WAYPOINTS (UPTON) LTD

Waypoints (Upton)

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?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

The inspection visits took place on 1, 7 and 8 September 2015 and we spoke with professionals over the following week.

Waypoints (Upton) is a purpose built nursing home registered to provide care for up to 67 people in the centre of the village of Upton. The service opened in March 2015 and at the time of our inspection there were 38 people living there. People were living on two of the three floors. The people living in the home had complex care needs associated with their dementia.

The person registered with the Care Quality Commission as the registered manager was no longer in day to day management of the home, although they were available throughout our inspection. The current manager was applying to take on this role. 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 moving in to the home at the time of our inspection; 11 people had moved in during the previous month.

Staff were not monitoring all areas of the home and this put people at risk of harm. Care plans to reduce risks

Summary of findings

associated with what people ate and drank and keeping their skin healthy were not always followed effectively and new and emerging risks were not assessed and planned for appropriately.

The provider had made appropriate applications for Deprivation of Liberty Safeguards as people were unable to make a decision as to where to live to receive the care and treatment they needed. This was in line with the Mental Capacity Act 2005. Some people needed further restrictions of their liberty to keep them and others safe. This meant that the staff used forms of restraint with some people. Staff were trained to use restraint but its use was not effectively monitored and did not reflect the provider's policy.

Records kept by staff about people did not accurately reflect people's experiences. This put people at risk of receiving care that was not appropriate because care support was planned based on inaccurate information.

Staff had an understanding of the provider's ethos about dementia care and this was shown through their kind and gentle interactions with people. People had access to activities and the garden area of the home was well used throughout the time we were there.

The management team were responsive when we made them aware of our concerns. They also responded to staff concerns that were discussed in a whole team meeting. Concerns identified previously by the local authority had been responded to but this had not led to improved care for people.

There were breaches of regulation related to: how risks were managed; how people's medicines were managed; how quality was monitored and how records were kept.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not safe. Staff did not have consistent understanding of the risks faced by all the people living in the home.

People did not always receive their medicines safely.

People were relaxed with staff and staff understood their role in protecting people from abuse.

Is the service effective?

Requires improvement

The service was not effective. People were at risk of not getting enough food and drink to stay healthy because their needs were not consistently understood and support was not planned effectively.

People had access to healthcare but staff did not always record their support for people's health needs. This put people at risk of not receiving the right care and treatment.

Some people needed to be restrained for their own safety and the safety of others. This was not always used as a last resort and the use was not reviewed with everyone involved. This put people at risk of being restrained unnecessarily.

Deprivation of Liberty Safeguards (DoLS) had been applied for people who needed their liberty to be restricted for them to live safely in the home.

Is the service caring?

Requires improvement

People's dignity was not always respected because staff did not always have the guidance necessary to support people with personal care when this was refused.

Staff spoke to people kindly and used their names whenever possible.

People were supported by staff who took time to build relationships with them when this was possible.

Is the service responsive?

Requires improvement

The service was not responsive. Records about people's care did not accurately reflect their daily experiences and the support received. This put them at risk of receiving inappropriate care.

People were supported to live in their own reality when this did not cause distress to themselves or others. They had access to activities including open access to the secure garden.

Complaints were responded to robustly and used to improve the quality of care people received.

Summary of findings

Is the service well-led?

The service was not well led. At the time of our inspection the manager was applying to become the registered manager of the service.

The service did not have robust quality assurance systems in place and some of the issues found during our inspection had not been picked up by the management team.

Staff described the managers as approachable. Problems of communication had been identified and the management team responded with an opportunity for staff to share concerns openly. The management team listened to staff concerns and put a plan in place to respond to them.

There was a clear ethos of care related to how people experience dementia and staff understood, however this this had not been translated into safe person centred care.

Requires improvement

Waypoints (Upton)

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 visits took place on the 2, 7 and 8 September 2015 and was unannounced. The inspection team was made up of two inspectors, an expert by experience and a specialist adviser. 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 had specific experience of dementia care and the specialist adviser had nursing expertise.

The provider had not completed a Provider Information Record (PIR) prior to the inspection as we had not requested one. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We were able to gather this information from other information we held about the service. This included notifications the home had sent us about safeguarding concerns and during our inspection through discussion with the management team and staff.

During our inspection we spoke with five people living in the home and six visiting relatives. We also spoke with nine members of staff, and four members of the management team including the provider's nominated individual and the registered manager. We observed care practices throughout the home. We also looked at records related to 13 people's care, and reviewed records relating to the running of the service such as staff records, rotas and quality monitoring audits.

