Springfield Manor UK Limited

Springfield Manor Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 01 August 2018 and was unannounced. The last inspection was in June 2017 where we rated the Service as 'Good' but identified one breach of the legal requirements in relation to consent. At this inspection we found that action had been taken to address this but we identified two further breaches of the legal requirements relating to staff training and governance.

Springfield Manor Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Springfield Manor Nursing Home supports up to 30 people in one adapted building. The service provides support to older people with long term conditions, physical disabilities and people living with dementia. On the day of our visit there were 23 people living at the service.

There was not a registered manager in post, the manager was in the process of registering with CQC. 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.

There were shortfalls in governance and record keeping. A new manager had been recruited and had started to make improvements to the audits that were carried out. However, there had been a lack of audits previously and we identified shortfalls in record keeping.

Staff did not always have the right knowledge and expertise for their roles. Staff had completed a variety of training courses but we identified instances where staff knowledge in relation to dementia care was lacking. Staff told us that they did not always feel confident supporting people living with dementia and we observed instances where staff did not seem competent. The provider had a plan to address this, we will follow up on the impact of these improvements at our next inspection.

People's consent was sought in line with legislation and where we did identify some documentation missing, this was addressed after our visit. People were involved in planning their care and care plans were person centred and reflected their needs. The provider encouraged people to express their individuality and where people had particular cultural or religious needs, these had been met. People's wishes with regards to end of life care were recorded and regular reviews took place to respond to changes in people's needs.

People's medicines were managed and administered safely, by trained staff. Staff ensured people's clinical needs were met and people had regular access to healthcare professionals. Where people had particular dietary needs, these had been planned for and responded to. People's preferences in relation to food were known to staff and catered for.

Risks to people were assessed and managed appropriately. Where incidents occurred risk management plans were reviewed and new measures were identified to keep people safe. Staff understood their role in safeguarding people from abuse. Management analysed incidents to learn from them and had notified CQC appropriately where significant events had occurred.

People spoke positively about the activities on offer. People were supported by staff that got on well with them and we observed a number of pleasant interactions between people and staff. Staff supported people in a way that encouraged them to maintain skills. People's dignity was maintained by staff who provided care in a way that was respectful.

There were sufficient numbers of staff working at the home to keep people safe and the provider had carried out appropriate checks on staff to ensure they were suitable for their roles. Staff had regular contact with their line managers through supervision meetings and systems were in place to enable good communication between staff.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Risk management plans were routinely implemented to keep people safe.

Incidents were responded to appropriately with measures identified to reduce risk. Staff knew how to respond to safeguarding concerns.

People's medicines were stored, managed and administered safely, by trained staff.

People lived in a clean home environment with systems in place to reduce the risk of the spread of infection

There were sufficient numbers of staff to safely meet people's needs and the provider had carried out appropriate checks on staff before recruiting them.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People had consented to their care and staff had followed the correct legal process outlined in the Mental Capacity Act 2005.

Staff had received training for their roles but we found shortfalls in training provided to enable staff to support people living with dementia.

People were prepared food that matched their preferences and dietary requirements.

Staff supported people to maintain good health and regularly access healthcare professionals.

People received an assessment before coming to live at the home. The home environment was suited to people's needs.

Is the service caring?

Good

The service was caring.

People were supported by kind and caring staff.

Staff involved people in their care and systems were in place to encourage people to express their diversity.

People were supported to maintain skills and independence. Staff promoted people's dignity when providing care.

Is the service responsive?

Good

The service was responsive.

People had access to a range of activities.

Care was planned in a person-centred way and reviews were carried out regularly to respond to changes in people's needs.

End of life care was planned for sensitively and appropriately.

People's complaints were documented and responded to appropriately.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Whilst there were improvements already underway, we identified shortfalls to audits and there was information missing from records.

People were involved in the running of the service.

The provider understood the responsibilities of their registration and had notified CQC of important events when required.

Springfield Manor Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 01 August 2018 and was unannounced.

The inspection was carried out by an inspector, an assistant inspector, a specialist advisor in nursing care 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.

Prior to this inspection we reviewed all the information we held about the service, including data about safeguarding and statutory notifications. Statutory notifications are information about important events which the provider is required to send us by law. We asked for feedback from the local authority and the local clinical commissioning group (CCG).

