Four Seasons (Bamford) Limited

Churchfield Care Centre

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**

Summary of findings

Overall summary

This unannounced inspection was carried out on 17 and 31 July 2017. Churchfield Care Centre provides accommodation nursing and personal care for up to 60 older people. On the day of our inspection visit there were 29 people who were using the service.

The service had a registered manager in place at the time of our inspection. 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 supported by staff who understood the risks people could face and knew how to keep them safe. Some risks to people's health and safety were not being clearly identified and managed.

People may not be provided with their care and support when this was needed because there were not always enough staff on duty. People may not receive their medicines safely at the time they needed these. People were placed at risk of infection because safe practices were not being followed.

People were being cared for and supported by staff who had been trained to do so. People's human right to make decisions for themselves was respected and they provided consent to their care when needed. Where people were unable to do so the provider followed the Mental Capacity Act 2005 legal framework to make the least restrictive decisions in people's best interest. Staff were unaware which people had their freedom restricted lawfully and some people had been restricted by the use of locks on doors.

People were provided with support to have sufficient nutritional and fluid intake. Staff understood people's healthcare needs and their role in supporting them with these.

People were cared for and supported by staff who respected them. People did not always have their privacy and dignity respected. Where possible people were involved in planning their own care.

People received their care and support in a task oriented manner rather than in a person centred and proactive way. People's care plans were not always kept up to date and staff rarely referred to these. We have made a recommendation about people having greater opportunities to be involved in activities and follow their own hobbies and interests. People knew how to raise any complaints or concerns they had and these were acted upon.

The management of the service relied on the registered manager's presence and there were not effective systems to ensure this was maintained in their absence. There were systems in place to monitor the quality of the service and make improvements.

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 entirely safe.

People were not always protected from the risk of infection as safe infection control procedures were not followed.

People did not always receive the support they required to take their medicines as prescribed at the time they needed these.

People's needs were not being met by a sufficient number of suitably qualified, competent and skilled staff.

People may not be protected from known risks because practices to keep them safe may not be followed.

People felt safe using the service and staff looked for any potential risk of abuse and knew what to do if they had any concerns.

Is the service effective?

Requires Improvement

The service was not completely effective.

People were supported by staff who received appropriate training and supervision and had an understanding of people's care needs.

Staff did not know which people had a DoLS in place and people had their freedom restricted. People were supported to make choices and decisions for themselves. People's capacity to make decisions was assessed. .

People were provided with a nutritious diet and received any support they needed to have sufficient to eat and drink. Staff understood people's healthcare needs and their role in supporting them with these.

Is the service caring?

Requires Improvement

The service was not always caring.

There were occasions when people's dignity was compromised.

Staff had positive relationships with people and respected them as individuals.

People and their relatives were involved in planning and reviewing their own care.

Is the service responsive?

Requires Improvement

The service was not completely responsive.

Some people did not always receive the care and support they require. Staff did not always read people's plan of their care and the care plans did not include all the information required for people's care..

People knew how to raise any complaints or concerns they had and felt confident that these would be dealt with.

Is the service well-led?

Requires Improvement

The service was not completely well led.

There were not arrangements in place that ensured the effective running of the service in the absence of the registered manager.

People had opportunities to provide feedback and make suggestions.

Staff were provided with support and guidance about their role.

Churchfield Care Centre

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 17 and 31 July 2017 and was unannounced. The inspection was carried out by two inspectors and two experts 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 our inspection we reviewed information we held about the service. This included a Provider Information Return (PIR) completed by the provider. 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 looked at previous inspection reports, information received and statutory notifications. A notification is information about important events and the provider is required to send us this by law. We contacted some other professionals who have contact with the service and commissioners who fund the care for some people and asked them for their views.

During the inspection we spoke with eleven people who used the service as well as nine relatives and friends. We also spoke with five members of care staff, the cook, the activities coordinator and the nurse in charge. The registered manager was on leave and the provider arranged for two covering managers from other services to come to the service and assist us with the inspection. We also spoke with a visiting healthcare professional. We returned to the service on 31 July 2017 to discuss our findings with the regional manager and registered manager.