We also spoke with three social care professionals and one healthcare professional who had worked with the home or had visited people living at the home.

Requires improvement

Is the service safe?

Our findings

People were at risk of harm because known risks were not well managed. One person was identified as being at high risk of falls as recorded in their care plan. Not all staff identified this risk; when asked one member of staff said the person was at "very low risk of falls". Another person's pre admission assessment stated they needed a soft diet. This was not referred to in their care plan and the care and kitchen staff were not aware this was the case. This risk had not been properly assessed. People who were at risk of dehydration were on fluid charts that kept a record of what they drank. One of these people had lost a substantial amount of weight in the month prior to our inspection and was at risk of malnutrition and dehydration. These charts were not completed consistently which meant that staff could not respond to any changes in their fluid intake to reduce risks to their health.

There were kitchens known as pantries in all the areas of the home. The manager told us that these rooms were locked when people were not with staff or their families as they had kitchen equipment in them that could be dangerous. We were later told that one pantry did not contain dangerous equipment and could be left open. We found different pantries open on two days of our inspection. One of these pantries had knives on the side. The pantries were not visible from the corridor and this meant people were at risk of hurting themselves or others. People who were vulnerable and stayed in their rooms, and people who might be aggressive if other people came into their rooms, had stairgates in their doorways to stop people entering their rooms. These restrictions had been discussed with social care professionals and best interest decisions were recorded. However, these restrictions were not effective in allowing people to be in their rooms without interruption as their doors could be opened and we saw that this happened regularly throughout our inspection.

People were put at unnecessary risk of harm because new and emerging risks were not properly assessed. During our inspection we witnessed an altercation between two people during which one person grabbed another person's arm and spoke aggressively about them. This was witnessed by staff but records did not reflect this; they stated that the person who had grabbed the other had been "happily walking around the home… and chatting to other residents." The person's care plan detailed that their: "behaviour does not pose a risk to himself or others." This was not reviewed and the person was involved in another incident five days later in which they were injured. Staff did not have a consistent understanding of the person's needs and were not consistently monitoring them hourly in line with the provider's procedure when someone moves into the home. This meant that they were not able to assess the risks they faced, and posed others, effectively.

People's medicines were not always administered safely. The specialist advisor found that two people's medicines records detailed that they had not taken their medicines consistently for eight days. One person was recorded as being asleep at the time their medicines should be taken. There had not been a review of whether the medicines were necessary or whether they could be taken at a time that suited the person. Another person had not had medicines that were used to treat diabetes because they had refused them with the exception of one day over an eight day period. There was no record of contact with the person's GP to discuss how this should be managed safely for the person although a nurse was sure the GP had been contacted to arrange covert medicines. Managers were aware that this was a concern and told us they were having difficulties arranging covert medicines. Medicines can be given covertly if a person who does not have capacity to decide not to take their medicines refuses to take them. The decision to give medicines in this way must be made following the principles of the Mental Capacity Act 2005. This put the person at risks to their health. One of the rooms that medicines were stored in had recorded temperatures of 29 degrees centigrade on a number of days. This put medicines at risk of not working effectively. There was an accurate record of all drugs that are covered by the Misuse of Drugs Act 1971.

The home smelled of urine near some bedrooms which undermined the dignity of people in the rooms. Cleaning records did not enable us to check when people's mattresses and beds had been cleaned, two cleaning staff working did not know about the records they should complete. Cleaning staff told us that care staff cleaned the beds and they cleaned the floor. One member of care staff told us cleaning staff cleaned the beds and another member of care staff said the care staff cleaned the beds. Therefore the system to ensure that people's mattresses, beds and floor had been cleaned was not understood by staff putting people at risk of harm through the lack of

Requires improvement

Is the service safe?

effective infection control procedures. We discussed this with the manager and the head of the cleaning team. They told us that they would make this process more robust and that new products for cleaning had been ordered and would be introduced in the next month.

The above evidence constituted a breach of Regulation 12 of the HSCA 2008 (Regulated Activities) Regulations 2014.

The people living in the home were living with dementia and had complex support needs requiring skilled staff intervention to ensure their safety. Staff working on the ground floor told us they were following written guidance that meant four staff were present during four individual people's personal care. This guidance was recorded in the four people's care plans. The staff told us this meant they were "stretched" and they could not monitor people. They told us the impact of this was some people may have to wait for support. The lack of staff supervision put people at risk of harm because the people living in the home had high support needs and could become anxious and agitated with their environment or other people. We observed an altercation between two people in a communal area, one person was approached and touched by another person and pushed their arm away forcefully and raised their voice. We also observed a person taking other people's food. These incidents were not witnessed by staff.

