The Manor House (Halifax) Limited

The Manor House Nursing Home

Inspection report

Wakefield Road, Lightcliffe,
Tel: 01422202603
Website:

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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

This inspection took place on 8 October 2015 and was unannounced. This service was last inspected in September 2013 and was found to be compliant with the five standards inspected.

The Manor House Nursing Home provides accommodation and nursing care for up to 30 older people, some of whom may be living with dementia. At the time of our visit there were eighteen people living at the home.

The home has a registered manager. 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 told us they felt safe and we saw that staff had received training in keeping people safe. Risk assessments were completed but these were not always followed up where a risk had been identified. Systems for managing medicines were safe and the home was clean and tidy.

Summary of findings

There were not always enough staff available to meet the needs of the people living at the home.

Staff received appropriate levels of training and felt supported by the management of the home.

Staff did not demonstrate a good understanding of the Mental Capacity Act (MCA) or Deprivation of Liberty Safeguards (DoLS). The provider was working with the local council to try to further their understanding however staff were not working in line with the requirements of the MCA.

People told us they enjoyed the food at the home but we found some restrictions in choice.

People's healthcare needs were met appropriately.

We found staff to be kind and caring in their approach and respected peoples needs for privacy and dignity.

We did not find a person centred approach to care planning and review. Some care plans were detailed whilst others had not considered all of the person's needs. We saw little evidence of people being involved in the care planning process.

Activities were available although they were not always accessible and appropriate to all of the people living at the home.

People felt able to raise any concerns or complaints they had and we saw these were acted on appropriately.

The home is family run and we saw the providers were well known to people who lived at the home. Systems were in place to make sure the home was safe but there was a lack of effective auditing in relation to care records, medication and staffing.

We identified five breaches in regulations – regulation 18 (staffing), regulation 12 (safe care and treatment), regulation 11 (consent), regulation 9 (person-centred care) and regulation 17 (good governance).

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 always safe.

People felt safe and staff knew how to maintain peoples safety.

Some improvements were needed in the management of medicines.

The home was clean.

There were not enough staff at all times to meet people's needs safely.

Is the service effective?

Requires improvement

The service was effective but some improvements were needed.

Staff received good levels of training and felt well supported.

Staff did not fully understand their responsibilities under the Mental Capacity Act and Deprivation of Liberty Safeguards.

People enjoyed the food at the home although there were some restrictions in choice.

People's healthcare needs were met appropriately.

Is the service caring?

Requires improvement

The service was caring.

People felt well cared for and said staff were kind and caring.

People were not always involved in their care planning.

People felt their privacy and dignity needs were met.

Is the service responsive?

Requires improvement

The service was responsive but some improvements were needed.

Care was not always planned with a person centred approach and did not always reflect people's needs.

Activities were available but did not meet the needs of all the people living at the home.

Complaints were managed well.

Is the service well-led?

Requires improvement

The service was not always well led.

Systems were in place to gain people's views about the service and to make sure the environment was safe.

Auditing was not always effective.

The Manor House Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 8 October 2015 and was unannounced.

The inspection team consisted of two inspectors and an expert by experience with expertise in dementia care. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the home. This included looking at information we had received about the service and statutory notifications we had received from the home.

We usually send the provider a Provider Information Return (PIR) before the inspection. 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 did not send a PIR to the provider before this inspection.

We used a number of different methods to help us understand the experiences of people who lived in the home. We spoke with eight people who were living in the home, three relatives, three members of care staff and two nurses, the chef and the provider.

We looked at three people's care records in detail, two staff files, medicine records and the training matrix as well as records relating to the management of the service. We looked round the home and saw people's bedrooms, bathrooms and communal areas.

We observed interactions between staff and people who lived at the home and we spent time in communal areas to see how people spent their time.

Requires improvement

Is the service safe?

Our findings

We asked people if they thought there were enough staff to meet their needs safely and we received mixed responses. People said: "The staff are alright. I think there are enough of them", “There aren't enough staff. There are so many different needs for us that live here and we could do with extra (staff)" and “There aren't enough staff because of the number of times you ring and are told "you'll have to wait" but there are a lot of us wanting to do the same thing at the same time."

