B and E Thorpe-Smith

Adelaide House Residential Care Home

Inspection report

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Warwickshire
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Tel: 01926420090

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 18 December 2015. The inspection was unannounced.

Adelaide House is a care home registered to provide personal care and accommodation for a maximum of 23 older people. The home is located in Leamington Spa in Warwickshire. There were 18 people living at home at the time of our visit. 12 people at the home were living with dementia.

The service had a registered manager. This is a requirement of the provider's registration. 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. We refer to the registered manager as the manager in the body of this report.

The provider had not established effective procedures to check and monitor the quality and safety of the service people received, and to identify where areas needed to be improved. This meant that a number of shortfalls in relation to the service people received had not been addressed.

Risks associated with the delivery of care and support for people who lived at the home had been assessed. However, risk management plans and risk assessments had not always been up dated when people's care or support needs changed and were not always followed by staff.

People's care records were not always reflective of their care and support needs therefore did not provide staff with up to date information about how people should be cared for and supported. However, overall staff a good understanding of the needs and preferences of the people they supported. People and their relatives thought staff were caring and responsive to people's needs.

People were not always supported to develop the service they received by providing feedback about how the home was run. The manager did not gather feedback from people or their relatives through meetings or quality assurance questionnaires. However, the manager worked alongside people at the home, and gathered verbal feedback from people during their day to day activities.

There were processes in place to ensure medicine was securely stored. However, medicine was not always stored at the correct temperature and the timing of medicine administration required improvement. People were supported to attend health care appointments with health care professionals when they needed to, and received healthcare that supported them to maintain their wellbeing.

There were enough staff at Adelaide House to support people with care tasks. Staff reassured and encouraged people in a way that respected their dignity and promoted their independence. People were given privacy when they needed it.

People and their relatives told us they felt safe living at the home and staff treated them well. Staff knew how to safeguard people from abuse, and were clear about their responsibilities to report concerns to the manager.

The provider had effective recruitment procedures that helped protect people, because staff were recruited that were of good character to work with people in the home. Staff had completed an induction. Some staff training was not up to date. However, the manager had identified this and was scheduling training.

People were supported in line with the principles of the Mental Capacity Act 2005 (MCA). People were able to make some everyday decisions themselves, which helped them to maintain their independence.

People who lived at the home were encouraged to maintain links with friends and family who could visit the home at any time. However, people were not always supported to take part in interests and hobbies that met their individual needs and wishes.

People, relatives and staff felt the manager was approachable. People and relative's told us they knew how to make a complaint if they needed to. However, no-one had made a compliant regarding the home.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the 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

The service was not consistently safe.

People told us they felt safe living at Adelaide House. Staff knew how to safeguard people from abuse. However the arrangements in place to manage the risks associated with people's care and the management of people's medicines required improvement. Staff were available at the times people needed them.

Is the service effective?

Good

The service was effective.

People were supported to access healthcare services to maintain their health and wellbeing. Staff had completed some of the training necessary to give them the skills they needed to effectively meet the needs of people at the home and further training was planned. Where people could not make decisions for themselves, people's rights were protected. People received food and drink that met their preference, and supported them to maintain their health.

Is the service caring?

Good

The service was caring.

People told us they were happy at the home and felt staff were caring and respectful. Staff understood how to promote people's rights to dignity and privacy at all times. People were able to make everyday choices which were respected by staff.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People were not always supported to take part in interests and hobbies that met their individual needs and wishes. People's care records were not always reflective of their care and support needs. However, overall staff had a good understanding of the needs of people they supported. People and their relatives knew how to make complaints if they needed to.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Systems were not in place to monitor and improve the quality and safety of the service. The manager was approachable, and people who lived at the home, their relatives and staff felt able to speak to the manager at any time.

Adelaide House Residential 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 18 December 2015 and was the first inspection since a change of ownership of the home. The inspection was unannounced and was undertaken by two inspectors and an expert by experience. An expert by experience is a person who has personal experiences of using or caring for someone who uses this type of care service.

