Aden House Limited

Aden Mount Care Home

Inspection report

Perseverance Street
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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?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 11 and 12 January 2016 and was unannounced. The service was last inspected 20 May 2013 and was found to be compliant in all areas.

Aden Mount is a purpose-built home situated in Primrose Hill, a residential area of Huddersfield. It offers personal and nursing care and accommodation for up to 45 people aged between 18 and 65 years. All bedrooms, which are over three floors, are single en-suite and all floors are accessed via a passenger lift or stairs.

There was a registered manager in post. 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 who lived at Aden Mount told us they enjoyed living there. They felt staff had the skills and knowledge to support them in a safe and caring way.

Staff we spoke with had received training in safeguarding vulnerable adults and had a good understanding of what constituted abuse. They were able to tell us what they would do if they had any concerns about the way people who used the service were being treated.

Medicines were administered by staff that had the training to do so. People we spoke with told us they received their medicines on time. However, we observed staff did not always stay with people to ensure they had taken their medicines.

We observed two mealtime experiences. At lunchtime people had a lighter meal with the main meal served at tea time. We saw people had a choice of food and drinks. The food looked nutritious and people were offered a choice of vegetables with the tea time meal. Drinks and snacks were available for people during the day. If people had issues with weight loss, we saw evidence the service referred them to the appropriate services, such as the dietician or the general Practitioner.

Staff had a good understanding of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. They understood the need to ask for consent before they carried out any personal care. The registered manager was aware their responsibilities in protecting the rights of people who do not have the capacity to make their own decisions.

We looked at the training matrix for the staff team and saw all training was up to date. Staff we spoke with told us they felt the training helped them to carry out their role effectively. People and relatives we spoke with felt staff had the right skills and knowledge.

The home was spacious with rooms for people to meet their visitors privately. However, there were no signs on the doors to the bathrooms and the communal areas. The bedroom doors did have people's name on them but did not have any other form of identification. Sometimes people living with dementia have difficulty recognising their name when it is written and use pictures to help them identify their own rooms.

We observed the interactions between staff and people who used the service. We saw it was warm and respectful. People who lived at Aden Mount told us they thought the staff were lovely and very caring. Visitors we spoke with also felt staff were very approachable and their relative was cared for.

The service carried out an annual survey which asked people who used the service to say what they think of the care and support they receive. It showed us people were being asked their opinion of the service.

In the care records we looked at we saw people had been asked how they wanted to be supported toward the end of their life.

The care records we looked at were centred on the support needs of the individual. People told us staff talked to them about their care records and we saw people had signed their consent to care. People's bedrooms were decorated in a way which reflected their own personal tastes.

Food and fluid charts were not being completed on a consistent basis and it was difficult to establish how much people, who were at risk of malnutrition and dehydration, had to eat and drink.

Activities took place on a daily basis and each person had a copy of the weekly activity sheet. Activities were varied and included arts and crafts and quizzes. People who were unable to take part in group activities were offered one to one activities.

The visitors and people who used the service told us they knew what they would do if they were not happy with any aspect of their care. In people's bedrooms we saw a copy of 'How to complain' which meant people had the information they needed when they wanted to make a complaint.

Staff felt supported by the registered manager. They had an understanding of the vision of the home and what it was trying to achieve. People who used the service knew who the registered manager was and felt able to talk to them.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can what action we have asked the provider to take at the end of the full version of this 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 always safe.

Staff had training in safeguarding and understood their roles and responsibilities in keeping people safe from harm.

People who used the service told us they felt safe.

The service had robust recruitment practices in place which ensured people were kept safe from staff who were not suitable to work with vulnerable adults.

Whilst medicines were administered by staff who had the necessary qualifications, staff did not stay with people to make sure they had taken their medicine.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had training in the Mental Capacity Act and in Deprivation of Liberty Safeguards.

The registered manager was aware of their responsibilities in relation to protecting people's liberty.

Staff did not always record the food and fluid intake of people who were at risk of dehydration and malnutrition

People had a choice of food at mealtimes and were kept safe from the risks of poor nutrition because the service monitored people's weight.

People were supported to maintain good health because they had access to on-going health care services and support.

The environment was not friendly for people living with dementia.

Is the service caring?

Good

The service was caring.

We saw interaction between staff and people who used the service was warm and respectful.

Staff understood the needs of people who used the service and people felt supported.