Staffing had been increased in the home as people moved in and during our inspection measures were put in place to ensure the times when staff were providing four to one care were support by staff from other parts of the home. We discussed staffing with the manager. They told us they would review how personal care was provided to people who currently had care plans stipulating four staff should be present. They also told us would change how people moved through the building with the intent of improving how staff monitored people's safety and increase staff numbers in one part of the home.

Staff understood their role in identifying and reporting abuse. They described where information about safeguarding was kept and knew which agencies were involved in keeping people safe. Incidents of alleged abuse had been referred appropriately to both the local authority and the Care Quality Commission. However potential abuse and improper treatment had not been identified as such and had not been referred appropriately. The person not receiving their diabetes medicines should have been identified as possible neglect. This situation was being investigated by the local authority.

Staff were recruited in a way that protected people from the risks of being cared for by staff who are not suitable to work with vulnerable people. The home had not, however, made sure that agency staff had the appropriate checks and training in place to work safely with vulnerable adults. This information was available with the agency but it had not been available in the home when the staff were working. We spoke with the manager about this and they contacted the agency immediately and assured us that these documents would be checked.

Most people living in the home were not able to describe how they felt with words but we observed that they were relaxed around staff throughout our inspection. A relative felt that their relatives were safe. One relative told us: "I know (person) is safe here, It's a nice home, staff are friendly and they reassure me and are caring."

Requires improvement

Is the service effective?

Our findings

The home had a policy of using restraint with people who were assessed as requiring this intervention for their own and staff safety. The policy highlighted that restraint should only be used as a last resort when all other approaches had failed, and that a follow up discussion should be recorded involving all the people involved in the incident. Incident forms were being completed and reviewed only when people were aggressive not all times when restraint techniques were used.

Staff had received training from a trainer suggested by local health professionals and one staff member described this training as "very good". The health trust had also provided specialist support to people and staff in the home. This support was designed to ensure that people received the care they needed and staff developed skills. Staff were not, however, aware of the content of the restraint policy and described the use of most restrictive restraints as a first option in some instances. For example, they spoke about attending to people's personal care needs with four staff present and involved in the person's care from the outset. Care plans, developed with professional input, however, allowed for three staff to be actively engaged in a person's personal care with a fourth member of staff stood behind them as necessary with the exception of one person who required this support at all times. Follow up discussions were not undertaken to ensure learning and staff support after these techniques were used. We discussed staff understanding of the restraint policy and the impact of four to one care with the manager and nominated individual who told us they would be reviewing the ongoing use of restraint in the home with appropriate professionals. They were not confident that four members of staff were needed every time these people needed personal care. The nominated individual told us, "If you start with three (staff) you are going to trigger a response." This view that this use of restraint may not be appropriate was shared by two social care professionals who knew two of the people being restrained in this way.

Care plans reflected elements of the principles of the Mental Capacity Act 2005 (MCA). Some people had a care plan that related to capacity that detailed that staff should give full choice unless it was apparent the person lacked capacity and then staff should act in their best interests following the principles of the MCA 2005. An audit of care plans had identified issues about the recording of consent in daily records and identified that all care plans would be reviewed to ensure they reflected the MCA 2005 by October 2015. Care plans included consent to aspects of care but these were not always signed by people who had the legal authority to do so. For example one person had a power of attorney to make decisions about their health and welfare, but another relative had signed a consent form. Staff understood their role in supporting people in their best interests but did not talk about the principle of the least restrictive option. This put people at risk of receiving care that did not reflect the least restrictive option and is particularly relevant to the use of restraint by staff. The home had applied for Deprivation of Liberty Safeguards (DoLS) to be authorised appropriately. DoLS aim to protect the rights of people living in care homes and hospitals from being inappropriately deprived of their liberty. The safeguards are used to ensure that checks are made that there are no other ways of supporting the person safely.