We considered information contained in some of the records held at the service. This included the care records for four people, staff training records, three staff recruitment files and other records kept by the registered manager as part of their management and auditing of the service.

Requires Improvement

Is the service safe?

Our findings

People were not always protected from the risk of infection as safe infection control practices were not being followed. Following an injury to one person there were some drops of blood along one of the corridors. People who used the service and staff were seen to walk along the corridor before the blood had been cleaned up. A housekeeper cleaned this up by spraying and dabbing the blood with a cloth. However we had to twice point out to them when they had finished that there were still some drops of blood that needed to be cleaned up. The floor was not washed until sometime later after we informed one of the visiting managers that this had not been done.

Another incident occurred in one of the communal areas that resulted in a housekeeper being requested to clear up an infection risk. We saw this had not been fully cleaned and we informed one of the visiting managers about this and they had to arrange for this task to be completed. There was a description in the person's care plan which described the cleaning process to be followed if this incident occurred, which was not followed on this occasion. We also detected areas of the service and pieces of furniture where there were unpleasant odours.

During lunchtime we observed a staff member visited the bathroom whilst wearing a protective apron. The staff member resumed supporting a person with their meal after this, but did not change their protective apron. We also saw some people were able to hold and stroke the service's pet rabbit. However they were not provided with any hand cleaning support after having done so. The examples described demonstrated that safe and good practice guidance was not being followed by staff to protect people from the risk of infection.

People's known behaviours and other indicators were not used as a way of reducing or preventing risks. One person who was assessed to be at risk of falls was being cared for in bed. During the afternoon we heard the person shouting out and entered their room to find them lying on the floor having fallen out of bed. We immediately summonsed staff to come and assist the person. We were unable to ascertain what had actually happened, but we did establish that the person's alarm had been sounding for approximately 10 minutes without being responded to. We discussed this with the regional manager and registered manager who said they had started an investigation into this to find out what had happened.

Another person who was known to need support in managing their continence needs presented in a way that indicated they may need some support. However this was not acted upon and the person did not receive the support they required The person's care plan stated, "Continence is problematic and requires timely and skilled intervention beyond routine care" which was not provided.

People were not always being protected as intended because recommendations made in risk assessments were not being followed. For example one person who was mobile had been assessed to be a high risk of falling and was meant to have hourly checks. These checks were recorded as having taken place during the night, but not during the day. Additionally some people were at risk of harm because the risk assessments did not provide guidance on how certain risks should be managed. One person who had a health condition

required weekly blood sugar monitoring. The risk assessment for this did not contain the detail staff needed to support the person with this.

During the inspection we saw some people did have aids to assist them with their mobility, however there were some people who walked around without adequate footwear which increased the risk of falls for these people. Following our visit a covering manager wrote to us and stated that, "I have been through the care plans this afternoon of those residents who walk around the home without any footwear on, this was documented in all care files that this is the residents preference and how staff should try to manage this and minimise any risk." We did not see staff encouraging people to wear footwear as described in their care plans. People were at risk of injury due to lack of appropriate foot wear that they could wear.

Staff said they were trained in using the equipment and knew which pieces of equipment to use in different circumstances. Staff told us people who were hoisted did not have their own slings to use. A visiting manager said people should have their own slings. The registered manager said some slings had been discarded as they had begun to show some signs of wear and tear and they would be ordering some new ones. Staff spoke of following people's risk assessments to ensure they were able to maintain their independence as safely as possible. A staff member told us they were informed in a handover meeting when someone's risk assessment had been updated.

People may not always receive their medicines safely and as planned. One person told us that staff, "Leave my tablets with me to take and trust me. I do my own eye drops as well." However this was not included in the person's medicines care plan and the person told us they had kept some pain relief medicine in case they needed this later. Additionally the risk of other people who used the service picking the person's medicines up had not been considered.

