dementia.

At the time of our inspection 57 people were using the service.

The service was arranged as three units. Seventeen people who required residential care were using 'The Coach house'. Ten people living with dementia were using 'Sunflower'. Thirty people requiring nursing care were using 'The Nursing Unit'.

This inspection was unannounced and took place on 12 and 13 May 2016.

There was a registered manager in post. 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.

People were not kept safe from the risks involved in the management of medicines. Medicine administration records were not completed accurately, medicines were not always stored safely and guidance on the administration of medicines was not always available to staff.

The provider had not ensured there was enough staff. The provider used a staff dependency tool to calculate staffing levels. However, people and relatives said there were not enough staff and, we saw there were not enough staff to safely meet people's needs.

People were not kept safe from the risks of infection. Staff used shared 'slings' to move people who required hoisting, hand washing facilities were not available in sluice rooms where commode pans were washed and, some equipment was not clean.

Risk assessments were not always in place and those that were, often lacked sufficient detail to safely provide care or, on occasions, were incorrect.

The registered manager and staff team understood their role and responsibilities to keep people safe from harm. Staff knew how to raise any concerns regarding people's safety. Pre-employment checks were carried out on staff before they started work to assess their suitability to work with vulnerable people.

The service did not always provide effective care and support. Some staff had not received training on caring for people living with dementia. The service was adhering to the principles and requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

People seemed to enjoy the food and menus were planned in advance. People did not always have easy access to drinks. People's food and fluid intake or their weights were not monitored effectively. Arrangements were made for people to see their GP and other healthcare professionals when they needed to do so. We have recommended the provider seeks advice on providing a suitable environment for people living with dementia.

People did not always receive a caring service. Staff did not always give people the care and attention they wanted or needed. People received care from staff who knew them well many of whom had worked at the service for a number of years. People were able to maintain contact with family and friends. People's wishes were respected about their end of life care.

The service was not always responsive to people's needs. Care plans were not person centred and lacked the detail required to provide consistent, high quality care and support. There were not enough activities for people. The provider investigated concerns and complaints and made changes as a result.

The service was not consistently well-led. Quality checks were in place. However, these audits had not identified shortfalls in areas such as medicines management, record keeping and the correct use of some equipment.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to safe care and treatment, staffing levels, staff training and good governance.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Medicines administration records were not consistently completed, medicines were not always stored safely and the provider's own policy on the administration of medicines was not followed.

The provider had not ensured people were safe from the risks of infection.

Staffing levels were not sufficient to safely meet people's needs.

Risk assessments were not always in place and those that were often lacked sufficient detail or were incorrect.

The registered manager and staff team understood their roles and responsibilities to keep people safe from harm. Staff knew how to raise any concerns regarding people's safety.

The provider carried out checks on staff before they started work to assess their suitability to work with vulnerable people.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not received training on caring for people living with dementia.

The service complied with the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

People seemed to enjoy the food and menus were planned in advance. People did not always have easy access to drinks. People's food and fluid intake or their weights were not monitored effectively.

People's healthcare needs were met and staff worked with health and social care professionals to access relevant services.

The service was not always effective in meeting the needs of

people living with dementia.

Is the service caring?

Requires Improvement

People did not always receive a service that was caring.

Staff did not always give people the care and attention they wanted or needed.

People received care from staff who knew them well.

People were able to maintain contact with family and friends.

People's wishes were respected about their end of life care.

Is the service responsive?

Requires Improvement

The service was not always responsive to people's needs.

Care plans were not sufficiently detailed or written in a person centred manner.

There were not enough activities for people.

The provider investigated concerns and complaints and made changes as a result.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

People and their relatives knew who the registered manager was. The registered manager knew people by name and had an understanding of their care needs.

Staff said they respected the registered manager.

Quality checks were in place, however, these audits had not identified shortfalls in areas such as medicines management, record keeping and the use of equipment.

Warmley House Care 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 12 and 13 May 2016 and was unannounced. The inspection team consisted of three people. One adult social care inspector, a specialist advisor with professional knowledge of services for older people 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.