Meal times were a varied experience for people, as support was not planned for and delivered effectively. We observed focussed personalised support provided for some people; for example two people were given their food on the move when efforts to encourage them to sit had not been successful. One person told us that the "food is ok… nice". The provider was keen to promote a relaxed social atmosphere and had a policy that when staff ate with people their meal would be free. We saw that members of the management team ate with people during one meal and the maintenance staff ate with a person in another communal area. Staff did not always effectively support people with their meals. For example, one staff member was supporting two people who needed physical assistance to eat and was talking to another member of staff whilst doing this. On occasions we saw staff stood next to people they were supporting with food when the person was sitting down. We also saw one person who had a care plan stating they should be supervised during meals eating off the floor unsupervised on two occasions.

People's needs and preferences were not always reflected in the food available. One person's care plan required that staff learn the food preferences of a person as they were at risk of losing weight because they did not engage with mealtimes. The chef was not aware of this person having any preferred foods and there was no system in place to ensure this information was captured. The chef was aware

that some people preferred finger foods but their food was not adapted to reflect this knowledge. However, sandwiches were available if people did not want the main meal.

Staff did not have consistent understanding of people's nutritional needs. Nurses gave people nutritional supplements when these were prescribed. We spoke with the chef who told us the food prepared in the home was fortified. It was clarified that this meant that food that could be fortified was fortified, though certain foods like vegetables, meat and cereals, as well as healthy options like salad, were not fortified. The chef also told us they prepared milkshakes for people who were at risk of malnutrition but they did not know who these people were. They told us the care staff knew who to give the milkshakes to. We spoke with care staff about people's nutritional needs and they did not have a common understanding of the people who should receive milkshakes. Care staff also told us that one person was being supported to lose weight. People were at risk of receiving food which did not meet their needs. We spoke with the manager about this and they ensured that this information was shared immediately.

Plans had been made with the local surgery to improve people's access to healthcare by arranging regular communication and protected GP input. Professional advice was sought, however, whilst there were plans of care in place to meet health needs inconsistencies in recording put people at risk of receiving inappropriate treatment. For example, one person was identified as being at risk of skin damage and needed help to change their position regularly. The provider had a system to ensure this happened which included a chart for staff to record which position they had been in to ensure they were supported to move appropriately. This chart had not been completed on two consecutive occasions and this could have resulted in the person being supported to move incorrectly putting them at risk of skin damage. We raised this with a member of staff who told us they had helped the person to move and completed the record retrospectively.

During our inspection this person needed pain relief and this was arranged in conjunction with health professionals quickly to ensure that the person was not in unnecessary pain. We spoke with a visiting healthcare professional who had been asked to review another person's support and medicines. They were satisfied that the service was following guidance appropriately for this person.

The Care Certificate had been introduced in the home and all staff had received an induction. The Care Certificate is a national induction for people working in health and social care who have not already had relevant training. No staff had received a formal supervision session and there had been plans for the staff who would be supervising to have training before this commenced. This was changed after staff feedback to ensure that staff could discuss issues that were concerning them with their supervisors straight away. Staff had received specialist training in dementia awareness and were able to describe how this helped them in their work. The home had a training plan that ensured staff had access to and were booked to attend all training that they needed to do their jobs effectively.

Requires improvement

Is the service caring?

Our findings

Personal care was provided in a way that protected people's privacy but did not promote their dignity. Some people were able to choose not to have help with personal care if this was not putting them or others at risk. We spoke to the manager about this as people appeared to have not been supported with personal care during our inspection. They explained that people could express this choice but that staff would return and try to encourage personal care at a later time. They told us that this would be recorded in people's care delivery records. However, we observed two people remained in food stained clothes, or had dirty glasses and food on their faces throughout the day. We did not see staff encouraging them to have support with personal care and records did not reflect that staff had tried again throughout the day. We also observed two people wearing clothes that showed their underwear. Whilst it is important to respect people's choices and to avoid causing people agitation and anxiety, it is also important to ensure that staff return and find approaches that work for the person in order to promote and protect their dignity.

The service was about to introduce a policy around dignity following staff training in October 2015. This policy involved checklists for ensuring staff sought to promote dignity throughout their work and across people's support needs. For example, it covered dignity in meal times, reducing loneliness and supporting people to express their needs.

Relatives were involved in decision making through the gathering of this life story information and this was starting to be used to plan care that responded to people's preferences. There were plans in place to use this information throughout care plans and at the time of inspection they had been used to record how people liked their drinks had been made up. People who used words to communicate were offered choices of food. We saw a person who had not wanted a cooked lunch offered a sandwich option and this being provided straight away. Where people did not use words to communicate we were told that people were offered a physical choice of meals. People were able to choose where they went in the building, whether they took part in organised activities and when they spent time in the garden.

Care plans reflected the philosophy of the home describing that staff should always greet people with their name whether they are providing care or passing in the corridor. We saw that this happened throughout our inspection. The area manager told us that this practice was embedded to support people developing an emotional memory of staff being kind. People and relatives described staff in ways that reflected this approach was successful. One person said, "The staff all seem lovely." One relative told us, "The staff are always pleasant." Another relative told us the staff were all "kind and polite".

Staff were taking time to build relationships with people when possible. One person was distressed and a staff member spent time reassuring them. Another person wanted to speak with the manager about a situation that was causing them concern and we saw that the manager followed through on their promise to find the person to discuss this as soon as they were available. This caring approach was reflected by all members of the staff team including administrative, cleaning and maintenance staff. The staff member responsible for home maintenance ate their lunch with a person living in the home who enjoyed their company. This was evidently valued by the person who looked forward to this time. The activities coordinator was working to provide staff with additional information to help them build relationships by gathering life story information about people. This was still in a developmental stage and the expectation was that these documents would be reflected in all care plans.

Requires improvement

Is the service responsive?

Our findings

People did not always receive the care and support they needed. We saw one person who had one to one support receiving this, in a sensitive manner, throughout our inspection. However, another person was assessed as needing support to get out of bed. They asked to get out of bed and were told they could not because a staff member was on their break. This person was not supported to get out of bed for more than two hours after they made their request and we observed they were also in their bed three hours later.

Staff said they sometimes found it difficult to be up to date with people's needs. They said this was particularly an issue of they had been off work for few days of and people had moved in. 11 people had moved into the home during the month prior to our inspection so this had been a regular occurrence for staff and assessment information was not always readily available for staff in some instances. For example a senior staff member was not aware that a person had one to one funding available for part of each day. Another person moved in during our inspection and staff were referring to information sourced from the service the person used to live in as they were not aware of a pre admission assessment available to them. This lack of pre assessment information was acknowledged as a concern by the management team at a whole staff meeting on September 9 2015 when undertook to improve communication about people's care plans.

Records were not accurate enough to review the effectiveness and quality of people's care. For example it was not possible to tell whether people were spending long periods of time in bed. Staff were not able to distinguish between the coding for people being in bed and people being in the bedroom on observation records. We spoke to a member of staff about another person who appeared to be in an uncomfortable position in their bed. The staff member told us that they thought they may be in pain and told us that the nurse had checked them. Their records did not reflect this. Monitoring records were not consistently completed for a person who required hourly staff observation with gaps of up to five hours noted. Another person who had recently moved in was distressed and spent time with a member of staff who was reassuring them kindly about when their relative would be visiting. Neither the person's anxiety nor the support the person received were referenced in their care records.

The disparity between records, people's experiences and staff understanding meant that reviewing people's care needs and developing care plans would not be effective.

Where information had been gathered records had not always been updated to reflect this. One person had a care plan that referred to them wearing an item of protective clothing due to their risk of falls. This had been queried at the beginning of July 2015 and a request was on file that this be investigated and the person's care plan updated. The person's care plan had not been updated at the time of our inspection.

We discussed the anomalies in records with senior staff who told us that care planning training had been planned for early October 2015 and that they wanted to alter care delivery records as they were aware some staff wrote better notes than others. Whilst this plan addressed concerns around care planning we were not able to assess the impact of changes to recording systems.

This was a breach of Regulation 17 of the HSCA 20908 (Regulated Activities) Regulations 2014.

The philosophy of the home was to support people with dementia in the reality they are living in if this is not causing them any distress. We saw staff use this philosophy effectively to engage people and help distract them when they were at risk of becoming anxious. Staff referred to places, loved ones and possessions to support people as they made sense of their worlds. There were plans to develop this further when using life story information to develop care plan. For example engaging people in safe activities that were meaningful to the person because they reflected their previous profession. Staff had an awareness of this information for some people and this reflected the varied information available for people.

People were able to take part in activities such as a breakfast club, going to church, arts and crafts and cookery. Volunteers supported the activity coordinator to ensure that group activities were accessible. The activities coordinator also spent time with people individually. This meant that people were able to access activities in the local community and one person attended a group at a community centre during our inspection. Community

Requires improvement

Is the service responsive?

groups were also welcome in the home and this made opportunities available to people. There was a regular knitting group and a table tennis group available to people in this way.