We saw that the staffing arrangements for the home were set at one nurse with three care assistants between 8am and 5.30pm. This reduced to one nurse and two care assistants from 5.30pm and one nurse and one care assistant between 6pm and 8pm. The nurse in charge had told us that twelve of the eighteen people living at the home needed two staff to support them. This meant that when only two staff were available, only one person would be able to receive support at any one time. A member of care staff told us, and the nurse confirmed, that the nurse in charge was often busy with medicines during that time which left only one care assistant available to people. When we asked what would happen if a person who needed two staff to support them during this period needed the toilet, the member of care staff told us they would have to wait.

A visitor we spoke with said they felt that staffing was not sufficient to meet the needs of the people living at the home particularly with regard to meeting people’s social and recreational needs. Another visitor told us, "On the whole there seems to be enough staff but sometimes when I come all the residents will be sitting in the lounge but no staff around. The staff are always happy and cheerful but they're overworked."

We saw that a dependency tool had been used to assess the staffing hours required in relation to people’s needs. However we did not see any individual breakdowns of the assessment and there was no information to show how the results of the assessments were used when organising staff rotas.This meant there were not enough staff available at all times to meet people’s needs and is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people who lived at the home if they felt safe. All of the people we spoke with said they did. One person said, "Yes, I do. That's one thing I've always felt - that I'm in a safe environment here."

When we asked people if they felt confident that staff would respond promptly when they called for help or if they had to wait. People said, "When I can ring it they're pretty prompt" and "I ring the bell if I can get it but if no one answers it's because "there's an emergency" - it's not often. I don't usually wait long."

Staff we spoke with told us what they would do to keep people safe. They were able to give us examples of different types of abuse and said they would report any concerns they had to the registered manager. A member of the care staff and a nurse were able to tell us how they would raise a safeguarding concern directly with the local authority if they needed to. They told us that contact numbers were available within the home.

One member of staff told us there was a whistleblowing procedure for staff to follow if they had any concerns about care practice within the home.

We saw that care files contained some risk assessments for people’s individual needs. For example, moving and handling, falls, nutritional risk and pressure sore risk assessments. Whilst some of these were detailed and up to date and had been followed up, others were not. For example, the nutritional risk assessment for a person who had been losing weight had not been updated to reflect this and therefore the risks associated with weight loss for this person had not been identified. In another care file we saw that whilst the risk assessment had identified the person to be at very high risk of pressure sores, no plan had been put in place to manage and minimise the risk.

All of the files we looked at included personal emergency evacuation plans. We suggested to the provider that they may wish to review these as some of the evacuation plans included moving the person from their room on their mattress. Where people were using air mattresses this would not be possible and use of mattresses for evacuation purposes may block escape routes and increase the risk to people.

Requires improvement

Is the service safe?

We saw that accidents and incidents were recorded and any identified risks to people were updated on risk assessment documentation and staff informed of this during handover to make sure they were aware of any new risks to people.

We noted that call bells were not always in reach of people either in their rooms or in the lounge areas. As staff were not always available in communal areas it is important that people are able to alert staff to make sure their needs are met and to maintain their safety.

This was a breach of the Regulation 12 (2a& b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. (Assessing and mitigating risks to service users)

When we asked people about how they received their medicines, one person said, “I get my tablets on time. I can get pain killers if I need them."

We looked at the systems in place for the receipt, storage and administration of medicines within the home. We also looked at a sample of Medication Administration Record (MAR) sheets. We noted that not all of the MAR sheets included a photograph of the person. It is important that this is in place to assist staff unfamiliar with people living at the home in making sure people are given the correct medicine.

We looked at the medicines with the nurse in charge. We saw that medicines, including controlled drugs (CDs), were stored securely in a locked clinical room. Medicines were supplied from the pharmacy mainly in in a monitored dosage system (MDS), or where this was not appropriate, in boxes and bottles. We found appropriate arrangements were in place for the ordering and disposal of all medicines. A locked medicine fridge was used for medicines requiring cold storage and fridge and room temperatures were recorded daily. Records we saw showed temperatures were within the recommended safety range.