People and their relatives were as involved with the care record of the person as they wanted to be. This meant people's support needs were personal to them.

Staff were aware of the need to protect people's privacy and dignity.

Is the service responsive?

Good

The service was responsive.

The care records were person centred and focussed on the needs of the person. They had been reviewed monthly and any changes were made to reflect the changes to the individual. This meant people were being supported by staff who understood their support needs.

People had access to activities which were varied. People had the choice of whether or not to take part in activities. People's social preferences had been recorded and taken into account when activities had been planned.

The registered manager recorded formal complaints and acted on them to improve the quality of the service.

Is the service well-led?

Good

The service was well led.

The service was well led.

People who used the service knew who the registered manager was and felt able to approach them.

Staff felt supported by the registered manager.

The registered manager carried out spot checks on the home to ensure standards were being maintained.

The registered manager carried out quality assurance audits on care records, food and fluid charts and this helped them identify areas for improvement. They had recently started to carry out audits of the controlled drugs.

Aden Mount 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 11 and 12 January 2016 and was unannounced. The inspection team consisted of an adult social care inspector and a specialist adviser in end of life care and medicines.

Before an inspection we usually ask the provider to complete a Provider Information Return (PIR). 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. The service had returned a PIR that was detailed.

We talked with five people who used the service, four visitors, the registered manager, one nurse, a team leader, a senior carer, two carers and the housekeeper. We observed two mealtime experiences. We observed interaction between staff and people who used the service and we looked around the home, including the bedrooms of seven people.

We looked at the care records of six people who used the service, five staff files, health and safety audits, fire risk assessments, water safety files, staff and manager meeting minutes, the training matrix and the supervision matrix.

Requires Improvement

Is the service safe?

Our findings

All the people we spoke with told us they felt safe living at Aden Mount. One person told us, "I do feel safe here, if I didn't I would leave." Another person told us, "Yes I feel safe; people are allowed to do what they wish."

The staff we spoke with confirmed they had received training in safeguarding. They were able to tell us what they understood abuse to be and what they would do if they had any concerns. One staff member told us, "Safeguarding is about keeping people safe and free from abuse." Another staff member told us, "It's important to keep people safe from harm." We asked staff what they would do if they felt any concerns they had raised had not been acted upon. One staff member told us "I would keep going up the management ladder and if I still wasn't happy I would contact the local safeguarding team." This showed people were being kept safe from the possible risk of harm because staff had the required skills and knowledge to minimise risk.

In the care records we looked at we saw risk assessments had been put in place to reduce the risk of harm. We saw risk assessments in place for mobility and nutrition, call bell and safe environment. The risk assessments were thorough and reviewed monthly. At the review stage we saw the risk assessment and care record would be amended to reflect any changes. We looked at the handover notes. Each person who lived at the home was discussed at the handover and any concerns staff had about people's condition would be passed on to the next shift.

Staff had received training in moving and handling with annual updates. Staff told us they felt they had the skills and knowledge using equipment such as the hoist. We observed staff using the hoist to transfer people and we saw they used the hoist safely.

The registered manager told us they used a dependency tool to decide how many staff would be required. During the day there would be four domestics, two kitchen staff, three nurses and seven care assistants. During the night there would be one nurse, one senior carer and four care assistants. There were staff vacancies and the registered manager told us they were in the process of recruiting into the vacant posts. When they had to use agency staff, the registered manager told us they tried to use the same agency staff all the time. They felt this helped minimise any risks. The registered manager felt there were enough staff on duty to meet people's needs.

Some people we spoke with told us they felt there were enough staff on duty but other people felt there should be more staff available. Call bell response times were being actively monitored by the registered manager; however, during the inspection the call bells were sounding for long periods of time. The registered manager told us there were three call soundings on the system. One to alert staff initially, a second one to ask for more help and a third one which registered as an emergency on the call bell board. The registered manager told us the call bell would go to the third 'emergency' bell if it had not been answered within a specific period of time. We noted the 'emergency' bell sounded frequently during the inspection. This meant people had to wait long periods of time for their call bell to be responded to. Even

though we noticed the call bells were not being answered in a timely manner, people who used the service felt they did not have to wait long for staff to respond when they pressed the call bell.

We looked at the personnel files of five staff members. We found the service followed their recruitment policy. Each file had a current photograph of the member of staff, two references and a Disclosure and Barring Service check (DBS). The DBS enables organisations make safer recruitment decisions by identifying potential candidates who may be unsuitable to work with vulnerable adults.