Before our inspection we reviewed information we held about the service, for example, information from previous inspection reports and notifications the provider sent to inform us of events which affected the service. This is information the provider is required by law to tell us about. We looked at information received from commissioners of the service. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority.

12 of the people living at the home were not able to tell us, in detail, about their experiences of living at Adelaide House because of their diagnoses, so we spent time observing how they were cared for and how staff interacted with them. This was so we could understand their experiences of the care they received. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk to us.

During our inspection we spoke with six people who lived at the home and five visitors or relatives of people at the home. We spoke with one lead care worker, four care workers and a visiting district nurse. We also spoke with the manager, deputy manager and the provider.

We looked at a range of records about people's care including three people's care files, and other records relating to people's care, for example, medicines records and fluid charts. This was to assess whether people received the care they required. We reviewed records of the checks the manager and the provider made to assure themselves people received a quality service.

We looked at personnel files for two members of staff to check that suitable recruitment procedures were completed, and that staff received support to continue their professional development.

Requires Improvement

Is the service safe?

Our findings

All of the people we spoke with told us they felt safe living at Adelaide House. One person said, "I do feel safe because I have staff around me all the time." A family member told us their relative had lived at the home for a number of years and they had always been well looked after and was safe in the home. A staff member told us, "All the people here are safe because we look out for them, we [Staff] are always here to make sure they [People] are kept safe."

Staff knew how to safeguard people from abuse and understood their responsibilities to keep people safe and protect them. We asked staff what they would do if they had concerns and they told us they would intervene directly to prevent any abuse, and immediately report the incident to a senior manager. One staff member said, "One of the first things I was told when I started working here was, if I have any concerns at all that someone [Person] is not safe, even if I'm not sure, I must report it. That has always stayed with me." Staff told us they were confident the manager or the deputy manager would act to protect people from harm. One staff member told us, "I know how to report abuse, and use our whistleblowing procedures, I'm confident I won't have to here though."

The manager had identified potential risks related to each person who lived at the home, and care plans had been written to tell staff how to manage and reduce potential risks. For example, we saw one person presented behaviours that could result in harm to themselves, or other people around them. There had been a number of incidents during December 2015 where the person had displayed these behaviours to staff and people at the home. We saw risk assessments and risk management plans were in place to encourage the person to take part in preparing their own food, as this helped to manage some of their anxiety. We found staff were following these plans.

However, although risk assessments and risk management plans were in place, we found they did not always reflect people's current care and support needs. For example, records showed one person was at high risk of falling. They had fallen on two separate occasions during November 2015. Risk assessments and risk management plans had been reviewed following the falls. Records gave staff clear instructions on how to minimise the risk of the person falling again. There were plans for staff to follow in how the person should be assisted to move around, including encouraging the person to use a specialist walking frame. We observed staff did not use the identified equipment whilst assisting the person in the lounge and communal areas of the home. We spoke with a member of staff who said, "I wasn't aware [Name] needed to use that equipment." Another member of staff told us, "[Name] doesn't like to use the frame, so we don't use it. It's in their bedroom." We spoke with the manager who told us, "The person doesn't like to use the equipment, so we respect their choice." This meant the risk assessments and risk management plans were not being followed by staff which may place the person at risk of experiencing further falls.

Other risks to people's safety was not always managed well at the home. For example, we saw a fire exit on the first floor of the home was partially blocked by another door. The door had been propped open by staff with a cloth and had been left open. We asked staff why the door was propped open and were told it made it easier to assist people to move between different floors. Staff had not identified this presented a risk to

people's safety in the event of a fire.

We found that people did not have personal emergency evacuation plans (PEEPS) in place to instruct staff or emergency services how people needed to be supported in the event of a fire or other emergency situation. We discussed this with the manager and they agreed people did not have PEEPS in place and said they were going to write these. We also saw that emergency information lists about the people living at the home were not correct. This meant that in the event of an emergency, accurate information about people was not available to staff or the emergency services.