Other people told us they received the support and encouragement they needed to take their medicines. However one person required their medicines to be administered at specific times throughout the day. The records made on the person's medicines administration record (MAR sheet) did not show the person had been given these at the times they required them. A staff member told us that they had given the person their medicines at the time they required these but had not recorded on the MAR sheet that they had done so. The person's relative told us, "I have to trust them really, but I do worry."

People's medicines were not always stored or made secure in a safe way. One member of staff who was undertaking a medicine round did not lock the medicines trolley whilst they went into another room to administer a person's medicines. The trolley was left unattended for approximately ten minutes which provided an opportunity when someone could have removed medicines from the trolley.

The failure to assess the risks to people's health and safety and mitigate any risks is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always provided with the supervision and support they needed. People on the ground floor told us about times throughout the day there were not enough staff on duty to supervise people who were living with dementia in the communal areas. As a result a number of people experienced people living with dementia intruding into their space, including taking their food and drinks. During our visit we saw some people take food and drink from other people and consume these, this was not always seen by staff. We also saw a person's visit being interrupted by another person who sat in between them and their visitors. A person who used the service told us, "I get annoyed by the people who bother us but the staff can't be everywhere to stop them." One relative told us, "I don't think some people are watched enough." Another relative said some people who used the service "need better supervision".

A health care professional told us some of the people who had moved into the service had displayed behaviour that others found to be challenging. They told us this had caused them some difficulties, including the increased risks from people who were able to mobilise independently.

People's needs were not always being met because there were not the number of staff required on duty to meet these. One person told us they sometimes had to wait when they rang their call bell for assistance. They told us, "It can be an hour or more sometimes. They (staff) say they're busy doing something." During our visit we saw the person come from their room to find staff saying they had been "calling for ages" and "needed assistance". People on the first floor said they thought there were usually enough staff on duty, but this did vary at different times of the day.

Staff we spoke with felt the staffing levels did not meet the needs of the people who used the service. There had been a number of recent admissions to the service and the needs of these people had created a significant impact on the staff workload. Staff said they felt some incidents that had occurred were due to not having had the right number of staff on duty. One member of staff told us, "Some people need more monitoring. The needs of people have changed and we need more staff." Another member of staff told us, "Lack of staffing is having a big impact on care."

The provider informed us on their PIR they used a dependency tool to calculate the number of staff that were needed on duty to meet people's needs. This was not being followed and the numbers of staff identified to be needed by this tool were not on duty. The dependency tool showed there should be eight staff on duty during the daytime. However the rota showed that there were either six or seven staff on duty each day. There was a reference to staffing levels having been reduced due to a lower occupancy in the staff meeting minutes from May 2017. The staffing levels had not then been increased when more people started to use the service.

The failure to deploy sufficient numbers of suitably qualified, competent, skilled and experienced persons is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they generally felt safe in the service but several people had concerns about the way some people who used the service moved around unsupervised. One person told us, "I'm okay apart from the odd ones (people who use the service) who come in my room but I tell them to go off. I don't like it when those with dementia come round and lean on you or take things from you or drop things." A relative told us, "I worry about the other people here and [relation]'s safety."

Staff were able to describe the types of abuse people may be exposed to as well as indicators that could signify a person had been abused. These included a change in a person's usual behaviour or having unexplained marks or bruising. Staff told us what action they would take if they were aware of any potential abuse. One member of staff said, "I would speak to the manager, and inform the nurse on duty. If necessary I would take it higher. We have the area manager's details." They went on to say, "If I wasn't happy I could also inform the local safeguarding team." The nurse we spoke with told us staff were very good at raising issues of concern and told us the registered manager dealt with issues promptly and staff could be assured of confidentiality.

