Malhotra Care Homes Limited

Heatherfield Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 13 and 14 December 2016. The visit on the 13 December 2016 was unannounced. This meant that the provider and staff did not know we would be visiting. Heatherfield Care Home provides accommodation and care for up to 74 people. The home is divided into three units for those who have general nursing, dementia nursing and younger physically disabled care needs. Accommodation is spread over two floors. There were 71 people living at the home at the time of the inspection.

The last comprehensive inspection of this service was carried out in February 2015. At that time the service was in breach of Regulation 12 HSCA (RA) Regulations 2014 Safe Care and Treatment. We followed up on this breach at a focussed inspection in August 2015 and saw the breach had been met, however that inspection found the service in breach of Regulation 17 HSCA (RA) Regulations 2014 Good Governance.

During this inspection we found that whilst some actions had been taken to improve the quality and monitoring systems, shortfalls in care remained. The provider's system had not identified the shortfalls which we found during our inspection.
A registered manager was 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.

Risks related to the receipt of care had not been mitigated. Two people at risk of developing pressure damage were using pressure relieving mattresses which were set incorrectly for their body weight. Nursing staff were unable to tell us when the settings were last checked as there was no formal process for monitoring this equipment.

Risks related to covert medicines had not been assessed. Records were not kept to note where medicines administered via a patch on people's skin had been applied, putting people at risk of discomfort.

People and relatives told us they thought one area of the home was understaffed. The registered manager advised staffing was determined by an assessment of people's needs. We saw from rotas that staffing numbers in the home had met the assessed number. During our inspection the atmosphere was unhurried and people were responded to quickly.

Robust recruitment procedures had been followed to ensure checks the suitability of potential employees had properly considered.

Steps had been taken to mitigate the risk of infection.

During observations in the dementia care unit over lunchtime, we found there were not enough staff to support the people with the highest level of need so they had to wait a considerable amount of time before

staff could support them to eat. There was not enough room in the dining room to accommodate people comfortably.

People in the dementia care unit were not offered a choice of meal, and steps had not been taken to ensure that choices could be provided in a way which would meet people's needs.

Care Quality Commission (CQC) is required by law to monitor the operations of the Mental Capacity Act 2005 (MCA), and to report on what we find. MCA is a law that protects and supports people who do not have the ability to make their own decisions and to ensure decisions are made in their 'best interests'.

Where decisions had been made on people's behalf, records showed capacity had been assessed and best interests process followed. The provider had sought authorisation to deprive people of their liberty where it was considered they would not be able to keep themselves safe if they left the home alone.

The provider had identified a set of training modules for all staff to undertake. We saw this training was monitored to ensure staff stayed up to date with any refresher training required. We have made a recommendation about staff training on the complex needs of some people using the service.

New staff inductions included policies and procedures, shadowing experienced staff and undertaking training. Staff received regular supervisions sessions, an annual appraisal and opportunities to develop their skills and knowledge.

The home was purpose built, and had been designed to meet the needs of the people who used it. Steps had been taken to aid people's orientation on the dementia care unit, but the manager advised us further improvements were planned in this unit to ensure it met best practice for people with dementia conditions.

People and relatives told us the staff were warm and friendly. We observed staff were considerate of people's privacy and dignity.

Processes were in place to ensure that people were supported in compassionate way, by appropriately trained staff, at the end of their lives.

Assessments of people's needs and the care plans which described how they should be cared for did not always contain accurate information and some were out of date, which put people at risk of receiving inappropriate care.

The home employed four activities coordinators but some people and relatives told us that there was not enough for people to do.

The provider did not have a robust system to monitor the quality of the service provided. Whilst a scheduled of audits were carried out regularly they had not addressed the shortfalls which our inspection highlighted.

We found two breaches of the Health and Social Care Act 2008. These related to safe care and treatment and good governance.

The provider had not sent us notifications which are a legal requirement of their registration. This was a repeated breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We will continue to work with the provider to monitor and improve service. You can see further action we

have asked the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Risks had not been always mitigated.