We looked at the safety of the home's environment and found the provider had not acted to identify all the risks to people at the home, and put plans in place to mitigate the risks to people's health and wellbeing. For example, there were no signs on some steps at the home to alert people to a change in the level of the flooring in a communal corridor area. The steps were immediately adjacent to a doorway which people used each day to walk to the dining room at the home. We saw several people at the home needed assistance to move safely around the home, and used mobility equipment. We found the lack of signs was a risk to people's safety.

We found people were at potential risk of harm due to the unsafe management of medicines. We observed and staff confirmed to us that the required gap of four hours between some people's medicines was not always followed. For example, the morning medication round was scheduled to start each day at 8.00am. The manager and staff told us this medicine round could take up to an hour each day to complete. The next medicine round was scheduled for 12.00noon. This meant that some people might receive medicine at around 9.00am, and have another dose of medicine at around 12.00 noon. A gap of four hours between some medicines is important because it takes time for medicine to be effective and/or to prevent overdosing of a medicine. We brought this to the attention of the manager during our inspection visit. They stated they would discuss the medicine round times with the pharmacist, and gain up to date advice on how this could be managed in the future.

One person told us, "The times I get my medicine seems to have changed, but no one has told me why. I would prefer them with my food and I think one should be taken with food." We found staff were not following the prescribing guidance when administering some medicine. For example, one person needed to have a medicine daily at least 30 minutes before their breakfast. This was so the medicine did not cause the person a reaction. Another medicine they were prescribed should have been given to the person with their meal to ensure the medicine was effective. We saw that both of the medicines were being given to the person at the same time each day.

Some medicines require storage below 25 degrees centigrade to ensure their continued effectiveness. There was no temperature monitoring in place for either the medicines stored in the trolley or in the designated lockable room. We asked to see the most recent records of temperature recording. These dated up until the end of October 2015. Information in the records showed that throughout the month of October 2015, all medicines had been stored at, or above, 25 degrees centigrade. We brought this to the attention of the manager and deputy manager during our inspection visit who agreed to put temperature monitoring in place.

Some people were prescribed creams for their skin. These were administered by care workers at the home. We found that people's MARS for the recording of when creams were applied were not completed by staff. We found daily records of people's care did not always describe when people had been administered their cream. This meant there were no records of when people were receiving some of their prescribed items. We asked a member of staff when people received their cream. They said, "We follow a routine about when they

should be used. There are no written instructions though, we just know what to do because we speak with each other and we have been told verbally." They added, "I don't write it down anywhere when I have administered it." This meant that staff did not follow their training to record when prescribed items, such as creams, were applied to people. We discussed this with the manager who said they would ensure MARS were completed by staff, when creams had been applied.

We observed staff administering medicines to people. Medicines were stored in a locked, secure medication trolley during the medication round when unattended by staff. Staff who administered medication told us they received training in how to administer medicines every three years. One member of staff confirmed their training included checks on their competency before they could administer medicines to people at the home.

Each person at the home had a medication administration record (MAR) that documented the medicines they were prescribed and how and when they should be taken. We looked at five people's MAR charts. All records had been completed to show when people had taken their medicine.

Records showed staff were recruited safely. For example, prior to staff working at the home, the provider checked they were of good character by contacting their previous employers to obtain references, and the Disclosure and Barring Service (DBS). The DBS is a national agency that keeps records of criminal convictions. This was to minimise the risks of recruiting staff who were not of suitable character to support people who lived in the home. Staff confirmed they were not able to start working at Adelaide House until the checks had been received.

All the staff we spoke with told us they thought there were enough staff available to care for people effectively and safely. One staff member said, "Yes there are enough staff at the moment. The manager and the deputy manager are also extra staff if we need them." We found there were adequate numbers of staff available during the day to care for people safely including dedicated staff to cover housekeeping roles such as cooking and cleaning. There were staff in the communal areas of the home for most of our inspection, ready and available to assist people if they needed support.