The garden had been partly developed by people living in the home who had planted up the raised beds earlier in the year. It was in use throughout our inspection. During fine weather there was no restriction on access to the garden and we saw people using it alone, with relatives and with staff support.

Despite the inherent risks the ethos of freedom of movement was welcomed by some people and relatives.

We saw people used the whole building and garden and a relative told us: "(their relative) loves it here – (they) came from another home – can't praise this place highly enough. It is light and airy and people can move around."

Complaints were used as a learning opportunity and changes instigated were reviewed by the manager. Following a complaint from a relative a change was made to how staff undertook hourly checks on people who were in their rooms. The manager then undertook a spot check on the care of the person involved in the complaint. Relatives told us they felt able to talk to the senior staff and whilst they were not always in agreement it was clear that there was open dialogue.

Requires improvement

Is the service well-led?

Our findings

The day to day management team in the home consisted of the provider's nominated individual, the manager and the head of care. The manager was in the process of applying to become registered with the CQC. The service had a registered manager however they were not involved in day to day management as they managed another service for the provider. This did not reflect the legal responsibilities of this role.

Staff told us that they felt the managers were approachable but it was apparent that communication between staff and the senior team had not been effective. The manager had realised there were communication difficulties and had instigated a full team meeting. This meeting happened during our inspection and was planned in a way that enabled staff to raise concerns anonymously that would then be discussed. This meeting covered a wide array of staffing and care issues and led to actions being agreed. For example staff supervision sessions were instigated immediately after the meeting and a commitment was made to share assessment information before anyone moved into the home. This reflected the managers stated goal of listening to staff concerns and addressing them to ensure the welfare of staff and people, however it was indicative of poor communication over a period of time that these issues had developed.

The service had been open since March 2015 and was in the process of taking in new residents. They had started monitoring and quality assurance work but had not picked up a number of the concerns identified during our inspection.

Incident and accident records had been reviewed by the manager against risk management and behaviour plans that were in place. This had highlighted when care plans had been followed or needed to be reviewed, but did not identify when most restrictive restraint measures had been used as a first option by staff. This meant the system was not effective for monitoring whether people were cared for in the least restrictive way possible. Two incident records highlighted potential concerns regarding staffing levels, including the use of one to one staffing, these had not been addressed fully although the home had increased staffing prior to and during our inspection.

Where audits had been undertaken they had led to some quality improvements. For example a review of care plans had highlighted a need to improve recording and planning informed by the MCA 2005. However, quality monitoring had not satisfactorily addressed the concerns identified about poor recording practice such as gaps in monitoring charts. We spoke with the head of care about this and they acknowledged that reporting was variable but had not addressed this formally with staff and the reporting remained inconsistent.

The manager and head of care were working with professionals to improve the service people received. There was work underway to ensure improved communication with the local GP practice. We spoke to professionals who mirrored the experience of our inspection in finding the managers to be receptive and positive about improving the quality of the service through partnership working. We received a plan of actions following our initial feedback that addressed many of the issues contained in the report and concerns and suggestions made by staff at the staff meeting. However, during this inspection we found concerns about the support people received around food and drink that mirrored concerns raised by the local authority in July 2015. At this time the provider assured the local authority that measures would be put in place to ensure information in people's care plans was shared and that monitoring quality of care in the home would be a priority.

The policy on restraint had not been reviewed effectively to support safe and appropriate care. It did not reflect Department of Health guidance issued in April 2014 which requires for example that there must be a lead identified for increasing positive behavioural planning and reducing restrictive interventions, that accurate information about restraint must be gathered and that post incident debriefs must be planned so that lessons are learned. The policy was last reviewed in January 2015 although it was recorded as being under review in June 2015. This need was identified due to the: "increase in the needs of the residents. Staff are being trained to use figure of 4 and policy will reflect this."

The above was a breach of Regulation 17 of the HSCA 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service well-led?

There was a strong ethos to the care provided in the home. Staff understood the framework for supporting people with dementia that the service reflected. This had not been translated into safe, person centred care due to the concerns identified during our inspection.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People did not receive safe care and treatment. Risks were not assessed or mitigated effectively. People did not receive their medicines safely and the risks of cross infection were not being managed effectively. Regulation 12 HSCA (RA) Regulations 2014 (1) (2) (a) (b) (g) (i)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems and processes were not in place to ensure compliance with specific relation to assessing and monitoring: quality, safety and risks. Complete, contemporaneous and accurate records were not maintained Regulation 17 HSCA (RA) Regulations 2014 (1) (2) (a) (b) (c)