Processes in place to properly manage medicines were not robust.

Incidents of a safeguarding nature had not been referred to the safeguarding team or the Care Quality Commission.

Whilst some people told us there were not enough staff, we found the atmosphere in the home was calm and unhurried. Staffing had been determined by an assessment of people's needs.

Safe recruitment procedures had been followed. The home was clean, and steps were taken to reduce the risk of spreading infection.

Is the service effective?

Requires Improvement

The service was not always effective.

The mealtime experience within some of the units was poor. People had to wait a considerable amount of time, and some people were not offered any choice.

Where decisions had been made in people's 'best interests' the Mental Capacity Act 2005 had been followed.

The provider had identified a programme of training for staff and this was well maintained. However training related to people's complex needs was not yet in place.

Staff were provided with opportunities for personal development.

Is the service caring?

Good

The service was caring.

People spoke highly of the staff. Observations showed that staff were friendly and knew people well.

People were encouraged to be independent and treated with respect.

There were plans in place to support people with compassion at the end of their lives.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Whilst people's needs had been assessed, care plans did not always contain specific information to ensure staff could meet people's identified needs.

The home employed four activities coordinators, but people's feedback was that there were not enough things for them to do.

Complaints had been responded to, investigated and complaints records were well maintained.

Is the service well-led?

Requires Improvement

The service was not always well led.

The systems in place to monitor the quality of the service had not addressed the shortfalls we had found during our inspection, in relation to medicines, addressing risks, and care planning.

People, their relatives and professionals spoke highly of the manager.

Feedback had been sought from people, staff and professionals about their views on the service.

Heatherfield 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 13 and 14 December 2016 and was unannounced.

The inspection was carried out by an inspector, a specialist advisor and an expert-by-experience. Specialist advisors are clinicians and professionals who assist us with inspections. The specialist advisor on this inspection was a registered nurse with management 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 expert-by-experience who was part of this inspection team had expertise in older people and those who had a dementia related condition.

Before the inspection we reviewed all of the information we held about the service. This included reviewing statutory notifications the provider had sent us. Notifications are records of incidents that have occurred within the service or other matters that the provider is legally obliged to inform us of. We reviewed information we had received from third parties. We contacted the local authority commissioning and safeguarding teams. We also contacted the local Healthwatch and a Clinical Nurse Specialist. We used the information that they provided us with to inform the planning of this inspection.

During the inspection we spoke with seven people who used the service and four people's relatives. 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. Throughout the inspection we spent time in the communal areas of the home observing how staff interacted with people and supported them. With consent we looked in seven people's bedrooms.

We spoke with the registered manager, five registered nurses, seven care workers, three activities coordinators, the cook, kitchen assistant and a domestic staff member. We discussed our findings and feedback with the provider's operational manager and compliance manager. We reviewed nine people's

care records including their medicines administration records. We looked at six staff personnel files, in addition to a range of records in relation to the safety and management of the service.

After the inspection we wrote to the provider. They sent us information to evidence that prompt action was being taken to address the inspection findings.

Requires Improvement

Is the service safe?

Our findings

A range of assessments had been carried out to determine risks people faced, such as developing malnutrition, tripping over or choking. But where risks had been identified they had not always been addressed. Two people at risk of pressure damage were using pressure relieving equipment which was incorrectly set for their weight. One of these people had developed pressure damage. There was no formal process for checking the settings on pressure relieving equipment, and nursing staff were unable to tell us when it had last been correctly set. This may have limited how effective the equipment was, and meant all practical steps to mitigate this risk had not been taken. We fed this back to the registered manager who ensured the nursing staff immediately amended the settings for the two people we had identified and arranged for settings to be checked for all other pressure relieving equipment in the home.
Medicines were not always properly managed. Some people received their medicines covertly, where medicines are concealed in food or drink. This was because these people refused their medicines, but had been assessed as not having capacity to understand the implications of this decision. The risks related to covert medicines, such as the risk another person may ingest the food or drink containing the medicines, or that people would only ingest part of the food or drink and therefore part of their medicines, had not been formally assessed, and staff had not been provided with information about how these risks should be mitigated.
Some people received their medicine via a patch which was placed on their skin every day. This medicine stated the patch should be placed in a different area each day to avoid skin irritation. The patch should not be reapplied to the same area for a minimum of 14 days. There were no records in place to detail where patches had been applied. This meant staff did not know which areas to avoid to minimise the risk of skin irritation. We discussed this with the registered manager who arranged for records to be created to record this information.