A health professional told us, "There always appears to be enough staff on duty. A staff member is always available to support us [District nursing service] whilst balancing the need to cover other areas where people are. This is really helpful as staff know the people who live here, especially those who may struggle with communicating."

Good

Is the service effective?

Our findings

People told us the food served at Adelaide House was good and there was at least two choices of main meal each day. One person said, "Meals are very nice and well presented. I like that." Another person told us, "If I don't fancy what's on offer I just ask and I get something else that I like."

We observed the support people were offered during a lunchtime meal at the home. People told us they enjoyed their meal. The dining room tables were set with Christmas table cloths, centre pieces, cutlery and glasses. There were no condiments. However, we heard people asking for salt and pepper which staff quickly provided. People sat down to eat their meal where they preferred, and with people they wished to spend time with. We saw the deputy manager asked two people if they could join them and was observed engaging with people in a friendly, familiar manner. This made the dining experience enjoyable for people at the home, as it provided social interaction whilst they ate their meal.

Staff were available to support people when needed and made sure people had the specialised equipment they needed for eating and drinking, without being prompted, such as adapted cutlery and crockery. This helped people to maintain their independence, and demonstrated staff knew people well.

We saw cold drinks were available and accessible to people in lounges and bedrooms. We observed staff offering people hot drinks throughout the day. Staff encouraged people to have a drink which they liked as people were offered a selection of drinks. Staff prepared what people wanted. One person told us, "I can have as many cups of tea as I like. I just have to ask." The cook told us none of the people living at the home were on special diets. The cook was aware of people's food preferences and said, "If a person requests something special I can normally get it for them. It's important because some people have small appetites and getting something they really like encourages them to eat." This meant people's health was being supported by access to fluid and nutrition that met their needs.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. One person at the home had a DoLS in place at the time of our inspection. We spoke with the manager regarding other people at the home who may require a DoLS application. The manager told us since taking up their position they had spent time getting to know the people who lived at the home and were now using the information they had gained to review each person's care needs to assess whether people were being deprived of their liberties and planned to make DoLS applications to the local authority where needed.

Staff were able to explain to us the principles of MCA and DoLS, which showed they had a good understanding of the legislation. They gave examples of applying these principles to protect people's rights, for example, asking people for their consent and respecting people's decisions to refuse care where they had the capacity to do so. One person told us, "Every morning the girls [Staff] ask me if I'm ready for help getting out of bed and dressed. Sometimes I say no, because I want to lie in bed, so they go away and come back later." Staff told us they asked people for their consent before they provided care and support. A staff member said, "It's really important to get their [People's] permission before we do anything. That's one of the things that I was told was very important when I started working here."

People had been asked to sign that they consented to their care and support being delivered by staff at the home. We saw where people had the ability to be involved in decisions about their care and support needs, their involvement had been recorded. The manager told us and relatives confirmed they were involved in making decisions for people who lacked capacity. One relative said, "[Name] can't make decision anymore because they get muddled but we know what [Name] likes and what they would want. So we make all the decisions based on that. We have discussions with the home and they follow what we have said. It's not a problem."

People, relatives and a healthcare professional, expressed confidence in the knowledge and skills of staff members who worked at the home. One person said, "I know staff understand me because they [Staff] always do what I need." A relative told us, "I visit regularly and I see the way the staff work. It is clear they know what they are doing." A district nurse who regularly visited the home told us they felt staff had a good understanding of people's needs and always sought advice if they had any concerns or needed guidance about a person's health.

Staff told us they received an induction when they started working at the home which included working alongside an experienced member of staff. One new staff member told us they had been able to spend time during their induction getting to know each person and how they liked their care and support to be provided. The staff member said, "This helped me a lot, because when I started to work on my own I already knew about the people who lived here and what I needed to do for them."