We observed the medicine round during lunchtime. As people sat at the dining table for their meal, we saw staff leave prescribed medicines in a pot on the table for people to take. The staff then left the pot without checking whether the person had taken them nor did they return later to check whether the medicine had been taken. Whilst we observed the person did take the medicine left for them the staff member should have come back to check the person had taken their medicine.
The lead clinical nurse told us they did not carry out audits of the CDs. They only checked the number of CDs when they were administered. They were aware the CDs should be audited weekly and there were plans in place to amend this. The plan was for the night staff to carry out the audit.

These examples demonstrate a breach of Regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (regulated activities) Regulation 2014.

People had been prescribed medicines which were taken as and when required. These types of medicines are called PRN medicines. We saw the service had PRN guidance in the MAR sheet file so staff could follow best practice. Although staff did ask people if they wanted pain relief, they had already prepared the medicines. If the person declined the pain relief medicine, it was disposed of. This meant a lot of medicines had been wasted because staff administering medicines did not ask the person if they wanted the pain relief before they prepared it.

Staff were aware of how to dispose of and record all unused and unwanted medicines. The lead clinical nurse showed us how they managed unused controlled drugs (CDs).

The medicine trolley was kept in a locked clinical room and was secured to the wall in the room via a chain and lock. During the medicines round, if staff had to leave the trolley unattended, they made sure it was locked. We looked at the medicine administration record (MAR) for five people, we saw each MAR sheet had a photograph of the person and we could not see any missed signatures.

The service had two controlled drugs (CD) cabinets in use. One for the residential unit and one for the nursing unit. Each cupboard was locked and bolted to the wall. We looked at the records for five people in receipt of controlled drugs. We saw the number of drugs reconciled with the number in the register.

People who used the service were given the opportunity to administer their own medicines and we saw when people did want to administer their own medicines risk assessments had been carried out and reviewed monthly.

Staff we spoke with had a good understanding of their responsibilities in relation to infection control. They told us there were plenty of aprons and gloves available for them to use when providing any personal care. Although the home was clean with no malodours, there were lots of wheel chairs and hoists in the corridors. This could make it difficult for people to manoeuvre their wheelchairs around the home.

The registered manager told us personal emergency evacuation plans (PEEPS) were in place for people. PEEPs contain information about people who use the service and what their support needs would be in an emergency. We found the PEEPS in the 'emergency grab bag' used by the home to store fire safety information such as a map of the building.

The maintenance person carried out regular health and safety checks of the building. We saw fire drills had been carried out and emergency lighting had been tested. Water temperature checks had been recorded and the portable electrical tests had been carried out. Wheelchair maintenance had also been carried. We saw when any faults had been identified with a wheelchair they had been rectified. This showed the registered manager had taken steps to minimise the risk of harm from faulty equipment.

Requires Improvement

Is the service effective?

Our findings

People who used the service felt staff were skilled and knowledgeable in their role. One person told us, "Staff are informed and up to date." One of the visitors we spoke with told us, "I think staff have the skills yes."

We looked at the training matrix and saw training for staff was up to date. The registered manager told us the lead clinical nurse carried out clinical competency checks on the nursing staff and we saw the records of these checks.

Staff had a period of induction and worked through an induction booklet. They then shadowed other more experienced staff before delivering personal care on their own. Staff told us they felt this gave them the skills and confidence to work alone. Each member of staff had an annual development plan in place and staff confirmed they received supervision. The files we looked at confirmed what staff had told us.

We spoke with the staff about their experience and understanding of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguard (DoLS). The 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. The staff we spoke with understood what the MCA and DoLS was. They did find it hard to give example but were able to explain how important it was to gain consent from individuals before carrying out personal care. If people did not give their consent to personal care, staff told us they would respect people's wishes but would try again later on in the day.

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). In the care records we looked at we saw where people were not able to make their own decisions a capacity assessment had been carried out. The registered manager told us they had people who were subject to a DoLS. We reviewed the paperwork in relation to the applications. We saw evidence of best interest meetings and mental capacity assessments. The views of the family had also been taken into account when the decision was made. This showed the service was upholding the rights of the individual whilst keeping them safe.

Each of the care records we looked at had a Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) record in place. They had been completed by a medical officer and countersigned either by the person or by a relative with a Lasting Power of Attorney in place. The DNACPR from was also recorded in the persons end of life/advance care record. This meant staff were aware of and understood the wishes of the person in the event of their death.