Due to technical problems, the provider was not asked to complete a Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

As part of the inspection we spoke with 14 people and three relatives. We spoke with the registered manager, the nominated individual, one nurse, three care staff, the activities co-ordinator, the chef and the administrator. We reviewed care plans for five people, including risk assessments and daily notes. We looked at medicines records, mental capacity assessments and applications to deprive people of their liberty. We also looked at a variety of audits, surveys and meetings minutes.

Good

Is the service safe?

Our findings

People told us that they felt safe living at the home. One person told us, "I don't think you could better it, they look after us so well." Another person said, "It is safe, very good."

Risks to people were assessed and managed. Care plans contained risk assessments that covered areas such as falls, malnutrition and skin integrity. Where staff identified risks, detailed plans were drawn up and implemented to keep people safe. For example, one person was assessed as being at risk of pressure sores due to the fact they spent a lot of time seated. To manage the risk, they had an air mattress to sleep on and a pressure cushion for when sitting in a chair. Staff checked the person's skin daily and recorded that they had done so. Staff applied skin creams during personal care and we also noted that the air mattress was checked regularly to ensure it was on the correct setting. Another person was assessed as at risk of falls and their risk management plan documented that they used a walking frame and required verbal prompts from staff when moving around the home. We observed staff supporting the person to move in line with this guidance. Risk assessments were reviewed regularly to identify any changes in people's needs that might affect their known risks.

Where incidents or accidents occurred, staff took action to ensure people were safe. Staff kept a record of all accidents or incidents, such as falls, and recorded the action taken to reduce the risk of them happening again. Staff actions showed staff identified measures to reduce the risk of incidents reoccurring. For example, one person had suffered two falls in a month. After each fall, their falls risk assessment was reviewed. To reduce the risk, staff introduced a sensor mat to the person's room to alert them if they got up at night, as this was when they often fell. The provider analysed all incidents in order to identify any patterns or trends and to learn lessons when things went wrong. We saw evidence of a learning culture at the service, as a recent safeguarding allegation had resulted in changes to staff practice at nights.

Staff understood their role in safeguarding people from abuse. Staff had received training in safeguarding adults and were able to tell us the potential signs of abuse and where they would report it. For example, one staff member told us they would inform their manager of their concerns but were also aware that they could go directly to the local authority safeguarding team, the police or CQC if necessary. Records showed that where a person had made an allegation, this had been escalated appropriately to the local authority, CQC and the police.

People received their medicines safely. Staff were observed administering medicines to people and they followed best practice. Staff ensured they washed their hands and checked tablets and dosages against medicine administration records (MARs) before administering medicines to people. Staff were observed telling people which medicines they were being given. After staff observed people had taken their medicines, they signed the MAR to record that they had done so. Care plans contained detailed information about people's medical conditions and their medicines. Where people were prescribed medicines on an 'as required' (PRN) basis, there were protocols in place to guide staff about how and when to administer these.

MARs were up to date with no gaps and management carried out regular checks of to ensure they were

accurate. Staff had received training in how to administer medicines safely and their competency had been assessed and was regularly reviewed. People's medicines were stored securely and staff carried out regular checks of amounts of medicines stored to identify any discrepancies. Staff also carried out checks on the temperature of storage areas to ensure medicines were stored in line with the manufacturer's guidance.

People were protected against the risks of the spread of infection. The home environment was clean with no mal-odours. The provider employed cleaning staff and they were observed cleaning the home during our inspection. Cleaning staff had schedules to work through to ensure all areas of the home were cleaned regularly. Management carried out regular checks of cleaning as well as a monthly audit that looked at infection control practices within the home.

Staff understood how to reduce the risk of cross-contamination. Staff were knowledgeable about what measures to take to prevent items becoming contaminated. We observed staff separating people's laundry to ensure soiled items were stored and washed separately from regular laundry. There was a system in place with colour coding and staff were observed following this. We also observed staff using gloves and aprons when appropriate such as when providing personal care or serving food to people. Staff had received training in infection control and our observations showed this had been effective in encouraging staff to follow best practice.