Staff said the manager encouraged them to keep their training and skills up to date, and maintained a record of staff training. One staff member said, "I have manual handling training every year, also we do safeguarding and mental capacity training regularly." However, we found some training to ensure staff had the knowledge and skills necessary to support people effectively was not up to date. For example, some staff had not completed refresher training in moving and handling. We spoke to the manager who told us they had identified staff training needed to be up dated and this was being addressed. For example, training in mental capacity and fire had been completed and training in other areas was being planned.
Staff said they had regular individual meetings with the manager, to discuss any issues of concern and areas for self-development. One staff member said, "Even if you don't have a meeting planned you can ask and one is arranged, almost straight away." This meant the manager was supporting staff.

Staff and people told us the home worked in partnership with other health and social care professionals to support people. Care records included a section to record when people were visited, or attended visits, with healthcare professionals. For example, people were able to see their GP, district nurse practitioner, and dentist where a need had been identified. A visiting health professional told us, "They [Staff] are very good at phoning us if they need a visit or want some advice."

Good

Is the service caring?

Our findings

People told us they were happy living at the home. One person said, "I can't criticise the place. I'm lucky to be here." Another person told us, "This is a nice place to live everyone is so nice to me." A relative said, "We couldn't ask for more. The staff are very caring and kind. [Name] couldn't be treated any better than they are. The home has a real family feel and [Name] gets on with all the staff."

People and their relatives told us they were involved in planning their care and support needs. One relative said, "We are involved in discussions about [Name] care, we are asked our views and are kept informed of any changes. There is always someone to talk to when you visit. It is very good."

We observed people had a good rapport with staff, and spoke to them with confidence. Staff sat with people and chatted to them. People laughed and seemed pleased with the way staff interacted with them. Staff took time to listen to people and supported them to express themselves according to their abilities to communicate. For example, we saw staff sat next to people to hold a conversation with them on the same level. This demonstrated people were supported by staff with kindness, in a way that they could understand.

Staff asked people how they were feeling, and if they needed anything. One staff member approached a person in their bedroom to remind them their favourite television programme was about to start. The staff member asked if the person wanted the channel on the television changed and then checked that the person was happy with the volume level.

People were able to spend time where they wished, and were encouraged to make choices about their day to day lives. Staff respected decisions people made. For example, we saw some people were up when we arrived, and other people were still in bed. Some people were eating breakfast in the dining room, and other people were eating breakfast in their room, which was their preference.

People told us their dignity and privacy was respected by staff. We observed staff knocking on people's doors and announcing themselves before going into people's rooms. One member of staff said, "I always knock on people's doors and wait to be invited in. We [Staff] all know peoples dignity and privacy is important." Staff spoke discretely and quietly to people regarding personal care routines, to respect people's privacy.

Staff we spoke with knew people's preferred names, and spoke of people in respectful and positive ways. People told us staff treated them with respect.

Staff told us they thought people received good quality care at the home. One member of staff said, "People get a very good service. We spend time with them. They [People] can have food and drink whenever they want and we make them smile which is really important." Another staff member said, "We are here for them [People] they are the priority, they come first. If someone [Person] needs something then we stop what we're doing and help them." We observed one person asking a care worker, who was clearing dirty dishes for assistance. The care worker stopped what they were doing and assisted the person. This demonstrated that

staff were person centred in their approach rather than being task focused.

People made choices about who visited them at the home. One person said, "My family and friends can come at any time they like." We saw people had visitors join them at the home during our inspection. Visitors were made to feel welcome, and used the communal areas of the home as well as people's bedrooms to meet. This helped people maintain links with family and friends.

Requires Improvement

Is the service responsive?

Our findings

People told us they received care and support from staff who responded in a timely way when they needed support. We heard one person comment the temperature in their room was cool. The person pressed their call bell and staff quickly responded to the person's request to close their bedroom window. A relative told us, "I visit regularly and every time I visit there are staff available so no one has to wait for help."