The home had a large dining area which was split into two rooms. People could choose where they wanted to sit and have their meals. We observed two mealtime experiences. We saw people sat at the tables in their

wheelchairs. We asked the registered manager about this and they told us people had chosen to stay in their wheelchair during their meal. There were tables available for people who chose to stay in their wheelchair. The tables could be lowered so people did not have to reach up to the table to eat their food. This made it easier for people to eat their meals. The food looked appetising and people told us they enjoyed the meals. One person told us, "There is always a lot of food and I really enjoy it." Another person told us, "If you don't like what's on offer you can always ask for something else."

People were asked to choose from a menu the day before. This meant there was a risk people living with dementia and other memory problems may find it difficult to remember what they had ordered. There were pictorial menus available to help people choose their meal.

On the tables we saw a menu of the meals available that day so people could read what was for lunch or dinner. The tables were nicely presented with condiments and napkins. People were offered the use of clothes protectors. Staff encouraged people to try and eat their meal independently as far as was possible but when people required support to eat their meals we saw staff did this discreetly. People were offered a choice of food at each mealtime. Staff asked people what they wanted rather than just take a plate of food to the person and set in down in front of them. This meant people had a choice of what they wanted to eat.

The care records showed people's weight was monitored on a regular basis. When people had lost weight, a referral was made to other health professionals such as the dietician or the general practitioner. The frequency of weight monitoring was increased when people were losing weight. Staff recorded food and fluid intake when required. We looked through six fluid and food charts. We saw staff had not been consistent in the detail when recording what people had to eat or drink, for example, some people's intake of fluid and the amount of food eaten at mealtimes had been recorded in detail, whilst others did not have the same level of detail. We discussed this with the registered manager. They told us they were aware of this as a problem and had addressed it with staff at regular intervals. They told us they would keep talking to the staff and to stress the importance of recording people food and fluid intake.

Whilst people did not look dehydrated and people we spoke with told us they had plenty to drink through the day, the issue of not recording the amount people drink is a breach of Regulation 17 (1) (2) (c) of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

Risk assessments were carried out when there was a risk of choking or poor nutrition. We saw these were reviewed monthly and updated to reflect any changes. Some people did require a special diet such as a soft diet and this was detailed in their care record. Each person had a Body Mass Index (BMI) recorded in addition to their weight and this was reviewed each month.

People we spoke with told us they felt they were seen by their GP quickly if they felt unwell. One person told us, "I don't feel too good today so they've got the Doctor coming to see me." In the care records we looked at we saw visits from other professionals were recorded and any changes to people's care was recorded in their care record.

Although the building was spacious with lots of floor space, a lot of the space was taken up with wheelchairs and hoists. There were several wheelchairs and a hoist in the corridor of the ground floor and there was a risk they would stop people in their wheelchair from moving about freely. There was also a risk the wheelchairs would pose as an obstacle in the event of a fire.

Although Aden Mount Care Home primarily supported people who required nursing care there were people living in the home who had memory problems and were living with dementia.There were no pictures on the

doors of the bathrooms and toilets and only a few of the bedroom doors had pictures on them of the person whose bedroom it was. This meant people who had difficulty recognising the writing on the doors may not know where the bathrooms or toilets were and they may not be able to find their bedroom. The home was not dementia friendly in that there were no signs directing people to the dining room or lounge. This meant people living with dementia or other memory problems had to rely on staff to guide them around the home.

These examples demonstrate a breach of Regulation 12 (1) (2) (d) of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

Good

Is the service caring?

Our findings

We asked the people who lived at Aden Mount what they thought of the staff who worked there. All the people we spoke with and their visitors felt the staff were very caring and supportive. One visitor told us, "The staff here are fabulous, this is a wonderful home." Another visitor told us, "The care is good here, my [relative] was in another home but we moved [relative] here because we felt the care was better and it is."

One of the people who used the service told us, "Ahh the staff are lovely, they are so caring and always speak to me in a lovely way."

We saw staff and people who used the service got on very well together and staff spoke to people with respect. Staff knelt down to people's eye level when they were talking to them.

Staff we spoke with told us they enjoyed working at the home. One member of staff told us, "I absolutely love it, all the team are really caring and friendly."