Topical medicines, such as creams to be applied to people's skin, had not been dated on opening, and records relating to them were poor. Information was not always in place to show staff where topical medicines should be applied. Topical medicines administration records were not always in place. Staff told us they regularly applied this medicine. However this lack of recording meant people were at risk of not receiving their medicines in a consistent way.

Processes in place regarding controlled drugs had not been adhered to. Controlled drugs are medicines which are liable to misuse, and therefore stricter storage and recording controls are needed. However we noted the key to the controlled drugs cabinet was left in the treatment room. These keys should always stay on the person of an assigned member of staff. This meant any staff member with access to the treatment room could have accessed the secure controlled drugs cabinet.

We checked Medicine Administration Records (MARs) and saw codes had been used to record when people's medicine had not been administered. Checks found one discrepancy, where two extra doses were in the medicine box than the MAR showed there should be. This meant the person had not been given their medicines on two occasions, but staff had signed to show it had been administered. We were unable to determine whether the person refused their medicines on these two occasions, or whether they were

omitted in error by staff.

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

During our observations we saw staff followed the medicines policy when administering medicines; washing their hands before handling medicines; explaining to people what their medicines were, and providing a drink of their choice. Medicines were stored appropriately and systems were in place to ensure unused medicines were disposed of appropriately.

Staff had undertaken training in identifying and responding to safeguarding concerns. They were aware of their responsibility and were clear in the process they should follow if they had they any concerns about people's care or treatment. People told us they felt safe and comfortable at the home. One person said, "The carers are out of this world, they keep me very safe." Staff told us they would refer any incidents of a safeguarding nature to their supervisor. However during our inspection we saw records relating to one incident of a safeguarding nature which had not been reported to the local authority or the Care Quality Commission.

Steps had been taken to ensure the building and any equipment used was safe. Specialist companies had carried out assessments of the electrical installations in the home, and the risk of asbestos or legionella. The home was meeting the required standards. The call bells and fire alarms were tested weekly. Equipment such as hoists, boilers, emergency lighting and lifts were serviced regularly so they were kept in good working order. Window restrictors were in place, and checked weekly by maintenance staff, to make sure risks had been minimised.

Each person had a personal plan stored within their care records which detailed information about what assistance they would require in the event of the home requiring to be evacuated. Emergency health care plans were also in place, completed with the person's GP, which set out how staff should respond to potential future illnesses. This meant processes were in place in case of emergency.

We looked at staffing levels at the home. Whilst feedback about the nursing and dementia care units was positive, we received some comments about the staff number on the young people's nursing unit. We spoke with the relatives of two people who were supported in this unit. Both of these relatives, and one of the seven members of staff we spoke with, told us they thought more staff were needed. One relative said, "There is not always enough staff, there is not always two carers on the floor." They described the staffing on a night as "horrendous." Another relative said, "They really need a fifth member of care staff, they are very short staffed." We spoke with the manager about these comments. She told us that staff numbers were determined by people's individual needs. We looked at the staffing dependency tool which took into account the level of need on each unit to calculate how many staff were required to keep people safe. We saw the number had fluctuated as people's needs had changed. We cross referenced these dependency assessments with staff rotas. We saw the identified required staff number had always been met. Agency and bank staff had been called in to cover any unplanned staff absence.