We asked people if they were supported to take part in activities and interests that stimulated them, and they enjoyed. One person told us, "When I first came there were lots of activities, but not now, nothing. I just sit down all day that's all I do. Sometimes I get fed up but I can't go out because I don't have anyone to go out with." Another person said, "I would really like to have sent Christmas cards to family and friends this year, but we weren't supported to do this here." A third person told us, "I love doing crafts but we don't do them anymore."

We saw specific events or activities were advertised on a noticeboard in the reception area. For example, we saw a singer had recently visited the home, and Holy Communion was planned at the home to celebrate the forthcoming Christmas festivities. One person told us, "They came and sang and it was lovely. I wish they came more often." However, a plan for activities at other times was not in place.

We asked the manager whether there was a designated member of staff who organised activities for people at the home. The manager told us activities was an area they had identified which needed to be improved and whilst currently there was no designated staff member, there were sufficient staff to offer people support to take part in activities each day. The deputy manager told us, "We used to have a weekly activity plan but people never turned up. So now we ask people each day what they would like to do." Staff told us they arranged activities with people each day. One member of staff said, "We support people according to their wishes, because we know them well. I know [Name] likes one to one time, so we do things with them in their room like manicures." We heard staff sharing information about the activities they had supported people with during the staff handover. For example, a staff member had been reading with one person. However, we did not see any group or one to one activities taking place during our inspection.

Staff told us they had an opportunity to catch up with any changes to people's health or care needs because they had a verbal handover at the start of each shift. We observed a handover which was well attended by staff and the manager. The handover provided staff with information about any changes since they were last on shift. One member of staff said, "We have a handover at the start of every shift, it's everything we need to know to catch up." Staff explained the handover was recorded, so that staff who missed the meeting could review the records to update themselves. This meant staff were able to respond to how people were feeling and their care and support needs on that day.

We reviewed the care records for three people. We found some care records were not up to date, for example care plans for one person who had come to live at the home in October 2015 were incomplete. We asked the manager why these records had not been completed. The manager told us, and the deputy manager confirmed, the care plans had been written with the person's family when the person came to live

at the home. The manager told us they did not understand why the records were missing and made arrangements for the file to be updated straight away.

Other records detailed people's preferences and gave staff information about how people wanted their care and support to be provided. For example, whether people wanted to be cared for by a female or male care worker. Staff told us these preferences were always respected. One member of staff said, "I never assist someone who wants to be supported with personal care by a different gender, it wouldn't be right." Staff rotas showed staff of different genders were available on some shifts.

Records detailed people's religious beliefs and their personal preferences about how they wanted to be supported to maintain their faith. One person told us, "I have communion every week when I go to church. This is important to me." Arrangements had been for another person, who was living with dementia, to be visited by the local priest to enable them to practice their religion which their family had said was important to them. This demonstrated that people's beliefs and personal preferences were understood and respected.

The provider's complaints procedure was on display in the reception area and in communal corridors on all floors of the home which gave people advice on how to raise concerns and informed them of what they could expect if they did so. The procedure included details of other relevant organisations, including the local authority and the Care Quality Commission. However, information about how to make a complaint or provide feedback was not on display in the communal areas of the home, or in an easy to read format for everyone at the home to access. For example, easy to read documents may be prepared using large print and pictures to make them accessible to people with limited communication. Documents provided in this way would give more people the opportunity to provide feedback to the provider, and could help people to maintain their involvement and independence. We brought this to the attention of the provider during our inspection who told us they would develop easy read documents.

People and relatives told us they knew how to make a complaint and felt able to do so. One person said, "I would speak to a senior person. I don't take things lightly and wouldn't worry about saying so. But I have had no cause to complain yet." A relative told us, "I have never had to make a complaint because any grumbles, which are very minor, are sorted out straight away. If I was unhappy with something I would have no hesitation in speaking to the manager or the deputy manager and I know they would respond." The provider told us no complaints had been received since they had owned the home. The provider said there was an 'open door' policy at the home and a member of the management team was always available should anyone want to make a complaint or raise their concern which would be taken seriously. The provider told us they understood the importance of analysing any future complaints to continuously improve the service.