People were supported by staff who had been through the required recruitment checks to preclude anyone who may be unsuitable to provide care and support. These included acquiring references to show the applicant's suitability for this type of work, and whether they had been deemed unsuitable by the Disclosure and Barring Service (DBS). The DBS provides information about an individual's suitability to work with people to assist employers in making safer recruitment decisions. Nurses employed were all registered with

the national midwifery council (NMC). Staff described having undergone the required recruitment process and recruitment files showed the necessary recruitment checks had been carried out.

A staff member confirmed that they had completed medicines management training and had been observed by their assessors administrating people's medicines competently. Staff training records confirmed staff who administered medicines had received training for this and had they competency assessed.

Requires Improvement

Is the service effective?

Our findings

People who used the service and their relatives were aware of some of the training staff received and commented they felt the staff were well trained. One person said that staff "tell me they are trained". A relative told us, "They are good on training, I think they have just had dementia training."

Staff we spoke with told us they received the training required to carry out their roles which was confirmed by the staff training matrix. One member of staff spoke positively about a recent course they had attended which had helped them understand how dementia could affect someone. Another staff member told us they were being supported to undertake further training that would allow them to expand their role and assist the registered nurse. The member of staff was very enthusiastic about the course and new role and felt they were being well supported by the nurse and registered manager. Other staff said they were happy with the training they received.

The provider informed us on their PIR that new staff were provided with an induction to explain their role and what was expected of them. A recently employed staff member said this included a period of 'shadowing' an experienced staff member. They said this had helped them learn the routines and get to know people who used the service. New staff were enrolled onto the Care Certificate as part of their induction. The Care Certificate is a recently introduced nationally recognised qualification designed to provide health and social care staff with the knowledge and skills they need to provide safe, compassionate care

Staff said they had regular opportunities to discuss their work and any support they needed in planned supervision sessions. A staff member told us they found the sessions useful and that they gained feedback from their supervisor on their work performance and were able to raise any topics they wanted to discuss. Records showed that staff had received their planned supervision sessions.

People were asked if they consented to being provided with any care and support before receiving this. We saw people being asked for consent and to make choices over everyday matters throughout our visit. One person told us, "They (staff) do ask me, things like if I'd like to get dressed." Another person said, "I can be my own boss really."

Staff we spoke with understood their responsibilities in relation to obtaining consent prior to giving care to people. One member of staff said, "I ask people if they are happy (for me to proceed) if they are not, I leave them and go back later or ask another member of staff to try to assist them." The member of staff said that "sometimes a different face helps".

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.

We checked whether the service was working within the principles of the MCA and saw that assessments of people's capacity in relation to specific decisions had been carried out when people's ability to make their own decisions was in doubt. If the person had been assessed as not having the capacity to make a decision, a best interest's decision had been made. Staff we spoke with had a good knowledge of the MCA. One member of staff was able to discuss the principles of the MCA and described how it was implemented to protect people's interests, keep them safe but where ever possible maintain their independence.

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 is called the Deprivation of Liberty Safeguards (DoLS). DoLS applications had been made for some people, however we found some restrictions had been used that required a DoLS application. Although staff knew what a DoLS was and the purpose of these, they did not know which people had a DoLS in place. Therefore they also did not know if there were any conditions made when a DoLS had been approved that needed to be complied with. The registered manager told us there had been a list in the office but this had been removed and said that they would ensure this was replaced.

When we arrived at the service we found that there were locked doors with keypads in place on two corridors where some people's bedrooms were. This appeared to restrict the movements of some people unnecessarily. In one of these corridors there were two people in their bedrooms and two others were walking in the corridor. One of whom was putting their hand against the glass window pane on the locked door. We saw another person who was walking in this corridor was carrying and at times tearing a plastic table cloth. The person had a cut to their hand but was resistant to let the nurse on duty attend to this. This door was then left open about 20 minutes later and remained so for the remainder of our visit. We asked staff about this locked door and they told us it was only locked on occasions, however we were unable to find out exactly when these occasions were. One staff member told us they had never been told when these were to be used or the reason for the locks, but said they were used occasionally. We were informed after our visit that the lock from one of these corridors had been removed the following day. The regional manager said they would ensure the other lock was also removed.