We saw that directions for the use of medicines were not always clearly recorded. For example the instruction on one person’s MAR was for the medicine to be used “as directed”. We saw that the instructions on the box for this medicine were also to be used “as directed.” This meant that staff did not have any clear instruction on how the medicine should be taken and needed to raise this with the supplying pharmacy or doctor’s surgery.

We checked a sample of medicines in stock against the (MAR) sheets and found most were correct. However when we checked one person’s Warfarin tablets we found there were too many tablets still available in relation to the amounts recorded as received and administered. When we checked on a previous MAR, we found that seven tablets had been carried forward which made the amounts correct, however this had not been recorded on the current MAR.

There was no protocol in place for the use and administration of ‘as required’ (PRN) medicines. This meant that no records were available to show what the medicine was used for, how effective it was, or where the prescription was for one or two tablets, how many had been administered.

We saw that three medication audits had been recorded as completed, two within a few days of the inspection. This was recorded in a book but contained no detail of how the audit had been conducted or what it had looked at. The outcome of the audits were simply recorded as “No errors.” None of the issues we had found had been recorded on the audit. Although these were minor a robust system of auditing would have identified them.

We recommend that the service considers the National Institute for Health and Care Excellence (NICE) Guidelines for Managing Medicines in Care Homes.

We found the home to be clean and tidy and saw that staff used personal protective clothing such as gloves and aprons appropriately.

Requires improvement

Is the service effective?

Our findings

We asked people who lived at the home what they thought of the staff's skills and abilities in looking after them. People said "I think they have the right skills - they seem to", "Some have more than others, but yes" and "I think most have the skill."

We also asked people if their permission or consent to care was sought by staff. People said, "Yes, they always check that I'm happy for them to do things for me" and "For some things they ask but often they don't need to because I can't do it for myself but they excuse themselves."

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

We saw that DoLS applications had been made for two of the people living at the home. When we spoke to staff about this they did not appear clear in their understanding of the MCA and DoLS despite having received training. The provider told us that they had worked with the local council to try to further their understanding and to make sure they were working in line with the requirements of the MCA and DoLS.

We saw further examples of a lack of understanding of the MCA within care records. For example we saw that the friend of one person had signed agreement with the person's care plans and with their 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) form. However there was no information to indicate that the person did not have capacity to consent themselves and other records stated that the DNACPR had been discussed with the person and they agreed with it.

We did not see any completed MCA assessments in the care files we looked at, including the file for a person living with dementia.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with said they received good levels of training although they felt they would benefit from more face to training rather than watching DVDs. Although the majority of training was through DVD we saw that staff completed work books following the training to check their knowledge. We looked at the training matrix which showed that most staff were up to date in areas such as moving and handling, infection control and safeguarding. Although there were some gaps, the provider told us that they had not yet updated the matrix with the most recent training completed by staff.

One care assistant told us that they had recently completed some training in caring for people living with dementia. They said that when staff had completed courses such as this they were expected to share their learning with colleagues. They said this was done formally and that time was allowed for it. They told us that another care assistant had completed the moving and handling course and was now the co-ordinator and "showed the rest of the staff how to do things properly."

Staff told us they felt well supported by the manager and the provider. They said they received regular supervision and could approach any member of the management team for advice whenever they needed to.

Although some of the people at the home were living with dementia or a degree of cognitive impairment, we did not see any environmental adaptations to assist them with their orientation around the home.

We would therefore recommend that the service explores the National Institute for Health and Care Excellence (NICE) quality standards for people living with dementia under Quality Standard 30 (QS30: Supporting people to live well with dementia) and Quality Statement 7 (design and adaptation of housing) on how premises can be designed or adapted in a way that helps people with dementia manage their surroundings, retain their independence, and reduce feelings of confusion and anxiety.

We did observe a care assistant interacting appropriately with a person who was distressed and uncomfortable and who appeared to be confused and disorientated.

During our visit we asked people living at the home what happened if they said they were in pain or uncomfortable. One person said, "They'll get someone to look at me. I can get pain killers if I need them." Another person told us "Some staff are better than others but they'll try to make

sure the problem is dealt with. One person told us, “I have pain all the time. I take pain killers but the doctor says I have to live with it. I have to wait for my medicines. If I tell them I have pain, nothing happens."