Requires Improvement

Is the service well-led?

Our findings

We found, audits to assess and monitor the quality of the service had not been completed or were not effective. For example, medicine audits had not identified that medicine was not being stored at the correct temperature and that some medicine was not being administered in line with the prescribing instructions. This meant people were at potential risk of harm due to the unsafe management of medicines. Care plans audits had not identified that some care records were out of date and did not reflect people's current needs. This meant staff did not have accurate information about people's needs and wishes.

Maintenance of the premises, and infection control audits had not been completed. We saw plastic covering on the back of commodes in bathrooms and toilets was ripped. Raised toilet seats were in use which had rust patches. These issues presented risks of possible cross infection.

The provider told us quality assurance processes was an area they had identified for improvement and they were planning to develop procedures and recording systems. A lack of auditing procedures meant the provider was not identifying areas where improvements needed to be made, and was not ensuring the service was safe and continuously improved.

The provider also said they were updating the home's policies and procedures to ensure they reflected the requirements of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014. The provider said, "We inherited theses [policies and procedures] from the previous provider. They need to be changed, because they do not reflect us or what we are required to do, so we are systematically reviewing them." We asked to see the policies and procedures that had been updated and were told none had been completed.

The manager told us since taking up their post they had identified a broad range of areas where improvement was needed and they were planning to develop action plans to address these. We asked the manager when the improvements would be made. The manager told us they had no set timescale due to competing priorities. We were concerned the lack of planning meant required improvements to the safety and quality of the service provided would not be completed in a timely manner.

We found people's views were not always sought about the quality of the service or how things could be improved at the home. One person told us, "I don't think anyone has ever asked me. I'd say more things to do." The manager told us the views of people, relatives and professional visitors were sought informally during daily contacts with people living at the home. There was no formal system in place such as 'resident and relative' meetings or quality feedback surveys. We could not establish how the provider acted on the feedback received.

We found this was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good Governance

There was a registered manager at the home. Staff spoke positively about the new manager who they described as approachable. The manager was also one of the providers of the home.

People, relatives and staff told us they liked the manager who they said was approachable. One person said, "The manager is really nice they [Manager] is always about. They often sit with me to have a chat and a cup of tea." Another person said," The manager is excellent." One relative said "The manager is charming and kind. We as a family much appreciate everything that they [Manager] do. We have found them [Manager] to be approachable and caring. I have nothing but praise for them."

A staff member said, "The manager is always on the floor chatting with people and checking things are okay which is good." We observed this taking place and saw people were relaxed during these interactions. For example, we saw the manager chatting with people in their bedrooms and communal areas in a friendly and familiar manner. This showed us the manager was known to people living at the home.

There was a clear management structure within Adelaide House to support staff. The manager was part of a management team which included a deputy manager and lead care workers. Staff told us the manager and deputy manager were available to support them when needed. Staff said this included outside "normal office" hours. One staff member said, "Getting them [Management] is never a problem we've got a number to call if we need something and they always answer."

Staff told us they had regular team meetings which gave staff the opportunity to be informed about any changes and to share their views and ideas. One staff member told us, "That's what I like about working here we get together to discuss things and you feel able to say what you think. I feel we are all listened to. The manager is very open." Another staff member said, "This is a good place to work."

The provider had acted to make some improvements in relation to the safety of the premises, in response to issues identified in a recent fire risk assessment. The provider had also completed work to upgrade areas within the kitchen. A plan was in place to re-decorate bedrooms when they became vacant.

The provider had sent notifications to us about important events and incidents that occurred at the home. The manager also shared information with local authorities and other regulators when required, and kept us informed of the progress and the outcomes of any investigations.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 Health and Social Care Act regulations 2014 Good Governance (2a) The provider did not establish systems and processes, monitor and improve the quality of the service (2b) the provider did not establish systems and processes to assess, monitor and mitigate the risks relating to the health and safety of service users. (2c) the provider did not maintain an accurate, complete and contemporaneous record in respect of each service user.