Most people were complimentary about the meals and said they had enough to eat. One person told us, "I quite like the meals. It's good enough for me". Another person said, "The food is hot you get a choice." Some people commented they did not like the food and said their relations brought them in other food they enjoyed. Relatives thought their relations ate well and their weight was maintained. We observed lunch on both floors and saw people mostly received the support they needed to eat their meal.

Staff we spoke with had a good knowledge of the different diets people required. They told us some people required a health related diet which they were provided with, but there was not anyone who required a specific diet for cultural or religious reasons. The chef explained they had a folder with information about people's weights, all their dietary needs and their birthdays. The kitchen was well organised and had a wipe board which the chef updated with people's diets. Each person had been assessed to determine if they were at risk of not receiving sufficient nutrition. People were referred to dieticians and speech and the language therapy (SALT) team when required by the registered nurse. SALT provided advice on swallowing and choking issues when required.

People were supported to maintain good health and had access to healthcare services. People told us they attended routine healthcare checks and appointments, and that a doctor would visit them if needed. One person told us, "I have the optician and chiropodist usually." A relative said, "They're really good at getting

the doctor in straight away." The relative also said they appreciated how their relation was accompanied to any healthcare appointments.

Staff knew about people's healthcare needs and told us they recognised any signs or symptoms if someone was not feeling well. They told us they would call for a doctor or nurse if required and obtained advice from the NHS advisory service. People had been referred to other health professionals when needed. Staff told us the registered nurse was quick to respond to health concerns raised with them and the registered nurse told us the care staff were quick to raise issues. The registered nurse told us they had a good relationship with the local GP practice and other healthcare professionals.

Requires Improvement

Is the service caring?

Our findings

Although staff we spoke with understood their role in maintaining people's privacy and dignity. We identified a number of incidents throughout our visit which had significant negative impact on people's privacy and dignity. Staff described how they followed good practices to respect people's privacy and dignity, but acknowledged we had seen some incidents during our visit where this could have been done better. They said they felt these had occurred due to not having had enough staff on duty.

The evening prior to our visit night staff had found a problem with one person's bed. They had moved the person into another room so this could be repaired the following day. However the person was moved into a room which was not appropriate to have been used. Another person who was being cared for in their room was frequently calling out. Staff did not seem to have a planned approach on how to support the person and they were left for periods of time alone. When we first saw this person on the morning of our visit in their room they did not have their dignity respected as they were not covered by their bedclothes. A staff member told us the person would only throw these off if they replaced them. However we later saw the person on several occasions where they were covered by their bedclothes resulting in their dignity being protected. When we spoke with a different staff member they said the person's bedclothes should always be replaced if they had come off. We also identified there were a number of occasions where people were not provided with the support they needed to manage their continence needs and other issues with their personal care such as nail care.

The failure to treat people with dignity and respect is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw several people were left sat in the dining room at breakfast for long periods of time. One person was left sat with some toast in front of them for over an hour without staff encouraging them to eat this. Another person was sitting in a wheelchair for almost an hour and a half waiting for staff to transfer them into an easy chair. Lunchtime could have been better organised which would have encouraged people to eat well. Service was slow and people were not being served their meal at the same time as others on their table.

People were cared for and supported by staff to whom they related well. One person told us, "The staff know me well, I like the staff, these two (staff) are good." Another person said, "They're (staff are) all fine with me, very kind and pally."

Staff spoke fondly about their work and wanting to provide people with a good service. One staff member told us, "We (staff) genuinely care about people." The staff member also described how they liked to help people and this gave them satisfaction. Staff felt there was a caring attitude among their colleagues towards people who used the service and their relatives. One member of staff who had worked at the service for a number of years told us, "We have some nice staff here, they are kind and caring to people."