When we asked if people had access to their GP or other health care professionals they said:

"They'll arrange for the doctor to come if I'm not well. I suppose it's the same if I needed anyone else", "The staff send for the GP, eye doctor, chiropodist, dentist - whoever you need to see",

"They manage my health. They suggest if they think I need to see someone" and "They're very good. If I say I've got a problem they will get the doctor. Other health people come here too - optician, dentist."

At breakfast time we had heard one person who lived at the home telling a nurse about a problem they were experiencing with their health. When we checked with the person later in the day they told us that the doctor had been to see them about it.

We saw from care records that healthcare professionals including GPs, opticians and dieticians were all involved in people’s care. However we were concerned that the advice from health care professionals may not always be followed. For example, in one person’s file we saw that a review from the Stroke Association recommended that the person be supported with gentle movement to support their mobility. We did not see any care plans relating to this and did not see any recorded evidence of this advice being followed.

When we arrived at the home, we saw that people were being served breakfast. This consisted of cereal or porridge, jam or marmalade sandwiches and toast. We asked staff if there was a cooked breakfast option. They told us this was only available at weekend when egg sandwiches were served on one day and bacon sandwiches the other. We asked if people were able to have bacon and egg together or if they could request cooked items on weekdays. Care staff said they would ask the chef if someone made that request but they didn’t think it would be provided. When we spoke with the provider about this they said that they did not advertise that they provided cooked breakfasts and felt that a smaller breakfast would encourage people to take a better lunch which the provider felt would be better nutritionally. We also spoke with the chef and asked if people might be able to have such as a boiled egg for breakfast if they wished. The chef said they may be able to provide this but the egg would have to be hard boiled due to the risk of salmonella. This meant that people may have been restricted in their right to make what might be considered unwise choices.

When we asked people what they thought of the meals they told us: "The food is alright. There's no choice, they just bring me what I like", “It's pretty good they tell me what there is for each meal. It's not a choice though. I think you can get a drink when you want one", "The food is very good. You get plenty. Most days there's a choice for dinner and tea. You get plenty of drinks - no need to ask for extras" and "It's not bad at all. You're never hungry. There's no choice at breakfast - they like you to stick to the same thing. There's no choice for the main meal if it's a roast. There's usually an alternative if it's not a popular dish - say, liver."

We saw the lunchtime meal looked fresh and portions were of a good size. However, people were served in an institutional way from a trolley wheeled into the dining room. No one was offered a choice about what they would like on their plate either verbally or visually during service and there were no alternatives available on the trolley. Although condiments were available on the tables, people were not given the option of any self-service of any component of the meal including stuffing and gravy.

This meant that people’s choices were restricted.

We saw that people sitting in the lounges were offered warm drinks at frequent intervals and that biscuits were served with these. However, people were told what some of the biscuits were rather than being offered the plate to make their own choice. We were concerned that people in their rooms did not always have drinks near to hand and noted that some people appeared to have dry mouths. We also noted that when staff went into the rooms to see if the people needed any support, they did not always take the opportunity to offer the person a drink.

We saw from weight charts that the majority of people had maintained their weight. However we noted that two people had very low body weights recorded. We looked at the care records for one person who had been seen by the dietician for previous weight loss until they had gained weight. There was instruction from the dietician to ‘self-refer’ again if needed. However, since that time the person had lost 2.3kg within two months. We asked the nurse if the referral had been made and they said it had not. They said the GP had been informed.

Requires improvement

Is the service effective?

We asked the nurse if any of these people were having their dietary intake recorded so that staff would know if they were receiving adequate diet or if more support was needed. The nurse said they were not. This meant that issues with people's nutritional intake may not be easily identified.

Requires improvement

Is the service caring?

Our findings

We asked people if staff were kind to them. They said: "I think they are kind and caring"; "They are exceptionally kind to you" and, "Well, some more than others but yes." A visitor told us, "The staff seem kind and (my relative) is happy here but has quite low expectations. (Relative) appreciates being clean, warm, tidy and well-fed."

When we asked if people thought the care they received met their needs people said, "I think so, they've been there for me when I've not been well" and “More or less, they try all sorts to make sure you're alright."

We also talked with people about privacy, dignity and respect. Most people were very positive. They said, "Yes, I'm always treated with respect and they're good about dignity. It's their job but we can kid about too" and, "I’ve noticed if you tell someone something then they all know. Some staff don't always knock when they come into my room. They always try to make sure I'm covered when they're doing anything though."

We observed staff to be kind, patient and caring in their approach to people. We saw that staff exercised discretion when, for example, asking people if they would like help to visit the toilet. When assisting people, staff explained what they were doing and offered reassurance.

Staff appeared to know people well and interacted easily. We saw that when a person became distressed, a member of staff spent time with them offering reassurance.

In people’s rooms we saw evidence that staff respected people’s belongings by making sure they were looked after.

When we asked people if they had been involved in their care planning and making decisions about their care they said: "They can't do any other - I have the final say, always", “Well, they talk about it to me and then I feel I can make the decisions for myself" and "No - I don't feel as involved as I'd like to. They don't discuss, they tell me."

We did not see much evidence of people being involved in their care planning and saw little evidence of life story work. Life story work is a way for staff to understand people, their backgrounds and any particular needs they may have in relation to culture and diversity.

We saw letters within people’s care files which had been sent to people’s families asking about their relative’s end of life wishes. Although sensitively worded, the letters said that it was a requirement of the Care Quality Commission to have these wishes recorded rather than it being a part of advanced care planning. We also noted that it was the families who had been asked about this rather than, wherever possible, the person themselves.

Requires improvement

Is the service responsive?

Our findings

When we asked people if they had been involved in the planning of their care some people told us they thought they had been consulted but others said not. One person said, "I think they work it out. I haven't."

We did not see any evidence of a person centred approach with the planning or review of care. An example of this was an assessment of a person's needs prior to their admission to the home. The assessment detailed information such as mobility, hearing, sight and continence but did not include any detail of the person's background, interests or friends and family. Neither did the assessment detail the person's strengths, abilities or preferences about their care.

None of the care plans we saw evidenced the involvement of the person, or where appropriate, their representative in the development or review of their care plans.

Some care plans were detailed and gave good information for staff to follow in how to meet individual's needs and included some detail of people's choices. We also noted that information from healthcare agencies had been included, where appropriate, within some care files. For example for a person who used a urinary catheter there was information from the NHS about catheter management. However we noted in one of the care files we looked at that aspects of the person's medical history and needs in relation to this had not been included in the care plans. For example we saw in the care file, an assessment of the person's needs which had been carried out by the local Clinical Commissioning Group (CCG) prior to their admission to the home. The assessment detailed a number of medical conditions the person was living with including arthritis, very poor vision, skin condition and previous stroke. None of the care plans in place for this person included any detail of these conditions or how they affected them.

Another care file we looked at said that the person had diabetes and that staff should be aware that the person's blood sugar level could drop quite rapidly. However there was no information about what the person's normal blood sugar levels were or what staff should do if the level dropped.

We saw that pressure sore risk assessments were in place. However, in one of the files we looked at we saw that although the person had been assessed as at 'very high' risk of developing pressure sores, there was no care plan in place to direct staff in what actions they should take to minimise the risk of pressure sores developing.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw detailed care plans in place for managing people's moving and handling needs and observed that staff followed the care plans when supporting people in this area.

When we asked people about how they spend their time and what activities there were available to them, we received mixed responses. People said "No one spends any time with me. I don't do anything", "I like to spend time reminiscing on my own. I've travelled a lot and I've got some good memories to keep me occupied. I go down and take part in balloon games, bingo or quizzes. It's a break from being up here" and "I watch a lot of TV. I play games with the carers - quizzes, I like them. I like to go in the garden when the weather's warm."

Visitors we spoke with said, "They try to do some sort of activity with the residents but not everyone can participate so it's always the more able - those who can't don't do anything. The TV is on all the time" and "There are no really stimulating activities that I know of other than I think they do quizzes and crosswords."

The home did not employ staff dedicated to engaging people in activities but the provider said that care staff would do this.