Nursing and care staff were supported by the registered manager, as well as four activities staff, and dedicated domestic and kitchen staff. We observed staff carried out their duties in a calm and unhurried manner. Staff were always available in the communal areas. We heard the call bell rang frequently, but was attended to quickly.

Safe recruitment practices had been followed. The application process included checking prospective staff's

identity and detailing their employment history. Two references were in place, including one from a previous employer, and an enhanced Disclosure and Barring Service (DBS) check had been undertaken. DBS check a list of people who are barred from working with vulnerable people; employers obtain this data to ensure candidates are suitable for the role. This meant robust systems were followed to determine if staff were of good character and suitably experienced for their roles. Nursing staff files showed their registration had been checked with the Nursing and Midwifery Council (NMC) to ensure their registration was up to date and that nurses were fit to practice.

The home was generally clean and tidy. Domestic staff were responsible for cleaning communal areas, bedrooms, and for laundering people's clothes. We saw the floors were clean, and soft furnishings were well maintained. When providing personal care staff wore protective equipment, such as gloves and aprons to minimise the risk of spreading infection. The home had a hydro pool, and we saw strict guidelines were provided for staff about the use and cleaning of the pool so it met hygiene standards. Records showed the home had carried our regular infection control audits and taken action where any areas for improvement had been identified.

Requires Improvement

Is the service effective?

Our findings

During our inspection we carried out observations in three of the four dining areas in the home. Within the dementia unit, people who needed the most assistance to eat from staff ate in the lounge. At the time of our observation there were eight people in the lounge, who all needed support from staff. For the first 20 minutes one staff member attended to these eight people, which resulted in people waiting a considerable amount of time for their meals. One person waited 30 minutes between finishing their main and being brought their dessert. None of the eight people were given a drink with their meals; however staff advised us they had been offered a drink before lunch. The table in the lounge was not used. When staff supported people they were engaging and displayed warmth, however there were long periods people were left to sit in silence unable to engage with each other because of the position of their chairs.

We also observed the main dining room in the dementia care unit. The room felt overcrowded as all of the spaces at the tables were being used. Two people ate their meals on their laps at the side of the room. We were told this was their preference, but at the time of our observation there was no room at any of the tables. The tables appeared bare. When discussing the dining experience with the registered manager, they advised us they would utilise some of the unused space in another of the lounges to create more room for people. They told us steps had been made to try and promote people with dementia's independence, such as specialist cutlery. They continued to tell us tablecloths were not used in the dementia care unit, as they considered that they could pose a risk to people, and a granite table top had been sourced instead.
Guidance produced by The Alzheimer's Society's regarding the dining experience for people with dementia states, 'Make the environment as appealing to the senses as possible. Familiar sounds of cooking, smells of the kitchen and food, and familiar sights such as tablecloths with flowers can all help.'
Some people were not provided with choice as to their meals. Whilst there were two options of hot meals for lunch, every person in the dementia care unit was given mince and dumplings. We discussed choice with staff, and they were unable to tell us what the second choice of meal was that day. They told us they chose for people as their communication needs meant they could not indicate their preferences. When we asked staff whether any methods were used to enable people to make a choice, for example using a photograph or a plate of each available meal option, they told us this practice was not currently used.
The provider told us they wanted to promote finger foods to allow people to be more independent. However, we did not see this made available during our inspection. The provider had also trained kitchen staff on producing pureed in to meaningful shapes, such as pureed carrot in the shape of a carrot, making it easier for people to recognise the food that was on offer.
We recommend the provider ensures that a consistent meal time experience is made available to everyone living in the home, which suits their individual needs and preferences.
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.

During discussions the registered manager was able to explain the principles of the MCA and how they were

followed. Where decisions had been made on people's behalf, we could see assessments had been carried out and the 'best interests' process followed.
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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The provider acted in accordance with DoLS. Timely applications had been made to the local authority to grant authorisation where people did not have the capacity to remain safe if they left the home unaccompanied. Staff were aware of people who did not have DoLS authorisation in place, and told us these people were able to come and go from the home as they wished.