People and their relatives were encouraged to participate in planning their care. Some people told us how they were supported by their relatives. One person said, "My [relation] does all my dealings nowadays and

visits me and sees the office (staff)." Another person told us, "I'm okay with them and can speak up if I'm not happy about anything." We saw correspondence in people's care plans inviting relatives to care plan reviews. A staff member told us they felt, "People were able to express what they wanted."

The registered nurse told us they would involve advocacy services if required when looking at people's capacity, should they not have relatives to support them. The nurse said there wasn't anyone who used the service at present who was supported by an advocate but there had been people previously who used these services. The nurse told us they knew how to contact an advocacy service if needed. Advocates are trained professionals who support, enable and empower people to speak up about issues that affect them.

Requires Improvement

Is the service responsive?

Our findings

People's needs were assessed when they moved into the service but they did not always receive the care that it was intended for them to receive. For example it stated in one person's care plan they preferred to have a shower, however the person had been given a bath instead. Other people's personal care records showed people tended to have a bed bath more rather than their preference of a bath or shower. Another person's finger nails showed several weeks of growth. However it had been recorded on the person's personal care chart that they had been supported with nail care. Relatives gave examples where their relations did not get the support they needed. One relative said how they had requested their relation had some assistance to help with their hearing but this had not been provided yet. Another relative said their relation needed to wear glasses but staff had not noticed they were not wearing these.

Staff told us they did not always read people's care plans and tended to rely on information passed onto them at handover or talking with other staff. One staff member told us they normally got to know people through working with them and from other members of the staff team. We tried to discuss the care plan for one person with a member of staff who was supporting them, however they said they had not read this but agreed that they should have done so.

We found that although people's care plans did contain a clear explanation of how a need should be met, these were not always accurate for the person or had not been updated. For example one person's care plan had not been updated to show they were currently being cared for in bed but the care plan referred to moving them to different parts of the service to provide different stimulation.

People told us they had limited opportunities to take part in activities. One person told us they had been able to play cards and other games previously, but these were not taking place at the moment. The person said, "I read my paper or a book as not much happens here now." Other people told us they would like more opportunities to sit in the garden or go on trips out. A relative said, "They don't go outside, they can get away out front and there are not the staff to stay with people. It'd be nice to have a place they can sit or walk round safely." Another relative said they would like, "Somewhere safe and pretty for [relation] to sit outside." We did note that the activities coordinator was refurbishing a seating area in the enclosed rear garden. The registered manager told us some people in the service had been involved with the project.

There was a separate lounge for people to use, described as a reminiscence room. This room did not appear to be well used and had little in the way of stimulation that would encourage people to reminisce. A day and date display was over a month behind the date we visited. There was a new activities coordinator in post and they told us they were looking to develop the activity resources including the reminiscence room. They also said they wanted to develop a full activities programme.
We recommend that the provider seeks advice and guidance to provide people with a programme of suitable activities.

People's complaints and concerns were recognised and acted upon. The provider operated a complaints procedure which included making a record of all complaints made. One person told us, "I'm always

complaining about what I see happening so they're used to me. The manager comes and has a chat." The person told us one of the complaints they had made was about how some people living with dementia did not respect their private space.

Staff we spoke with told us they knew how to deal with complaints from people who lived at the service and their relatives. One member of staff told us they would try to deal with any complaints at the time. But if it was something they could not manage they would pass this on to the registered manager or nurse and make a record of the complaint. The registered manager told us they had systems where people were regularly asked if they had any compliments, concerns or complaints and there was an electronic tablet in the reception areas relatives could leave any comments on. We reviewed the record made of any complaints made. These showed that people's concerns were noted and acted upon.

Requires Improvement

Is the service well-led?

Our findings

We arranged to undertake a second visit to the service to discuss the issues we had found during our first visit with the registered manager, who had been on two weeks annual leave when we first visited. They told us they were "very disappointed" and felt that many of these issues would not have taken place had they been at work. The registered manager said that although there had been daily management cover provided by managers from other Four Seasons services they would not have known the service as they did. They explained there was no deputy manager in post who would normally provide that oversight when the registered manager was on leave.

The provider had a system of monthly audits undertaken by the regional manager. The last three completed audits found the service was compliant, although one audit had highlighted a lack of activities. However, the registered manager explained this was due to the previous activities coordinator being off work and they had now recruited a new member of staff to fulfil the role. These audits had not identified issues we found during our inspection including poor infection control practices and medicines management, staffing and a lack of dignity and respect.

We reviewed some other audits undertaken to maintain the quality of the service, including the kitchen and dining experience. We saw the results of this audit showed a high score covering areas such as music playing during meals, and napkins and condiments provided on the dining tables. These were not in place during our visit. Also the audit did not pick up the issues of people who took other people's food and drink so did not reflect the whole dining experiences of people.

The failure to operate systems or processes effectively in respect of assessing, monitoring and mitigating the risks relating to the health, safety and welfare of people who used the service and others who may be at risk which arise from the carrying on of the regulated activity is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People described having mixed experiences of using the service. One person told us they thought the service was run well and had a "friendly atmosphere". However another person said, "It can be good or can be disturbing with the 'dementia folk'." A relative said, "It's a good place, it feels nice." Another relative told us, "I think they do well and the staff here are fantastic." Several relatives remarked how friendly the staff were and that all the staff made them welcome at any time.

People told us they were able to attend meetings and discuss issues about the service. One person said, "They do have meetings. The manager was there and we raised all sorts. They listen and may do what we mention." A relative told us that another of their relation's relatives tried to attend the meetings. Another relative said they did not know about the meetings and they came to a Friday coffee morning for relatives, but nothing happened and they were just sat in the lounge.

Staff told us they felt they were a good team who worked well together. They spoke of getting things done and communicating with each other. One staff member said the staff team, "Pull their weight". Another staff

member said that they felt part of a staff team and involved in how the service was run. Staff were aware of their duty to pass on any concerns externally should they identify any issues that were not being dealt with in an open and transparent manner, this is known as whistleblowing and all registered services are required to have a whistleblowing policy.

Staff told us their ideas and suggestions were listened to and there were staff meetings held every three months. The registered nurse also told us that if there was anything important in between that time the registered manager would arrange a meeting to discuss things. There were minutes kept of various meetings held regarding the running of the service. These included each of the different service areas, such as activities, catering and maintenance as well as management and care staff meetings. These highlighted where areas of improvement in the service could be made and other management issues.

Most people who used the service and relatives said they saw the registered manager around the service and could speak with them if needed. They said they tended to initially discuss things with the nurse or other staff on duty. A relative said, "The staff listen to me, they are good caring staff and very approachable." Another relative said, "They do listen in the office if I raise anything."

Staff described the registered manager as doing "a good job". Staff said the registered manager was approachable and regularly walked round the service to see how people were. A new member of staff said the registered manager had made them feel welcome and they found them to be approachable. The registered manager told us they had been actively recruiting a deputy manager but due to some circumstances beyond their control this was taking longer than expected. They said that once a deputy manager was recruited they would provide a greater management presence around the service.

The provider complied with the condition of their registration to have a registered manager in post to manage the service. We found the registered manager was clear about their responsibilities, including when they should notify us of certain events that may occur within the service. Our records showed we had been notified of events in the service the provider was required to notify us about. We saw a report of an incident that had taken place involving one person which described them being restrained. In another report the person was described as being "isolated" however there was no explanation provided as to what this had involved. The registered manager told us this had been investigated and was a case of a poor description of what had happened rather than poor care. Providers are legally required to display the rating we give them in the service and on their website if they have one. The rating from the previous inspection was displayed as required.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider failed to treat people with dignity and respect. Regulation 10 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to assess the risks to people's health and safety and mitigate any risks Regulation 12 (1), (2) (a),(b),(g),(h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to operate systems or processes effectively in respect of assessing, monitoring and mitigating the risks relating to the health, safety and welfare of people who used the service. Regulation 17 (1)(2) (a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff. Regulation 18 (1)