There were sufficient numbers of staff working at the home to keep people safe. People told us that staff were always available when they needed them. People had call bells and when we visited people in their rooms we saw they could access them. During the inspection, we heard call bells were answered almost instantly and did not ring for a long time. Staff told us that they had enough time to spend with people and they were not rushed. By the time we arrived in the morning, people who wanted to get up had got up and been supported with their personal care.

Appropriate checks were carried out to ensure that staff were suitable for their roles. The provider had carried out a variety of checks to ensure staff were appropriate to be working in a social care setting. Staff files contained evidence of references, work histories, proof of right to work in the UK and a check with the Disclosure & Barring Service (DBS). The DBS carry out criminal record checks and hold a database of potential staff who would not be appropriate to work in social care. Staff files showed that a full application and interview process was followed to ensure staff embodied the values of the service and had the necessary skills and experience to carry out their roles. Where staff had had a professional nursing qualification, the provider carried out a check to ensure they were registered with the Nursing and Midwifery Council (NMC).

Requires Improvement

Is the service effective?

Our findings

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

At our inspection in June 2017, we found that mental capacity assessments were not always being carried out to establish people's capacity to make specific decisions. This meant that the correct legal process had not always been followed in relation to consent and this was a breach of Regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014. At this inspection, the legal requirements had been met in relation to consent.

People's consent was sought regarding decisions which affected them but documentation sometimes lacked detail. People's care plans contained mental capacity assessments to establish their ability to make the decision to consent to care and to live at the home. Best interest decisions had been documented and where required, applications had been made to the local authority DoLS team. However, we did find instances when documentation around consent lacked detail. For example, we noted that two people's mental capacity assessments were generic and lacked detail on the specific decision that was being assessed. The new manager had already identified this issue and we saw evidence they had carried out new mental capacity assessments for all other people who required them.

People's mental capacity to consent to photographs being taken of them had been assessed, but the assessment did not cover the decision to consent to CCTV which was in communal areas of the home. We saw evidence of CQC published guidance being followed in relation to CCTV. Records showed that CCTV had been discussed with people and relatives at meetings and the provider had carried out a risk assessment of the CCTV installation that considered consent and people's human rights. However, these measures did not cover people who were unable to provide informed consent to the CCTV installation. After the inspection, the provider introduced new consent forms for the CCTV and carried out capacity assessments and best interest decisions where people were not able to consent. However, the provider's systems had not identified they were not consistently applying the code of practice for the MCA.

We recommend the service seeks and follows best practice guidance on the application of the MCA.

Staff did not always have the training and support they needed to carry out their roles. Records showed that staff received an induction and completed the provider's mandatory training courses which were regularly refreshed and kept up to date. Courses covered important areas of practice such as moving and handling,

food hygiene and fire safety. Staff also completed the care certificate and were given opportunities to complete further qualifications in social care. The care certificate is an agreed set of training standards for staff working in a care setting.

However, two staff told us that they did not feel confident supporting people living with dementia. A relative told us that they felt staff lacked confidence and knowledge in how to respond to behavioural needs. We also observed two people who were living with dementia being supported to eat. Staff supported people without engaging with them. There was no conversation which showed a lack of confidence and best practice was not being followed to support and involve people living with dementia at mealtimes. The new manager had already identified this and we saw dementia training had been booked for two months after our visit. In the meantime, the manager had held supervisions with staff and had arranged for some training to be carried out by the community mental health team (CMHT) in response to one person with complex needs. Whilst this issue had been addressed by the provider, the failure to ensure that the appropriate training and support was in place for staff ahead of them supporting people living with dementia and we will require an action plan to address this.

The failure to ensure staff had the appropriate training to meet the needs of the people that they supported was a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staff had regular contact with their line managers. Records showed staff received regular supervision meetings and they told us these were useful to them in their roles. One staff member said, "We talk about people and discuss any help we may need." Records showed supervision was used to discuss training and performance. Staff received an annual appraisal and these documented goals for staff to achieve in order to develop themselves further. Nursing staff had regular clinical supervision and the provider supported them to maintain their nursing competencies. Nursing staff demonstrated a good knowledge of people's clinical needs through our observations and discussions with them.