People we spoke with and their relatives told us the care they received was effective and that staff were well trained. One person said, "Can't complain, the staff are good and the food is very good". A relative said, "They [Care staff] are dedicated and I think they are well supported by the home."

We looked at staff training records. The provider had identified a set of training requirements that they considered essential for staff to be able to meet the needs of people who used the service. These training modules were face to face sessions and included moving and handling, fire safety, safeguarding, nutrition and dignity. We saw training in these areas was well monitored and up to date. Clinical training for nursing staff was in-depth and varied, and there was evidence nurses had been supported to continue their professional development.

However, there was limited evidence that care staff had been provided with training to meet the more complex needs of people who used the service. The registered manager told us people supported on the dementia care unit had severe dementia and displayed behaviours which could challenge staff. However only 10% of staff had undertaken training in dementia care, and less than 15% had received training in challenging behaviours and mental capacity. People on the young person's unit had complex conditions such as Huntington's but staff had not received training on that condition. We discussed this with the registered manager who told us these areas were discussed during induction but the provider was also in the process of procuring specialist dementia care training from the Alzheimer's Society. We were told that dementia awareness and training is embedded in all the training delivered by the company trainer and that chefs had received additional training in presenting food to meet the needs of people with dementia.
We recommend that the provider ensures all staff are trained in the specialist needs of people living with complex conditions who are cared for at the home.

New staff undertook induction training. This consisted of reading policies, shadowing experienced staff and a range of training. The induction had been designed to incorporate the Care Certificate. The Care Certificate is a set of minimum standards for care workers. Staff told us the induction was sufficient for new staff to be able to carry out their role. One relative told us, "The new carer came without experience, I was concerned, but she picked it up quickly."

We spoke with seven care workers who told us they were given adequate support and opportunities for development. Staff attended regular one to one supervision sessions, to ensure they had the opportunity to discuss their practice and the needs of the people they supported. Appraisals were held yearly, and we saw staff were asked to consider their performance and discuss any training needs. Nursing staff received regular clinical supervision sessions with the manager, and senior nurses from the provider organisation.

Some staff were training to become nursing assistants. This training consisted of face to face training with the provider's head office in addition to individual learning. Nursing assistants worked closely with nursing

staff towards achieving a number of practical competencies. When the training was complete staff would be able to assist the nursing staff with tasks such as administering medicines, applying dressings and writing care plans. This meant there were opportunities for staff to develop their skills.

People were supported to have their healthcare needs met. Records showed people had access to a range of healthcare professionals. We saw evidence in people's care records of input from GPs, dentists, opticians and occupational therapists. Referrals had been made to specialists such as speech and language team where a person was having swallowing difficulties and the respiratory team. Relatives told us they had no concerns over their relative's healthcare needs, and that staff contacted GPs whenever they were required. The provider employed a full time qualified registered physiotherapist, who utilised the physiotherapy room and provided opportunities for people in the home to receive support with exercises to improve their quality of life and mobility.

The home had been purposed built and designed to meet the needs of people who lived there, this included specialist baths which helped to promote a pleasurable bathing experience. The home also had a hydrotherapy pool which was available for all people using the service.

All of the corridors were wide, and in each unit there were a number of places people could choose to spend their time, including a café area where families and people who used the service could make drinks and a smoking area with access for people with mobility needs. The home had a landscaped garden, with patios which had been developed to support people with dementia, specifically creating spaces. The garden had won the northern in bloom award for the last three years in a row.
Steps had been taken in the dementia care unit to aid people's orientation such as visual signs and toilet and bathroom doors had been painted in contrasting colours so they stood out to people. The provider had arranged for lit pictures of local landmarks on the wall. There was dementia friendly mood lighting throughout the unit so that people could appreciate different times of the day, which in turn promoted their wellbeing.

We noted the corridors of the unit were long and we could see no evidence that the environment had been adapted to help to create meaningful activities for people with dementia. The registered manager advised us they were researching ways to improve this further and were researching best practice to maximise the environment so it enhanced people's experience. They showed us brochures which they had sourced from Stirling University about improving environments for people with dementia.

Good

Is the service caring?

Our findings

Overall the feedback we received from people who used the service and their families was positive. Most people told us staff were friendly and caring. One person said, "The staff are called carers as you have to have a caring nature. You couldn't do the job if you didn't care. They have the care of the client as first and foremost to everything. They are always checking how I am. Are you okay? Are you alright? What can I do to help? Anything I ask they'll try and accommodate." Relative comments included; "Care is excellent couldn't be better;" "The staff are very caring, they work hard, I would say they are excellent;" "Staff are lovely, I am amazed at how good they are;" and "One of the carers is outstanding. He knows [my relative] inside out, he talks to [my relative] a lot." One of the seven people we spoke with did provide some negative comments on staff approach, they said, "It takes the staff all their time to speak to me." And, "I wouldn't say they look after me well, they just look after me." With permission we fed these comments back to the registered manager who told us they would speak with the person to gather more information and to find out what improvements they felt could be made.

We spent time in the communal areas of the home and watched people and staff interaction. The interactions we observed were positive. Staff talked to people whilst they were carrying out their tasks. Staff appeared to know people and their families well. Over lunch one staff member said, "This veg looks nice. Does your [name of relative] still grow the veg?" Later they told another person that they had seen their relatives in the town centre looking at the Christmas lights they said, "They [name of relatives] are getting so big. I couldn't believe it. Looked like they were really looking forward to Christmas. I think they'll call in on Christmas day. It'll be lovely for you to see them." We saw other examples throughout the inspection of staff engaging people in conversation whenever they could. Care records included a good level of detail about people's preferences and were personal to the individual.

During all of our observations people's privacy and dignity was upheld. We noted staff knocked on people's bedroom doors and waited for a response before they entered. When staff assisted people with their medicines or responded to people's requests for assistance to move around the home they were conscious of people's privacy and discussed their needs with them quietly. All care records were locked in the nurse's office. This meant people's private information was kept confidential.

People told us they were encouraged to be independent. One person told us, "The staff respect that I want to be independent and go over and above to help me. I know if would be quicker for them if they just put me in the wheelchair, but they will work with me. They'll say 'Now what do you want to do? How far do you want to walk today?' and they'll move the chair to wherever I tell them in the room, so I'll get to walk as much as I am able. It's helpful for me to walk and they encourage me."

Some people who used the service had particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010; age, disability, gender, marital status, race, religion and sexual orientation. We saw no evidence to suggest that people who used the service were discriminated against and no one told us anything to contradict this. One person who used the service did not have English as their first language. We saw the registered manager had sourced information in their first language, and a

member of staff able to speak the language was assigned to work with the person so they could communicate. The registered manager told us this staff member had sourced specific food items which were associated with the person's culture into the home.

At the time of our visit no one was using an advocate, but the registered manager told us they had previously referred people to advocacy services. An advocate is a person who represents and works with people who need support and encouragement to exercise their rights, in order to ensure that their rights are upheld.

People had been asked whether they wanted to make plans in advance about how they would like to be cared for at the end of their lives. These plans included information such as where the person would like to be cared for, at the home, or in hospital, and who they would like to be present. End of life training sessions had been provided to staff by the specialist palliative care nurse. We spoke with this specialist nurse who told us the registered manager monitored staff training in this area well, and was proactive in ensuring staff had been appropriately trained to support people at the end of their lives. The registered manager told us staff were given time off to attend funerals of people they had cared for, and that relatives were invited to leave a message on the memory tree about their family members who had been cared for in the home. This meant consideration had been made to ensure people and their relatives were supported at the end of people's lives.

Requires Improvement

Is the service responsive?

Our findings

Whilst people's needs had been assessed, care had not always been planned in a way which addressed them. Of the nine people's records who we looked at, we found records in place for four people which did not address their current needs.
We saw some examples where care plans were in place, but did not detail people's current needs. Two people who received covert medicines had care plans in place for medicines which stated they were 'compliant with medicines'. Where people had been assessed as requiring equipment to reduce their risk of pressure damage, care plans did not always specify what settings should be used. This meant people were at risk of inconsistent care which did not meet their individual needs.
Once care had been planned staff kept daily records about the care and treatment people received on a daily basis. However, we noted these records were generally very brief and consisted of two or three sentences each day. We saw from one person's records that they had been involved in an incident with another person. This incident was potentially distressing however; there was no detail about it in the other person's records. When asked staff were unable to tell us how the person had responded to this incident.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. Person-centred care
We noted one person's care records detailed contradictory information regarding the type of fluids they should be given. A risk assessment stated they should be provided with thickened fluids, whilst a care plan stated the person should be given normal fluids. We asked four staff members responsible for preparing drinks for the person. Two staff told us they gave the person thickened fluids, and two staff advised normal fluids. We fed this inconsistency back to the registered manager, who on further investigation told us the person was assessed as being able to drink normal fluids. This meant the person had been provided drinks in a potentially unpleasant consistency with no assessed need. The registered manager told us they would ensure staff were aware of the person's fluid needs immediately.
Whilst we identified these shortfalls in some people's records, we did note that other care plans in place were specific to the individual, detailed and up to date. People and relatives we spoke with told us staff were responsive to their needs. Their feedback included; "The staff know [my relative] very well;" and "We're very happy with the care provided."

The home employed four activities coordinators. We spoke with two of the activity coordinators who told us the manager and provider enabled the activities staff to be proactive in suggesting and facilitating trips out of the home and new things for people to take part in. Activities staff showed us their records which they kept about people's likes and dislikes, hobbies and details of the activities they had taken part in in the past. They also recorded times when they engaged people in less formal activities, such as sitting with people in their rooms if they were unable to take part in other activities. Whilst these records were comprehensive, the feedback we received from people and their relatives was mixed. One relative told us there was lots going on, they said, "[My relative] is normally out of bed and moving around the home and being involved in various activities." Whilst other comments were that more activities were needed. One person told us, "Nothing to do all day but read and watch telly." A relative said, "There are some activities going on, mostly upstairs, but not very much." Another relative told us, "He never gets outside with the carers, he goes out

with us only." On the first day of the inspection we noted long periods of time when there were no activities for people to take part in apart from watching the television. However this did coincide with a trip for six people to the local pub for Christmas lunch. We saw signs had been posted around the building to also invite relatives to this meal. On the second day of the inspection some people were involved in baking and reminiscing activities.

People we spoke with told us they knew how to make a complaint, but advised us they were happy with the service they received. Complaints records were well maintained. Complaints and minor issues were recorded to ensure these were responded to and addressed. The progress of each complaint was monitored and fed back on a monthly basis to the provider. Records showed communication had been recorded, and outcomes of complaints had been shared. Where appropriate, action had been taken in response to complaints, such as arranging specific additional training.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in August 2015 we had found that auditing systems to monitor medicines in the home were being used inconsistently, and that accidents and incidents had not been well monitored. This meant systems were not in place to monitor and improve the quality of the service. After that inspection the provider wrote to us to advise us of the steps they were taking to address these issues. This was a breach of Regulation 17. Good governance.

During this inspection we found that those areas had been addressed. Accidents and incidents were monitored and analysed. Records included body maps where people had sustained an injury, and details such as the time and place accidents had occurred. This information was used by the registered manager to determine if staff had responded appropriately, and if there were any trends in accidents occurring. We saw accident and incident information was shared with the provider, to determine that they were being dealt with and monitored appropriately.

Medicines audits were now carried out consistently across all three units; however they had not highlighted the issues with medicines which we found.

Whilst improvement had been made in those specific areas since our last inspection, we also identified other shortfalls in care which the home's internal quality assurance system had not highlighted and addressed.

During our inspection we found some people experienced a very poor dining experience, risks had not been mitigated and some care plans were out of date. The registered manager carried out a number of audits and checks on aspects of the service. However, these had not highlighted the concerns which we found. This meant auditing systems in place had not always driven improvements.

There was no audit in place to monitor people's dining experience, although representatives from the provider organisation told us these were about to be implemented and had sourced audit templates for the registered manager to complete.

Records showed representatives from the provider's organisation visited the home regularly. They monitored management information which was submitted such as the number of accidents, incidents, safeguarding issues, complaints, or disciplinary which were on-going to ensure these were being handled appropriately. We saw they completed regular quality assessment which included review of care records, observations, and discussions with staff. However whilst we could see that feedback from these quality checks was detailed, and action plans had been created and monitored to address any areas for improvement, these checks had failed to identify the shortfalls in addressing risks, care planning, and dining experiences.

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

At the time of our inspection there was a registered manager in place. She had been in post since December 2014, but had been formally registered with the Care Quality Commission in May 2016. The manager was present during our inspection and assisted us with our enquiries.

During our inspection we identified four incidents of serious injuries and safeguarding incidents which should have been notified to the Care Quality Commission. The submission of notifications is important to meet the requirements of the law and enable us to monitor any trends or concerns.

This was a repeated breach of regulation 18 of the Care Quality Commission Registration Regulations 2009.

We spoke with people, relatives, and a health professional about the leadership at the service. All of the feedback we received was positive. One person said, "[Name of Manager] is brilliant. Everything I ask she'll try and facilitate. I'm always kept up to date with when my appointment are booked in for, and if I ask the staff to pass a message on to her she'll always get back to me." A relative said, "The manager is nice, but she is too easy going she could do a lot more." Another relative said, "The manager is approachable, likeable." A healthcare professional told us "[Name of manager] is professional. She prioritises training and will ensure staff attend. She is proactive and that makes her easy to work with." The registered manager was supported by the provider's operations manager and compliance manager.

The registered manager told us that since the last inspection the service they had implemented formalised reflective practice for senior staff. These sessions focussed on a specific area, which may have been a complaint, accidents, an area for improvement such as topical medicines. The reflective practice involved considering the thoughts and feelings of people who had been involved such as staff or people who used the service, discussing outcomes and whether any improvements could be made. The registered manager told us these reflective practices had resulted in changes to policies to make processes such as complaints easier for people to use. She told us they were part of the provider's commitment to continuous improvement.

Feedback had been sought from people who used the service, staff and visiting professionals. Surveys had been sent out in February 2016. The responses were very positive. Professionals had responded positively to questions about; the home environment; whether they found the manager approachable and the staff friendly and communication within the home. People who used the service had responded with satisfaction to questions about; their privacy and dignity being maintained and the overall care they received. Meetings for people who used the service and their relatives were held every three months. Each unit held their own meeting, and minutes showed information about the service was shared with people; such how staffing numbers were determined and plans for future renovations. People could submit any questions for the registered manager in advance, but were also encouraged to share any discussion points during the meetings.

Staff told us they found the provider to be very supportive, and the staff survey results confirmed this. Staff meetings were held regularly. We saw from meeting minutes that in addition to receiving information about the home, staff were asked to feedback on their views on the service which was provided. One staff member told us, "The meetings were very good and we could talk about any issues with ease." Another staff member said, "It's a happy place to work and we all cover for each other. We work as a team "

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way as some identified risks to the people's health had not been mitigated. Medicines were not always managed safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes in place to assess, monitor and improve the quality and safety of the service provided were not robust to identify and address shortfalls. Records were not always an accurate account of the care people received.