There was evidence to show people had been involved in their care records. One person who used the service told us, "My keyworker sits down with me and talks about my care plan." Other people we spoke with could not tell us about their care record but could tell us the name of their keyworker. We spoke with staff about the role of keyworker. One staff member told us the keyworker role involved mainly ensuring people had a good stock of personal washing soap and keeping their room clean and tidy. They told us they felt the keyworker role enabled them to get to know the person and to understand their preferences.

Staff could give us examples of how they would respect people's dignity and how important it was to maintain people's dignity. We did see some good examples of staff respecting people's dignity; however we also saw an example of when a person's dignity was not respected. We observed one person being transferred from chair to wheelchair via a hoist. Staff ensured they explained to the person exactly what was happening and kept asking them if they felt alright as they were being transferred. This helped to reduce the person's anxiety. However, as the person was being lifted in the hoist, there was no cover over their knees and this resulted in the person's underwear being exposed. We brought this to the attention of the manager and they assured us staff were aware of the importance of ensuring people were covered up when they were being transferred in the hoist. During the inspection we saw examples of good practice where staff did respect people's dignity

Visitors explained how they appreciated the effort staff made to promote the independence of their relative. The registered manager told us the main door was not locked and people were able to go out of the building and make use of local shops.

We saw people came to visit their friend or relative at different hours of the day. The registered manager told us the only time they would ask people not to visit was at meal times which they felt should be protected to ensure people had their meal without any disturbances.

There were places throughout the home where people could meet with their visitor in private. People who used the service had the option of having a key to their bedroom so they could lock the door. This ensured people had the privacy they needed.

The registered manager told us they had a good relationship with the local Macmillan/palliative care nurse. They had experience in supporting people who were at the end of their life and were aware of how to ensure people had a death that was dignified and free from pain. If a person is in the last days of life it is helpful if medicines for end of life symptom control is available to they can be given if required without any unnecessary delay. These types of medicines are known as anticipatory medicines. In the CD cupboard we saw anticipatory medicines in stock. This meant the service would not have to wait for a GP to prescribe the drug and people would be kept free from pain.

Good

Is the service responsive?

Our findings

There was a mixed response from people when we asked them about their care records. Some people were aware of their care records whilst other people did not understand what we meant when we talked about care records. The registered manager told us they had recently updated the care records and had ensured staff included people who used the service as the records were updated.

We looked at the care records for six people. The care records were person centred and focussed on the needs of the individual. There was a personal history which gave a detailed record of a person's background, what they enjoyed doing in their leisure time and what type of work they had been employed in. This helped staff understand the person better and gave them a clearer picture of people's preferences. The care records had an index which made it easy to find the section required. The care records were thorough and had a high level of detail. Not all the staff we spoke with were involved in the writing up of the care records but they did try to find the time to read them. One staff member told us, "When I get the time to read them I find them easy to understand." We saw the care records had been reviewed monthly and updated to reflect any changes.

The service employed two activity coordinators and there was a dedicated activities room. The room was decorated with photographs of previous activities and day trips out. The registered manager told us the local mobile library visited so people could choose books to read, including audio books. Activities on offer included, quizzes, art and crafts, board games, dominoes and one to one activities for people who did not include themselves in the group activities. People we spoke with told us they did not feel pressured into taking part in activities but enjoyed them when they did.

The registered manager told us they carried out an annual survey with people who used the service and their relatives. The survey asked people what they thought of the support they received, communication, involvement and level of activities. We looked at the result of the most recent survey from August 2015. It showed a positive result in most areas and where people had made negative comments about the service, the registered manager had developed an action plan to address them. We looked at the action plan and saw the registered manager had addressed many of the negative comments. The registered manager told us the décor of the home was due be updated and was part of the 'Aden Mount development plan.'

We asked to see minutes from residents and relatives meetings held at the home. We saw evidence only one meeting for residents and relatives had been held at the home during 2015. During the inspection, we saw a resident and relatives meeting had been arranged for a date in January 2016. We asked the registered manager about the lack of formal minutes and evidence of meetings. They told us they often had feedback on an informal basis and through the review of care records.

The registered manager told us they recorded formal and informal complaints. We looked at the complaints and compliments file. We saw all complaints had been investigated within the time frame stated in the complaints policy. We did not see any evidence the complaints had been audited. This would give the manager an overall picture of the complaints made and pick up any patterns or trends. The people who

used the service knew what to do if they wanted to make a complaint or raise any concerns they may have. One person told us, "I would talk to the manager; [they] are easy to talk to." All of the visitors we spoke with told us they knew how to make a complaint if they felt it was necessary. One visitor told us, "I wasn't happy with the care and support [relative] was getting when they first moved in. I spoke to [registered manager] about this and things are much better."