People's nutritional needs were met. Care plans contained information about people's dietary needs and the support they needed to meet them. For example, one person was diabetic and their care plan clearly documented this and contained information about the types of foods they should eat as well as the signs they could be becoming unwell. Another person had low sodium levels which meant they needed to limit their fluid intake. Their care plan documented they should drink a maximum amount of fluid each day. Their fluid intake was documented by staff and the total was calculated each day. The provider's electronic care planning system provided staff with accurate measurements of people's food and fluid intake. The kitchen held records which included dietary needs, allergies and preferences for people and these records matched what we had seen in people's care plans.

People were provided with food in line with their preferences. The provider made a record of foods that people liked and disliked and menus were planned around these. For example, one person's care plan documented they liked 'traditional English foods' such as fish and chips and disliked spicy food. Records showed this person had recently eaten fish and chips and they had not been provided spicy foods. People were regularly asked about the food and minutes of meetings showed they were given opportunities to make suggestions. The kitchen prepared a choice of meals each day and there was an alternative menu for people who did not wish to eat the meal that day.

Staff supported people to stay healthy and access the healthcare professionals they needed. People's care records contained evidence of input from healthcare professionals. For example, one person's needs had recently changed and their medicines had been increased by the GP. This was clearly documented within their care records. We spoke with a visiting GP during the inspection and they told us staff were competent

and always gave them the information needed to reach clinical decisions. People's care records also contained evidence of visits to dentist, optician and specialists. For example, one person had support from a physiotherapist to improve their mobility. We saw correspondence with the physiotherapist and records showed that the person benefitted from regular support from the provider's in-house physiotherapist who visited the home regularly.

The home environment was suited to people's needs. The home was adapted to ensure there was enough space for people to access all areas of the home. Corridors were wide and brightly lit and we observed people using walking aids were freely able to access the home. There was signage throughout the home to help people to orientate themselves. These included photographs and names on people's rooms in order to help them to identify them.

We did note there was a steep staircase which could present a hazard to people if they tried to use it. The manager informed us that this was only used by staff and in response to our feedback, they had arranged for this to be cordoned off with a door to ensure safety. We also noted that some corridors within the home did not have hand rails for people to guide them and to hold onto. The impact of this was minimised as the people we observed using this corridor were either fully mobile or using existing walking aids. We fed this back to the manager and they told us would discuss these plans with people to identify if this was something they would like and would benefit from.

The provider gathered important information about people before they came to live at the home. Care records contained evidence of an assessment being carried out before people moved in and these were comprehensive and covered people's needs. Assessments contained input from people and relatives and documented needs as well as preferences. Where appropriate, additional documentation was sought to inform care planning. For example, one person came to the home from hospital and staff carried out an assessment and obtained documentation from the hospital such as a discharge summary and a social care needs assessment.

Good

Is the service caring?

Our findings

People told us that they were supported by caring staff. One person said, "The staff are very caring, very nice." Another person said, "I've got to know them all and there's nobody I can't get through to." Another person told us, "The staff are very good when carrying out intimate tasks. They give me some space."

We observed staff providing care in a way that demonstrated kindness and compassion. In the morning, staff were observed spending time chatting to a person who told us they had felt unwell. Staff enquired after their wellbeing and engaged in conversation with them about the view from a window. At lunchtime, another person sat and chatted with staff and there was lots of smiling and laughter. Later, a person became tearful and staff sat with the person, holding their hand and stroking it gently which caused an improvement in the person's mood. Throughout the day we observed that staff interacted with people pleasantly and warmly.

People were involved in their care. Care plans contained evidence of people's choices and preferences being documented and a one-page sheet of these was produced to help ensure staff provided care based upon these. People were regularly asked about their care at reviews to identify if there was anything that they wished to change. We observed staff offering people choices throughout the day. In the morning, people were given a choice of a variety of drinks and snacks. Staff asked people if they wished to attend an activity and we noted where one person did not wish to staff spent time with them on a one to one basis.

The provider encouraged people to express their individuality. Assessment records showed people were asked about their religion, sexuality and culture to identify any areas they may require support tailored to these needs. Where needs were identified, support was in place to meet them. For example, one person practiced a particular faith and this was documented in their care plan. We visited this person and saw they had religious iconography in their room and staff were aware of their religion and when they prayed. The person also received regular visits from a representative of their faith.