We spoke to a care assistant about this who told us they did engage people in activities whenever they had time. They told us they were reviewing the activities and had some new ones planned. The care assistant said activities currently on offer included bingo, cards, quizzes, balloon volleyball, mind games, puzzles, movie matinee and memory discussion. Plans were in place to introduce new activities such as bird feeding, afternoon tea and guess the item.

A visitor told us that staff would go through their relatives photograph albums with them whenever they had the time to that.

We saw a musical entertainer visited during the afternoon of our inspection. This was clearly enjoyed by all people who attended.

Requires improvement

Is the service responsive?

When we looked at the activity log in which staff recorded who had participated in activities. We noted that the same people participating in the regular activities. There was no listed activities for those who couldn't join in what was on offer.

This meant that although some activities were provided, they were not always available to all of the people living at the home.

People told us they would speak to staff or to the provider if they had any complaints or concerns and we saw there was information about making a complaint on the notice board inside the entrance door. We saw that one complaint had been received during 2015. The complaint was recorded and actioned in line with the provider's policy. The actions taken demonstrated that comments received from people who used the service and their relatives were listened to and acted upon.

Requires improvement

Is the service well-led?

Our findings

We asked people about the management of the home. Only one person was able to tell us the name of the registered manager but all the people we spoke with knew the provider. People told us that they felt they had no input into the day to day running of the home or in planning anything that might go on in the home.

When we asked about any meetings that had taken place one person told us, "The home did try to have a meeting with people. I think it was about Gold something. It was so poorly attended they decided it was better to speak to people individually after that."

There was a registered manager in post but they were not available on the day of our visit. We saw there was a clear management structure in place which involved the registered manager, providers and nurses. At all times throughout the day and night, nursing staff were on duty and a member of the senior management team was on-call to staff if required.

Staff spoken with were fully aware of their role and the purpose of the services delivered at The Manor House. The service's Statement of Purpose was present on the wall of the provider's office. This described the purpose of the service and what facilities people who used the service should expect to be provided.

Our observations of how the providers interacted with people who used the service, their relatives and healthcare professionals spoken with during the inspection showed us that leadership within the home was good at this level. Staff were aware of who the registered manager was and what their responsibilities were.

We saw that systems were in place to monitor and maintain equipment and the environment. For example, records demonstrated that regular checks of weighing scales, hoisting equipment, slings and elevators were checked and serviced in line with the supplier's recommendations. We saw the fire detection system was serviced annually with visual checks completed throughout the year.

Accidents and incidents were recorded and a senior member of staff told us they were looked at for identifying any trends which might help in improving safety within the home. Certain trends were recorded on a separate document so it was easier for staff to analyse. For example where someone had fallen it was recorded on the accident and incidents log as well as a separate document just for analysing falls within the home.

We did not see any evidence of auditing of care records and the medication audits we saw lacked any detail and did not indicate what areas had been audited.

The providers were unaware of the issues staff had raised to us in relation to staffing numbers in the evenings.

This meant that whilst some quality auditing was in place it had not been effective in identifying issues within the home.

This was a breach of the Regulation 17 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who lived at the home, family members and other stakeholders had been asked to complete questionnaires and surveys to give their opinions on the service they had received. We looked on the notice board in the hall way and saw seven different types of surveys for people to fill in. These questionnaires and surveys were audited by the registered manager of the service and when necessary acted upon. At the time of our inspection the service had received four responses from the 'satisfaction survey' since the start of 2015. The provider told us they had struggled to get people to fill these forms in because if people had any concerns, they vocalised them to the management. The provider told us; on a monthly basis a staff member would sit down on an individual basis with the people who lived at the home and review their care. Part of this process involved completing a survey. We spot checked and saw all questionnaires and surveys completed by people indicated a positive experience overall. For example 8 out of 8 surveys checked said they enjoyed the food and management were easy to approach. This showed us peoples overall impression and experience was a positive one and improvements were continually sought after.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed to meet people's needs safely. Regulation 18 (1)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Care planning was not person centred and was not designed with a view to ensuring service users preferences and making sure their needs are met. Regulation 9 (3) (b)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **Care and treatment of service users was not always provided with the consent of the relevant person. Regulation 11 (1)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Systems were not always in place to make sure people received safe care and treatment.**

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Quality auditing was not always effective in identifying issues within the home.**