The last full inspection of the service was on 30 May 2013. At that time we found the service was compliant with regulations. We also inspected the service as a result of information shared with us on 10 June 2014. At that time we found breaches of regulations and took enforcement action. We returned on 23 and 24 September 2014 and found the provider had taken action and was meeting all requirements.

Prior to the inspection we looked at the information we had about the service. This information included the statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by law. We reviewed the Provider Information Record (PIR). This is a form that asks the provider to give some key information about the service, tells us what the service does well and the improvements they plan to make.

We contacted five health and social care professionals, including community nurses, social workers and commissioners. We asked them for some feedback about the service. We were provided with a range of feedback to assist with our inspection.

Some people were able to talk with us about the service they received. We spoke with 15 people using the service. Not every person was able to express their views verbally. Therefore we carried out a Short Observational Framework for Inspection session (SOFI 2). SOFI 2 is a specific way of observing care to help us understand the experience of people who could not tell us about their life in the home. We also spoke with relatives of six people using the service.

We spoke with 12 staff, including the registered manager, the deputy manager, qualified nursing staff, a senior care worker, activities organisers and care staff.

We looked at the care records of nine people living at the service, three staff personnel files, training records for all staff, staff duty rotas and other records relating to the management of the service. We looked at a range of policies and procedures including, safeguarding, whistleblowing, complaints, mental capacity and deprivation of liberty, recruitment, accidents and incidents and equality and diversity.

Inadequate

Is the service safe?

Our findings

People and relatives gave mixed feedback on whether they felt the service was safe. People said, "Yes, I'm all right here, well looked after and safe" and, "Staff aren't always around when you need them". Comments from relatives included: "I'm happy my husband's safe here", "We don't really see staff, so I'm not sure how often they check on whether people are OK" and, "I feel (Relative) is relatively safe and has a pressure mattress and is turned every two or three hours during the night".

Medicine administration records contained gaps where the medicine had not been signed as taken. Most medicines were contained in individual 'blister packs'. When looking into these occasions we saw the medicine was no longer in the pack. Some people's administration records stated the medicine was to be given 'as directed'. Clear and specific individual guidelines were not in place for staff to follow. The provider's policy on the administration of medicines stated that when written 'as directed' the prescribing GP should be asked to amend the prescription to give specific guidance. This meant we could not be sure people were receiving their medicines as prescribed. Liquid paracetamol administered on four occasions in the month before our visit had an expiry date of September 2015.

The storage of medicines was not safe. The temperature of rooms where medicines were stored was not being measured and recorded. Some medicines needed to be kept in a fridge to control their temperature. A daily record of the temperature was in place for the fridges. However, there were a number of gaps in the recording of these. We saw one of these fridges was unlocked and in an unlocked room. One person in the area of the building caring for residents living with dementia had a bottle of liquid medication left on top of a chest of drawers in their room. Some people had a history of entering other people's rooms.

We saw other examples of unsafe practice regarding medicines. Some people were prescribed creams or lotions. These had not been dated when opened. Guidance for staff on the application of these did not always give the necessary information. For example, one person's records (their topical medical administration record) stated 'apply to private areas' with no indication of frequency. There was no mention of the use of this cream in the person's personal hygiene or tissue viability care plans. There were handwritten entries on medicine administration records. The provider's policy on medicines management stated any handwritten entries should be signed by two staff. This had not been done.

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

Some people required assistance with moving and handling. This involved using hoists, to which are fitted a 'sling' which is designed for the person to be moved safely and comfortably. The provision of individual slings allow for the best possible size and type of sling to be assessed for the person. The provision of individual slings also limits the possibility of the spread of infection. We saw staff using shared or communal slings.

There were 'sluice rooms' at the service. These contained bed pan washers but no hand washing facilities.

This meant staff needed to wash the bed pans (commode pots) then cross the corridor to use the hand washing facilities also used by people using the service. We saw one staff member carrying a commode pot without gloves. Commode pots were stacked one inside the other. This raised the possibility of the spread of infection. We noted that one commode chair, stored beneath a stair case, had visible traces of dried faeces on it.

A relative said, "Sometimes the room is really messy, and yesterday I found faeces on the door. I didn't bother to call anyone I just washed it off". They also said, "I complained that the home smelt of urine and they now have a new carpet shampooing machine and it smells much better - not of urine".

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

The question of staffing levels was raised with us by a number people and relatives. They said there was not enough staff. Comments from people included; "At times I don't think there's enough staff, especially lunchtimes", "The staff don't always come quickly when you call" and, "I think they're busy because there's not enough of them".

Comments from relatives included; "There are not enough staff", "People are much calmer and happier when staffing levels allow staff time with people" and, "We could do with more staff and more continuity particularly at night". One relative commented on the lack of staff and the fact that when they visited their relative they had to clean their nails. They also said their relatives continence needs were not met in a timely fashion. They said this resulted in them being left for long periods of time in wet continence pads with their skin becoming sore.

Staff said there were not always enough staff. One said, "We have to do everything, including laying tables and serving meals and often don't have time for people". Another said, "We could definitely do with more staff".

A dependency tool to assess the staffing levels to ensure people were safe had been completed. This identified the staffing levels required in each of the three areas of the service. The registered manager said the tool also allowed for additional weighting due to the challenges posed by the building itself. When we visited, two nurses, one senior care worker and 11 care workers were providing care. We were told one nurse, one senior care worker and four care staff were available at night. This was consistent with the findings of the dependency tool used by the provider. Staff rotas showed these staffing levels were provided consistently. However, although staffing levels were consistent with those identified by the tool we found there was not enough staff. This meant the tool used had not identified the correct staffing levels.

We observed people sitting for long periods of time with little or no interaction from staff. During meal times, there was not enough staff on the nursing unit to support the people that needed assistance. Four relatives had come in to support their relative at meal times. One said, "I come in at mealtimes to make sure (Name by which family member knew person) is helped to eat". On one occasion we heard one person calling out, 'help me help me'. On investigating this, we found staff were assisting another person in their room. There were no other care staff to assist the person calling out who remained in distress until a staff member became available.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

Risk assessments were not always in place and often lacked sufficient detail. Some contained an assessment of risk but lacked guidance for staff on how to manage the risk. Others were incorrectly completed. We saw a number of incorrectly completed risk assessments for people at risk of developing pressure ulcers. This was compounded by the lack of accurate up to date care plans. For example one resident who had a skin wound arising from a pressure ulcer had a care plan which read that the 'skin was intact' and their risk assessment detailed they were at low risk of developing a pressure ulcer.

People were kept safe by staff who knew about the different types of abuse to look for and what action to take when abuse was suspected. Staff completed safeguarding training as part of the induction and on-going training programme. They were provided with information regarding what is meant by safeguarding people, what constitutes abuse and what their responsibilities were to keep people safe. Staff told us they would report any concerns they had about a person's safety or welfare to the nurse in charge, the deputy or the registered manager. They knew they could report directly to the local authority, the Care Quality Commission (CQC) or the Police. Staff we spoke with knew about 'whistle blowing' to alert management to poor practice.

People were protected from the risk of unsuitable staff being employed because relevant checks were carried out before staff started work. These checks included a Disclosure and Barring Service (DBS) check. A DBS check allows employers to check an applicant's police record for any convictions that may prevent them from working with vulnerable people. References were obtained from previous employers. Recruitment procedures were understood and followed by the registered manager.

Requires Improvement

Is the service effective?

Our findings

People and relatives gave mixed feedback on the service they received. People said, "The staff are good and meet my needs" and, "I'm not sure this is a good place really". Relatives commented, "Concerns that have been raised in the past have been dealt with mostly well, and that the GP is on hand much more now, and if a visit is needed it is easily arranged", "(Relative) is prone to falling but hasn't had any since being here and enjoys the food. So do I when I stay and have some", "I'm worried my wife is more or less a prisoner in her own room as the lift is not big enough for her to be taken down in it with me or a member of staff on a regular basis" and "The home is much looser when the manager is not here".

Training records showed staff received a range of training to meet people's needs. Staff told us they had received training in basic first aid, safeguarding vulnerable adults and moving and handling. However, some staff had not received training in working with people living with dementia. Speaking with staff and observing their practice, it was evident they did not have a good understanding of caring for people living with dementia.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

The service had a programme of staff supervision in place. These are one to one meetings a staff member has with their manager. Staff supervision was delegated appropriately to each staff member's immediate supervisor. Staff members told us they received regular supervision. Staff records showed these were held regularly. Supervision records contained details of conversations with staff on how they could improve their performance in providing care and support. Staff said they found their individual meetings helpful.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA) and whether any conditions on authorisations to deprive a person of their liberty were being met.

The 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. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

The provider had policies and procedures on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Senior staff had received training on MCA and DoLS. Care plans contained an assessment of people's capacity to make specific decisions. Where people lacked capacity and, their liberty was being restricted, the provider had submitted DoLS application to the appropriate authorities.

During our lunchtime observations we saw the food was well presented and that people seemed to enjoy their meals. People had chosen their main course the day before from a choice of dishes which included a vegetarian option. Some people had changed their mind and their revised choice was accommodated. Some people chose to eat in their rooms and this was accommodated. People said they enjoyed the food.

People were served a cup of tea with their lunch but were not offered any alternative. During the morning of the first day of our inspection we noticed that people did not have drinks easily available to them. Some people using the service were not able to ask for drinks. This requires improvement to ensure people have access to drinks when they want them. People's food and fluid intake was not consistently recorded in their care records. People's weight was not routinely monitored. Some people were at risk of weight loss as a result of not eating enough. This requires improvement to ensure people eat and drink enough and any weight loss is identified.

People's care records showed relevant health and social care professionals were involved with people's care. One visiting healthcare professional told us they felt the service met people needs. They said, "Things have improved a lot here. We rarely get called out for skin tears, it's only when we are really needed. The staff use the correct dressings the senior carer is really on the ball she's been here quite a long while and they have a really good team now which is quite different from a while ago when it was not so good". However, a referral for one person to see a health care professional had been made three months before our inspection and, there was no record of this being followed up.

The building had been extended over time and as a result was not easy to navigate. The building also had few storage areas. As a result mobile hoists and other equipment were often in corridors. We saw several examples of people finding it difficult to get past these. Some attempts had been made to provide an environment suitable for people living with dementia. For example, some bedroom doors had photographs on them. However, there was little signage to help people find their way around.

Requires Improvement

Is the service caring?

Our findings

People and relatives gave mixed feedback on whether the service was caring. People said, "The carers look after us very well and the caring is good" and, "I have asked for a shave and I'm told 'yes I will – I'll be back soon', but then they don't come back". Relatives commented, "There's not enough staff and some don't really care", "Between seventy and eighty per cent are good and for some nothing is too much trouble", "I have found the carers to have a different attitude now the inspection is on" and, "The carers tend to come in and plonk food down with no real interaction".

We saw that people were not always treated in a caring way. During lunch we saw staff assisting people with eating. However, staff often seemed to concentrate more on the task itself than the person.

For example, one care worker didn't speak to the person they were helping. They gave another a spoonful of food every time the person opened their mouth until they indicated with a shake of their head they didn't want any more. The person was offered a drink but declined at which the care worker got up and said to her 'had enough' before removing the drink and dish and taking them away.

On another occasion two care staff were clearing up in the dining area. One prompted a person who had a drink in front of them saying 'drink your tea' each time they walked by but there was no real interaction or encouragement to finish their drink.

Another person was trying to take the top off their spouted beaker and in doing so spilt their drink. A care worker came into the lounge and assumed they were trying to put the top back on. They said to the person, 'let me put the top back on for you', without asking the person what they were trying to do. The care worker did not notice the person had spilt their drink and their trousers needed changing. We had to point this out to staff.

Relatives and family members described instances where they told staff people needed assistance and found them not to be helpful. They said they had found staff to be 'dismissive' and received responses like 'don't worry they are always like that' and, 'don't worry (Person's name) always collapses when seeing people'.

One relative described how they had found one person trying to fix the wheel on their wheelchair. The person's call bell was on the bed out of reach. The relative said they had told a care worker who responded by saying, "Oh don't worry he's confused, he's always like that."

We did see some positive interactions with people from some staff who were clearly trying very hard to provide the care people required. We talked with the registered manager about staff not showing a caring approach. They said they felt the care staff were nervous because of the inspection and were not as relaxed and naturally friendly and caring as they usually were. This requires improvement to ensure people are supported in a caring way. Staff said they felt people were treated in a caring manner.

People received care from staff who knew them well. Many of the care staff had worked at the home for a number of years. Staff knew people well and were able to tell us about their likes and dislikes. Staff usually addressed people by their first names. On occasions we heard staff using terms of endearment such as, 'my love'. It was not clear to us if this had been previously agreed with the person. Terms of endearment like this are often liked and appreciated. However, some people may not like these being used.

People were generally treated with dignity and respect. Staff knocked on people's doors and either waited to be invited in, or if the person was not able to answer, paused for a few moments before entering. We saw people's bedroom doors and doors to bathrooms and toilets were closed when people were receiving care.

Staff had received training on equality and diversity. People's care records included an assessment of their needs in relation to equality and diversity. We saw the provider had planned to meet people's cultural and religious needs. Staff we spoke with understood their role in ensuring people's equality and diversity needs were met.

People were able to maintain contact with family and friends. There was an open visiting arrangement. People confirmed they could entertain their visitors in the lounge areas or in their bedrooms. We observed some visitors sitting in the lounge area.

People's wishes were respected about their end of life care. Care files showed people were asked about their end of life care. Relatives provided further information including their contact details and when and if they would like to be contacted. Staff told us they would liaise with the district nursing team and GP to ensure all equipment and medicines were in place to ensure people were pain free when receiving this care.

Requires Improvement

Is the service responsive?

Our findings

The service was not always responsive to people's individual needs. The overall impression of the service was that it was led by routines and tasks rather than being person centred.

Care plans were not sufficiently detailed or written in a person centred manner. These plans did not give a clear picture of people's life history, likes and dislikes or hobbies and interests. There was little evidence of people being involved in developing these plans.

Some people did not have any guidance in their care plans for areas important for them. For example, some people used pressure relieving mattresses to reduce the risk of developing pressure ulcers. There was no reference to the setting of the mattress in people's care plans. The mattresses had been set at a variety of settings that did not correspond to the correct weight for the person, care staff did not know why they were at the current settings and how they related to the person's weight. Other people had guidance detailed in their care plans that was not being followed. For example, one person who required dressing for a wound was not receiving the correct dressings as staff were waiting for these to arrive.

Daily records of people's care were kept. These were repetitive and did not give an individualised report of their care. This was particularly noticeable for recordings done at night. Many people had the same entry for night records, with just the person's name being different.

Individual care planning requires improvement to ensure people's changing needs are identified and the service responds to these.

A notice board in the foyer of 'The Coach House' had a section headed 'Activities Today'. However there were no activities listed beneath it. A number of people sat in the foyer throughout both days of our inspection. When asked why they chose to sit there they said, "Because there are always people around". People said there were not enough activities at the service. Comments included: "I'd like more activities" and, "There's not much to do really but I don't think they have the staff for many activities".

Two activities organisers were employed at the service. They explained one of them took responsibility for organising activities and the other for running them. Both were passionate about their role and said they constantly sought the views of people and their families regarding possible activities. On the afternoon of the first day of our inspection they had organised tea and cakes in the garden. This was attended by 11 people who clearly enjoyed the experience. We were told that one to one activities were organised for people who remained in their rooms. They said these were recorded in people's daily records. We saw these records contained long gaps between recorded activities and did not detail if activities were offered but declined. There was no auditing of activities to ensure people were regularly offered the opportunity of participating in them.

One person who had recently been admitted to the home asked the inspector if they could go for a walk. They explained this was something they regarded as important to keep themselves healthy and something

they had enjoyed doing every day prior to admission irrespective of the weather. The resident was told by the carers that they could not take them for a walk 'as they could not leave the unit'. We discussed this with staff and they were supported to go for their walk.

People's bedroom doors were marked with the name of the occupant and sometimes a photograph but had no other distinguishing features. There were no other items to help the person recognise the room as theirs. Some people using the service were living with the early to mid-stages of dementia. Items linking them with their past would give them a sense of security and help staff communicate meaningfully with them.

Meetings where people were encouraged to express their views and opinions were held every three months. We looked at the records of these meetings and saw people's views regarding activities and other areas were recorded. However, we found no evidence of changes being made as a result of this.

The provider had a policy on complaints and comments. A record of complaints was kept at the service. The provider had received 18 complaints in the 12 months leading up to our inspection. Records of these showed the provider had investigated each, taken action and made changes where necessary and provided feedback to complainants. We saw the provider was arranging for weekly GP visits to the home as a result of requests from people. People and relatives said they knew how to raise any concerns they had. During our inspection, one relative raised a concern regarding their family member. The registered manager listened to their concerns and agreed with them a course of action.

Requires Improvement

Is the service well-led?

Our findings

Throughout our inspection we found the atmosphere in the home to be institutional and led by routine. The registered manager and some staff spoke passionately about person centred care and support and their vision for the service. However, this had not been translated into practice and staff did not have a clear understanding of the vision and values of the service.

Systems were in place to check on the standards within the service. These consisted of a schedule of audits. These audits looked at; health and safety, record keeping, equipment checks, an analysis of the dining experience and people's views on food. These audits were carried out as scheduled and corrective action had been taken in some instances. However, these audits had not identified shortfalls in areas such as medicines management, the correct settings for pressure relieving mattresses and record keeping. An external audit had been carried out into medicines management in September 2015. This had identified three areas requiring action. These actions had not been taken.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

A tablet computer was used to obtain the views of people using the service, relatives and staff. Information was collated and analysed by the provider. This had resulted in changes being made as a result of people's views. The registered manager told us they or the deputy manager completed a daily walk around which included looking at the environment, people's care records and speaking with staff, people who use the service and their relatives. They told us they used an electronic device to record the information, which was then shared with the provider.

People knew who the registered manager was and seemed to have a good relationship with them and be comfortable in their presence. Relatives knew who the registered manager was and spoke positively about them. However, several questioned why they didn't see the registered manager with people more. One said, "She's in her office most of the time". Another said, "It's a big home and I'm sure there's lot to do but I don't see her around the home much". The registered manager told us how they often took people's newspapers to them and we noted they knew people's names and a lot about their care needs. Staff spoke positively about the registered manager. Comments included; "The manager is really fair", "We've a good team and I think that's down to the manager" and (Manager's name) is very professional".

An on call system for staff to access advice and support if the registered manager was not present was in place. Staff confirmed they had used this system and found it worked well.

The registered manager, deputy and senior staff knew when notification forms had to be submitted to CQC. These notifications informed CQC of events happening in the service. CQC had received appropriate notifications made by the service.

The policies and procedures we looked at were regularly reviewed. Staff we spoke to knew how to access

these policies and procedures. This meant that guidance for staff was up to date and easy for them to use.

Regular staff meetings were held and records kept. Staff told us they found these meetings helpful. We saw from the notes of meetings that staff were encouraged to express their views and opinions.

Handover meetings were held when staff changed. These are meetings which allow staff who are finishing the opportunity to pass important information to those starting. Staff told us they had to come into work early or leave later for these handovers. The regional manager and registered manager confirmed dedicated time for these was not built into the rota. They said this was an area the provider was planning to improve. After completing our on-site inspection, the regional manager sent us the provider's plan to introduce this.

At the end of day two we gave feedback to the registered manager and regional manager. They listened carefully to what we had said and clearly wanted to ensure the service to people improved.

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 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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who use services were not protected against the risks associated with medicines. Regulation 12 (2) (g). The provider had not taken measures to ensure people were safe from the risks of infection. Regulation 12 (2) (h).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured there was an effective system in place to assess, monitor and improve the quality of service provided. Regulation 17 (2) (a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured there were sufficient numbers of staff to meet people's needs. Regulation 18 (1). The provider had not ensured staff had received the training required to effectively meet people's needs. Regulation 18 (2) (a).