People were encouraged to maintain their independence. Care plans reflected people's strengths to carry out tasks independently and we saw evidence of care being planned around these. For example, one person's care plan documented they liked to be involved in tasks around the home. Daily notes showed they sometimes helped with laying tables and making drinks. Another person was able to carry out a number of personal care tasks independently, such as washing their face and brushing their teeth. This was in their care plan and staff were knowledgeable about this person's strengths when we spoke with them. Staff gave us further examples of how they provided support in a way that encouraged people to be independent. A staff member said, "I noticed [person]'s wheelchair was too big which meant that it was not easy for her to do her make up in her room. We swapped to a smaller chair and she is now able to move around in her room to do her make up."

People were supported by staff that knew them well. The provider's rotas showed people were supported by regular and consistent staff and people told us they had developed relationships with them. There was a keyworker system in place which meant each person had an allocated member of staff who took the lead on

overseeing their care and getting to know the person well. People's rooms had photographs of their keyworkers in in order to help them remember who they were. During the inspection staff were able to give us information about people's needs and backgrounds without referring to care plans. For example, staff were able to tell us about one person's interest in gardening and another staff member talked to us about another person's relatives that visited regularly.

Staff provided care in a way that promoted people's privacy and dignity. Staff were observed knocking on people's doors and waiting for permission before entering. Where personal care was provided, this was done behind closed doors and we observed a discussion about someone's medical condition and saw staff were mindful to have this discussion in private. Staff ensured people were clean and we noted people were well kept when we met them.

Good

Is the service responsive?

Our findings

People spoke positively about the activities on offer. One person said, "[Activity co-ordinator] helped me use my brain and imagination, 'three balls' [an exercise activity] is a wonderful game." Another person told us, "They don't push you. [Activity co-ordinator] is lovely, she is a good teacher." Another person said, "I like the activity where you throw balls."

The home employed an activities co-ordinator and people spoke highly about the positive impact they had. There was a timetable of activities on offer at the home which included physical exercise, entertainment, quizzes and arts and crafts. There were photographs of recent activities on display within the home and these showed people participating in a variety of activities. Photographs showed people smiling and posing next to items they had produced such as quilts and painted sea shells. We saw people were asked about activities at residents meetings and through surveys. Where people were cared for in their rooms, we saw that they had regular visits from the activities co-ordinator and these were documented. We observed people spending time with the activities co-ordinator on a one to one basis during our inspection.

Care was planned in a person-centred way. People's care plans contained detailed information about their needs, as well their preferences and routines. Records showed that where specific needs had been identified, comprehensive care plans were put in place. For example, one person was living with dementia and could sometimes refuse care if they were anxious. Their care plan listed signs that they may be anxious and how staff should respond. It documented that staff should allow the person time and come back later. Staff had documented recent instances when they had delayed the person's personal care in line with this guidance. Staff were also knowledgeable about this person's needs when we spoke with them. Another person had a medical condition that sometimes impacted on their ability to mobilise and communicate verbally. There was guidance on how to support the person and how they liked to communicate and staff were observed following this guidance.

Care plans reflected what was important to people. One person's care plan documented how they took pride in their appearance and liked to wear makeup and nail varnish. When we met them we observed their nails had been recently painted and they had their make up on and hair done. Records of reviews showed people were asked about their care plans and any changes in their needs were documented and responded to. For example, staff had recently identified changes to one person's blood pressure and they were seen by the GP and their medicines were changed. This was updated and added to their care plan. Where staff noted changes to another person's mobility, a review was carried out and their care plan was updated to include additional equipment to be used when supporting the person to move.

End of life care was planned for in an appropriate and sensitive way. People had care plans that documented their advanced wishes and preferences for when they reached this stage of their lives. Records documented whether people wished to be admitted to hospital and when they would like their relatives contacted. Where one person had specific religious needs that would need to be considered, these had been included. Whilst the majority of the examples seen had enough detail to provide personalised and sensitive end of life care, we did identify one record where information was lacking. The new manager had

been working through care plans to improve the level of detail within them and we will follow up on the impact of these improvements at our next inspection.

People's complaints were taken seriously. There was a complaints policy in place and people told us they knew how to complain and felt confident any issues raised would be dealt with. The provider kept a record of all complaints received and documented their responses. Records showed complaints had been investigated and a response had been sent to complainants within the timescales outlined within the provider's policy. For example, relatives had complained about some maintenance issues in one person's room. The provider had this addressed by their maintenance staff and a response was sent. There had been five complaints within the last 12 months and all had been handled appropriately.

Requires Improvement

Is the service well-led?

Our findings

People told us there had been changes to management. One person said, "[Manager] is quite pleasant." Another person said, "It's very good here, but took a while to get used to it." However, another person said, "There have been a few ups and downs, they keep changing managers."

The new manager had started at the service in April 2018 and had made a positive start in their role. All people we spoke with had met the new manager and said they saw her regularly. We observed the manager interacting with people and working alongside staff throughout the day. Where we had identified issues during this inspection, the manager was already aware of them and had plans to address them. However, the provider had not identified or addressed these issues and did not appear to have oversight of audits to identify where they had not taken place.

Records were not always accurate and up to date. We noted that care records were not always presented in a way to show what was important to people. For example, one person was living with dementia and English was not their first language. Staff were knowledgeable about this and informed us they rarely had to use alternative communication techniques and daily records supported this. Whilst this person's needs were evidently being met, their records lacked detail about their language as this was not recorded prominently in their care plan. Another person had a care plan for reducing pressure damage that included unnecessary information. The person was able to mobilise independently but the care plan documented a need for a repositioning chart. The risk of pressure damage to the person's skin was being managed, but the records relating to it were not clear due to the additional information that was not relevant to their needs.

Audits were carried out to monitor and assess the quality of the care that people received, they covered areas such as infection control, medicines and documentation. However, some audits were lacking and work was still underway to get them up to date. For example, the monthly health and safety audit had not taken place since January 2018 and there had not been a catering audit since March 2018. The manager was aware of this and records did show an increase in audits since they came to work at the home. There were regular documentation audits being carried out but as we have reported we found inconsistencies to care plans and some records relating to consent were not clear. This showed audits were not yet regular and robust enough to proactively identify and address issues.

Whilst most people told us staff responded to them within an appropriate length of time, one person told us that they had to wait a long time for care at night. We asked management about this and saw a record was kept of all night call bells, but this did not record how long people had waited for support. The manager told us their current system did not allow for monitoring of response times to call bells. This meant that there was a lack of monitoring of call bell response times to track that there were always enough staff. The new manager had a plan to address these issues which was already underway, however we will require an action plan from the provider to outline when they will get these shortfalls addressed.

The lack of regular audits and effective systems to monitor the quality and safety of the care received was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People were involved in the running of the service. The provider had systems in place to enable people and relatives to have regular contact with management and influence change at the service. Annual surveys were conducted to provide opportunities to give feedback on all aspects of care. We also saw evidence of meetings involving people and their relatives and these showed an inclusive approach and actions to improve people's experiences. For example, records showed that the most recent meeting had been used to introduce the new manager and to improve communication with relatives by setting up email lists for communicating messages to relatives.

Staff felt supported by management. One staff member said, "I know my job and what I need to do, [manager] respects me." Staff had regular meetings to enable them to be kept updated on the running of the service as well as to provide opportunities to make suggestions. There was a daily handover meeting where important messages about people's care were passed on. We observed that on the day of our inspection changes to one person's health had been efficiently communicated to staff and the GP was visiting them that day. Regular staff meetings took place and records showed discussions were based on ways of improving people's care. The most recent meeting had discussed the new keyworker system and how to implement it as well as discussions about communication and rotas.

The provider understood the responsibilities of their registration. Providers are required to notify CQC of important events such as allegations of abuse, serious injuries or deaths. Records showed that where required, the provider had notified CQC of these incidents. For example, CQC were notified of a recent allegation of abuse which was used to inform inspection planning.

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 17 HSCA RA Regulations 2014 Good governance Regular audits were not always being carried out and we identified shortfalls in record keeping.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure that staff had the right training and support for their roles.