In the bedrooms we looked at we saw a copy of 'how to make a complaint' was attached to the door. This showed the service was making efforts which ensured people were aware of how to share their concerns and make a complaint.

Good

Is the service well-led?

Our findings

People we spoke with knew who the registered manager was and felt they listened to them if they had any concerns. Visitors we spoke with felt the home was well managed.

Staff we spoke with felt supported by the registered manager; they felt they were easy to approach and to talk to. They felt the registered manager dealt with any staffing issues especially poor practice in an effective way. Staff had a sense of the culture and vision of the home.

We looked at the staff meeting minutes for 2015. Each meeting had an agenda and covered a variety of topics. Staff we spoke with told us they felt the meetings were a useful way to share information. When they could not attend meetings they read the minutes to keep themselves up to date. In addition to the staff meetings, the registered manager also attended meetings for the domestic staff, kitchen staff, night staff and managers meetings. This showed the registered manager communicated with the different members of staff and from the minutes we looked at it was clear the registered manager encouraged open and honest conversations within the meetings.

The registered manager carried out spot checks on night staff to ensure staff were keeping up the standards of care expected by the registered manager. The registered manager told us they walked around the home with the lead clinical nurse each morning. They felt this helped them identify issues and deal with them as they arose. During the inspection we saw the registered manager and the lead clinical nurse interacting with staff and people who used the service.

The registered managers' office was near reception and they had an 'open door policy'. They felt this was important for all people to feel they could approach them at any time. The registered manager understood their roles and responsibilities and how important it was they sent in notifications to the CQC and referrals to the local safeguarding team.

The home employed a maintenance person who carried out audits on health and safety issues including equipment check, fire safety checks, fire drills and water temperature checks. The housekeeper carried out weekly checks on mattresses. This showed people were being protected from the risk of harm because the service had taken steps which ensured any risk to people was minimised through regular safety checks.

We looked at the incident and accident records for 2015. We saw from November 2015 the registered manager had started to audit accidents and incidents. The registered manager told us since they had started to do this, they had identified people were most at risk of falling at certain hours of the night and had changed the way staff were allocated during the night shift. They told us they had seen a reduction in the number of falls since they had introduced the new system.

The registered manager told us they loved their job. They said, "It's more than a job it becomes a way of life." We asked them what they felt their challenges were over the coming months. They felt keeping good staff was a major challenge. They told us the team they had at the moment was a very good team of staff who

worked together very well. It was important for the registered manager to give good feedback to staff and encourage them in their work. They felt this helped keep the team motivated and keen to stay.

Training for staff was important to the registered manager. They had recently become responsible for the training budget and felt this would help them organise training for staff in a more effective way than before. The training would be a mixture of e-learning and face to face learning. They acknowledged that not all staff were computer literate and staff had to carry out the e-learning at home. They hoped the change to face to face training would be more attractive to staff.

The care records we looked at had been audited by the registered manager and the registered manager told us if there were any issues with the way the care records had been created or reviewed, they would address this with the member of staff responsible for the care record.

Through audits of food and fluid charts and daily records, the registered manager was aware of the inconsistency in the documenting of people's fluid and food intake. They told us they had addressed the issue of food and fluid intake charts many times with staff and had tried to install in them why it was so important to record how much people had to eat and drink through the day. They admitted it was very frustrating for them when staff did not follow their instructions. The registered manager told us they would keep addressing this with staff and ask them for suggestions on what would help them fill in the charts consistently.

When we spoke with the registered manager about the environment not being helpful or friendly for people with dementia, they acknowledged there was work to be done. They told us there were plans in place to update the décor of the home and they would include plans to make the home more dementia friendly.

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 12 HSCA RA Regulations 2014 Safe care and treatment People were not always protected from the proper and safe management of medicines. No record of controlled drug audits. Staff did not ensure people took their medication. Regulation 12 (1) (2) (g) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There was no signage around the home and there were no photographs on people's bedrooms doors to help them identify their room. Regulation 12 (1) (2) (d) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service did not maintain accurate, complete and contemporaneous record of people's food and fluid intake. Regulation 17 (1) (2) (c) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance.