Parkcare Homes (No.2) Limited

Devon House

Inspection report

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Date of inspection visit:
16 March 2016

Date of publication:
26 April 2016

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?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 16 March 2016 and was unannounced. Our inspection of 13 and 14 May 2015 found that people who lived at the home were not always supervised adequately by staff and there was a need to review staffing arrangements. We also found the home lacked a varied activities programme to provide social and therapeutic stimulation.

Devon House provides accommodation, nursing care and support with personal care for up to 11 people. At the time of our visit, 11 people lived there who needed support due to acquired brain injuries or neuro-disabilities.

The home had a registered manager, who was on leave during the inspection. A manager from another service assisted us with the inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Medicines were not managed safely. The provider did not have arrangements in place for the proper and safe management of medicines.

People were not always protected from risks associated with their support, as some risk assessments were not updated to reflect the person's current needs or did not consider their specific health needs. Some risk assessments did not provide clear guidance to staff on how to mitigate risks relating to skin breakdown and challenging behaviours

Staff supervision was not consistent and regular one to one meetings were not being carried out. Some staff had not received annual appraisals.

People were given choices during meal times and their needs and preferences were taken into account. Nutritional assessments were in place for most people, which included the type of food they liked and disliked. We found food was not being monitored for some people with specific health concerns to ensure they had a healthy balanced diet. People's weight was monitored. However, we did not see an action plan to indicate what staff should do if people lost weight or gained weight drastically.

People's rights to make decisions about their care and support were not protected. Staff had limited understanding of the Mental Capacity Act 2005 MCA and Deprivation of Liberty Safeguards (DoLS) despite undertaking an e-learning programme. Five people were being unlawfully deprived of their liberty as they were not free to leave the service premises and the provider had not sought appropriate DoLS authorisations on their behalf. Additionally, we found that people's capacity to make decisions about their care and support had not been assessed by the provider in accordance to the MCA principles, and best interest decisions made on their behalf, particularly relating to support with finances.

People were not involved in activities that would provide social and therapeutic stimulation.

Regular audits were not being carried out to identify shortfalls and make continuous improvements. We did not see documentary evidence that audits were being carried out on people's and staff records such as care plans, risk assessments and supervision that would have helped identified the issues we found during the inspection.

We did not see evidence of quality monitoring systems in place such as surveys and questionnaires to allow people and their relatives to provide feedback on the service and if improvements were required.

People told us they felt safe. Staff were trained in safeguarding adults and knew how to keep people safe. They knew how to recognise abuse and who to report to and understood how to whistle blow. Whistleblowing is when someone who works for an employer raises a concern which harms, or creates a risk of harm, to people who use the service.

Recruitment and selection procedures were in place. Checks had been undertaken to ensure staff were suitable for the role.

People were referred to other healthcare professionals to maintain good health.

Staff had received induction when starting employment and had received regular training to help provide effective care.

People were encouraged to be independent and their privacy and dignity was maintained. People were able to go to their rooms and move freely around the house.

Staff and resident meetings were held regularly.

We identified breaches of regulations relating to consent, medicine management, risk management, nutrition and hydration, person centred care and good governance. You can see what action we have asked the provider to take at the back of the full version of this report. After the inspection the provider sent us an action plan assuring us that improvements will be made.

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

Some aspects of the service were not safe.

Some risk assessments were not updated to reflect people's current circumstances and health needs.

Medicines were not being managed safely.

Staff members were trained in safeguarding and knew how to identify abuse and the correct procedure to follow to report abuse.

Recruitment procedures were in place to ensure staff members were fit to undertake their roles.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

People's rights were not being consistently upheld in line with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. The staff we spoke to had limited understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Supervisions and appraisals were not consistently carried out with staff.

People's weights were monitored. Records did not include information on what action staff should take if people lost weight. Food was not being monitored for some people with specific health concerns to ensure they had a healthy balanced diet.

Staff had undertaken mandatory training and had received the relevant induction.

People had access to healthcare and enjoyed the food at the home.

Is the service caring?

Good

The service was caring.

There were positive relationships between staff and people using the service. Staff treated people with respect and dignity.

People had privacy and staff encouraged independence.

Staff had a good knowledge and understanding on people's background and preferences.

Is the service responsive?

Requires Improvement

One aspect of the service was not responsive.

The home lacked a varied activities programme to provide social and therapeutic stimulation.

Care plans included information on people's care and support needs.

There was a complaint system in place. People using the service and relatives knew how to make a complaint and staff were able to tell us how they would respond to complaints.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led.

Quality monitoring systems were not in place to attain feedback from people and relatives about the service.

Regular audits were not undertaken to make continuous improvements.

Staff told us that the registered manager was supportive and approachable.

Staff and resident meetings were held regularly.

Devon House

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.

The inspection was carried out on 16 March 2016 and was unannounced. The inspection team comprised an inspector, a specialist advisor in nursing and a pharmacist inspector.

Before the inspection we reviewed relevant information that we had about the provider including any notifications of safeguarding or incidents affecting the safety and wellbeing of people. We also made contact with the local authority for any information they had that was relevant to the inspection.

During the inspection we spoke with nine people, three relatives, five staff members and the service manager from another service that assisted us in the registered manager's absence. We observed interactions between people and staff members to ensure that the relationship between staff and the people was positive and caring. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people when they may not be able to tell us themselves.

We spent some time looking at documents and records that related to people's care and the management of the home. We looked at nine people's care plans, which included risk assessments.

We reviewed ten staff files which included training and supervision records. We looked at other documents held at the home such as medicine records, quality assurance audits and residents and staff meeting minutes.

Requires Improvement

Is the service safe?

Our findings

People told us they were safe at the service and had no concerns. Two people told us when asked if they were safe, "Yes." Another person commented, "I like it here, I do feel safe." A relative told us, "He is safe here, he is cared for." Despite these positive comments we found that some aspects of the service were not safe.

Medicines were not managed safely. The provider did not have arrangements in place for the proper and safe management of medicines.

People relied on staff at the service to order, store and administer their medicines to them. Medicines were always administered by the nurse on duty. We looked at medicines records and medicines supplies for the 11 people at the service. Two people were in hospital on the day of the inspection. The GP had recently reviewed people's medicines and the service had recently changed their pharmacy supplier. Staff told us that the changeover had impacted on how medicines were managed.

Most medicines were stored safely in a locked trolley. However, medicines that required disposal or refrigeration were not stored safely. Two people were prescribed insulin. One of these people was prescribed two different types of insulin. The dose of insulin to be administered was not recorded on their medicines chart. The insulin pens in use were not labelled with their name, or the date of first opening therefore we could not tell if these insulin pens were still in date, as these pens needed to be discarded four weeks after first opening. We found that there were 87 insulin pens being stored in the medicines fridge, which was not kept locked. These insulin pens had been dispensed from April 2015. The fridge was not being monitored appropriately, to provide assurance that these insulin pens had been stored between 2-8 degrees centigrade to remain effective. Some medicines, which included sedatives for disposal were stored in an unlocked room, accessible to people and unauthorised staff. These were removed during the inspection.

Medicines records were not complete. For example, when people had allergies to medicines, these were not recorded on their medicines administration charts. The quantities of some medicines received into the service had not been recorded, which meant we could not audit whether these medicines were being used as prescribed. Two people's medicines charts did not list all of their current prescribed medicines. When people were prescribed a medicine with a variable dose, such as one to two tablets for each dose, the actual dose administered was not recorded. Some medicines were recorded onto medicines charts by nurses, and these charts were being used to administer medicines to people without a second check that these had been had been recorded correctly. Two medicines were not being given according to the prescriber's instructions with no explanation recorded. One tablet, for bone protection, was not given at the correct time in relation to other medicines, which may have affected how well this medicine worked. Another person prescribed the same weekly bone protection medicine had refused it all month, however there was no evidence that staff had informed the GP or had offered it on another day.

We checked how four prescribed creams were being used for one person. The application of their prescribed creams was not documented. The date of opening was not recorded on any of the prescribed creams. Two of the prescribed creams did not have dispensing labels. One person was on a pain patch. The patch site

required to be rotated every three to four weeks to reduce the risk of side effects. However, records were not kept of the patch site to evidence that the patch site was being rotated.

Controlled drugs were stored securely but the controlled drugs register entries were not clear. Some balances had been changed by overwriting, with no explanation, and the index for one controlled drug had not been updated since July 2015. As there was one nurse on duty, the witness for the administration of controlled drugs was usually a care worker, who had not received any training in medicines, or training in what they were supposed to be checking as a controlled drugs witness.

Nursing staff responsible for administering medicines had not had their competency checked, which was a requirement of the provider's policy. For medicines prescribed to be given as needed, or PRN, such as pain relief, there were no PRN care plans or protocols available to explain how and when these medicines should be used, which placed people at risk of not receiving adequate pain relief. We witnessed one person on the day of the inspection, prescribed PRN pain relief, who had requested it but was not given pain relief until 40 minutes later. Another person said they had not received adequate pain relief the week of the inspection and had called an ambulance. Their medicines chart showed that they could have received pain relief more often than it had been administered.

A prescription-only medicine was labelled as a homely remedy, and there was no stock record of when and for whom it had been used. Prescription-only medicines should not be labelled as homely remedies. Medicines were audited monthly, however although the audit template was comprehensive, the audits were not completed accurately. The audit had not picked up that the provider's policy or that current national medicines guidance were not being followed by staff.

We also found that people were not always protected from risks associated with their support. Risk assessments were carried out with people to identify risks and were regularly reviewed, however these were not always comprehensive or provide strategies for staff to mitigate the identified risks.

There were some assessments specific to people's individual needs such as financial, mobility, allergies and sensory abilities. However, when on occasions a risk was identified risk assessments did not provide clear guidance to staff on the actions they needed to take to mitigate such risks. For example, one person was at high risk of falling and was able to walk short distances. The risk assessment included that the environment should be kept clear but did not include what staff should do if the person fell or to ensure the person did not walk long distance without support and the type of support that was required.

We found that some risk assessments were not completed in full. For one person who, at times, displayed behaviours that challenged the service, risk assessments were not completed on how to mitigate risks, such as the steps to be taken to de-escalate situations.
Three people used a wheelchair and two people required hoist transfers. We did not see evidence that risk assessments had been completed in moving and handling and use of wheelchairs. Records showed some people had specific health concerns such as obesity and diabetes. Risk assessments were not completed to demonstrate the appropriate management of these risks in order to minimise them leading to serious health complications.

Skin integrity was assessed using Waterlow charts to determine risk levels. In two Waterlow charts, we found that people were at high risk and we did not find evidence of action plans and risk assessment that showed the appropriate management of these risks to reduce the risk of serious skin breakdown.

The above issues related to a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated

Activities) regulations 2014.

Staff were aware of the risks to people around moving and handling and how to respond to escalating health concerns. For people at risk of high cholesterol levels or diabetes, staff told us that if people were unwell or lost weight, then this would be monitored through a balanced diet and an appointment booked with a GP if required.

People using the service told us they were happy with the help they had from staff and told us that staff members provided support as expected. We observed staff providing some good care to people and in most instances assisted people when required promptly. However, we did observe on occasions there was lack of interaction with people. People were either looking at the television or by themselves while staff were completing tasks. In one instance, a person was calling staff for help and as staff were not nearby, we had to locate a staff member to assist the person. The home employed four care workers and a nurse during the day, which was then reduced to three care workers and one nurse at night. One person told us, "There are lots more staff now." The service was currently in the process of recruiting staff members and the vacancies were covered by agency and bank staff. Staff expressed concerns on using bank staff as they may not have the required knowledge to support people. The service manager told us that recruitment was taking place and permanent staff would be employed at the service and the use of bank staff would reduce.

Staff had undertaken appropriate training in understanding and preventing abuse and up to date training certificates were in staff files. Staff were able to explain what safeguarding is and who to report to. Staff also understood how to whistle blow and knew they could report to outside organisations such as the Care Quality Commission.

Staff files demonstrated the service followed safer recruitment practices. Records showed the service collected references from previous employers, proof of identity, criminal record checks and information about the experience and skills of the individual. Staff members were not offered a post without first providing the required information to protect people from unsuitable staff being employed at the home. This corresponded with the start date recorded on the staff files.

Risk assessments and checks regarding the safety and security of the premises were up to date and had been reviewed. This included a fire safety policy, fire risk assessments, monthly evacuation drills and weekly fire tests for the home. The provider had also made plans for foreseeable emergencies including a personal emergency evacuation plan for each person at the home, which included details on people's mobility, visual and hearing abilities. Staff were able to tell us what to do in an emergency, which corresponded with the fire safety policy.

We saw evidence that demonstrated appropriate gas and electrical installation safety checks were undertaken by qualified professionals. Checks were made in portable appliance testing and hot water temperature to ensure people living at the home were safe.

Staff told us they had not used physical intervention to manage behaviours which challenged the service. Records showed staff had been trained in handling behaviour that challenged the service. They described how they used de-escalation techniques such as providing reassurance, talking in a calm manner and taking people outside to minimise the risk of harm to people and staff.

Requires Improvement

Is the service effective?

Our findings

People told us that staff members were skilled and knowledgeable. One person told us, "Staff know how to help me." Another person commented, "They look after me well." A relative told us, "The staff here are skilled and knowledgeable." Despite these positive comments we found that some aspects of the service were not effective.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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

We checked whether the service was working within the principles of the MCA.

Training in the MCA and DoLS had been provided. However, the staff we spoke with had limited knowledge of the MCA and how the principles were used to determine if people had capacity to make decisions. Staff also had limited knowledge on DoLS. The MCA and DoLS training was done online and staff requested that this area of training to be done in a class room. One staff member told us, "I do not really understand online, but we have to do it. I would rather a session or someone talking to me."

People's personal profiles showed they had capacity to make decisions about their care and treatment. However, we did not see forms that showed how capacity was assessed especially in relation to whether the person could understand, retain, and weigh the information, about the decision that needed to be made. The home managed seven people's finances. However, we did not see capacity assessments or best interests evidence that stated that the people were unable to manage their own finances. Some of the people required supervision when going outside and we did not see if the assessments checked if people had capacity to make that decision.

We saw that the front door was kept locked and most people did not go out. Staff told us most people were not allowed to go out without a staff or relative accompanying them due to risks to their safety. We found that DoLS applications had been made for two people who used the service. However, we noted that DoLS application had not been made for five people who they felt were unable to safely go out alone and therefore this meant that people may have been unlawfully deprived of their liberty.

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

Staff told us they always asked for consent before providing care and treatment. One comment included, "We do ask for consent." People confirmed that staff asked for consent before proceeding with care or treatment.

Nutritional assessments were carried out for some people, which included what type of food people liked and disliked. However, we did not see that nutritional assessments were carried out on most of the files we looked at. Some people had high cholesterol and diabetes and we saw people's weight was being monitored regularly. However, the records that were in place did not include information on what action staff should take if people were losing weight or gained weight drastically. In one care plan we found that the person had weight issues but we did not see what actions had been taken to ensure the person had been supported to maintain a stable weight.

We noted that some people had diabetes and weight issues. However, we did not see documentary evidence that food intake was monitored or recorded which showed the types of food that were consumed by people and the amount that was eaten to ensure people were on a balanced diet to avoid serious health complications. The home completed monthly malnutrition charts for people to ascertain if people were at risk of malnutrition. We found that malnutrition charts were incomplete for two people that may be at risk of malnutrition. We fed this back to the service manager and the nurse on duty, who assured us that food intake charts and malnutrition charts will be completed for these people.

This was a breach of regulations 14 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

Staff told us they were supported by the registered manager and if they needed support, that this was provided. However, out of the ten staff records we looked at, supervisions were inconsistent and irregular for five staff members. For example, one staff member had commenced employment on January 2015, the supervision was carried out once in February 2016 and we did not see evidence that yearly appraisal was carried out for this staff member. For another staff member who started employment in 2004, we found that supervision was carried out once during 2015 and the last appraisal that was carried out was in March 2014.

We recommend that systems are in place to carry out supervisions and appraisals for all staff members.

Records showed that people had been referred to healthcare professionals such as the GP, district nurse and dietitian. Outcomes of the visits were recorded on people's individual records along with any letters from specialists. Records showed that people were supported to go to hospital when needed and referrals were made to other healthcare professionals when required. Staff confirmed people had access to healthcare professionals particularly if they were unwell. They gave us examples of where they were able to identify if the person was not well, and take the person to the GP and records confirmed this. One person told us, "I go to hospital, staff help."

Most of the people told us that they enjoyed the food at the home and if they wanted more food, this was provided. A person commented, "I love the food". Another person commented, "Food is usually good." However, two people and one relative told us that people were not offered choices during mealtimes. We did not see records that showed what meals were served to people. We fed this back to the service manager who assured us that people's preferences were taken into account and this would be recorded. The staff who prepared the meals had good knowledge about people's individual dietary needs and preferences. The staff told us that views were sought from people about mealtimes and no concerns had been raised from people. Observations showed that people were given different meals during meal times and these were varied, nourishing and fresh.

We conducted a Short Observational Framework (SOFI) during lunch time. A SOFI is a way of observing people and their interactions when they may not be able to tell us themselves. We saw that two people who needed support when eating were assisted. However, staff did not explain what they were doing and did not interact with the people when assisting them with their meals. We saw a person that demonstrated some form of challenging behaviour and refused to eat. Staff used de-escalation techniques to keep the situation calm, speaking to the person in a calm and relaxed tone and outlined the importance of eating their meal in such a way that ensured the person calmed down and ate their meal. People were not rushed and did not raise any concern during the meal time with staff and their meals were placed within their reach.

Staff confirmed they completed an induction when they first started working in the service. This included working alongside more experienced staff members for a period of time to get to know people and their needs and reading peoples care plans. Staff had induction training before they started working at the service. Staff had undertaken training such as infection control, fire safety, basic life support, person centred care and moving and handling. The service had systems in place to keep track of which training staff had completed and future training needs. Staff told us that they had easy access to training and had received regular training.

Good

Is the service caring?

Our findings

People were relaxed and at ease with staff. Most people told us they liked the staff and staff spoke of people with affection and respect. A staff member told us, "I like looking after them." Relatives told us that they had no concerns about the staff. One relative commented, "They [staff] are very nice, very friendly." One person told us, "They [staff] are very nice." We saw people were well dressed and presented.

Staff told us they built positive relationships with people by spending time and talking to them regularly. We saw staff chatting with people engaging in meaningful conversations such as asking how people were and about their upcoming birthday. One relative told us, "He does like it here." A person told us, "I receive good care here, I like it. I got a hug when I was sad."

Staff had a good understanding about the people they cared for in line with their care and support arrangements. Staff members were able to tell us about the background of the people and the care and support they required. They described people's behaviours, likes and dislikes and health conditions. Relatives and people confirmed staff had a good understanding to provide care. One relative told us, "He is well looked after here." One person commented, "Staff know how to help me."

Staff supported people to be independent in their day-to-day lives. Staff members told us people were encouraged to be independent, one staff member commented, "We encourage independence." Observation confirmed staff encouraged people while supporting them. We observed people were able to move around independently and go to the lounge, dining area, toilets and hallways if they wanted to. A person commented, "They help me do things by myself."

Staff told us that they respected people's privacy and dignity. People could freely go into their rooms when they wanted to and close the door without interruptions from staff and people. A staff member told us, "We knock on doors." A person told us, "They give me privacy and close the door when supporting." Observations confirmed staff knocked on people's door before entering. Staff told us that when providing particular support or treatment, it was done in private and we did not observe treatment or specific support being provided in front of people that would had negatively impacted on a person's dignity.

The service had an equality and diversity policy. We observed that staff treated people with respect and according to their needs such as talking to people respectfully and in a polite way. One person commented, "The staff are lovely here." During the inspection we saw pictures that showed the home celebrated Christmas with people. Records showed that people's identity and religion were recorded and their dietary needs and preferences were recorded. Observations also confirmed that a person's dietary preference was being followed to accommodate their religious beliefs.

Care plans listed how to communicate with people. For example, one person's plan listed that the person speaks slowly and for staff to take time to listen to the person. Care plans provided detailed information to inform staff on how a person communicated and listed people's ability to communicate.

People had contact with family members and details of family members were recorded on their care plans. We observed pictures of people with their family members in their rooms. We saw relatives visiting their family member and the relatives confirmed that they could visit anytime.

Requires Improvement

Is the service responsive?

Our findings

People told us that staff provided the right support and responded appropriately and on time when support was required. One person commented, "Staff generally listen, they are friendly." Another person told us, "I find it difficult to eat, they [staff] help me." Records showed that a person preferred only a male carer to support them; observations and staff confirmed that the person was only supported by a male carer. Despite these positive comments we found that one aspect of the service was not responsive.

At our last inspection on 13 and 14 May 2015, we found that social or therapeutic activities did not take place when we were there. During this inspection we saw that there was an activities notice board that showed people celebrated Christmas and the activities that was planned for each day. However, most people and relatives we spoke to told us that people were bored and activities were not regular. One relative told us, "Not seen a lot of activities, one thing I do not agree with" and another relative commented, "No activities, what is there to do?" There was an activities planner in people's care plans. However, this section was blank and we did not see evidence of what activities people participated in.

Records did not show any involvement with other local services. We observed on occasions there was lack of staff interaction with people. We observed on one occasion a member of staff showing communication cards to a person. However, the staff member only showed the card to the person and there was no interaction and dialogue with the person by the staff member. When we spoke to the staff member on the meaning behind why this activity took place, the staff member was unable to provide a sufficient response. People told us that they wanted to go out but were not taken out regularly. One person told us, "We have not been out in the garden for ages."

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

Records showed pre-admission information had been completed. An assessment was carried out to identify people's support needs and included information about their medical conditions, behaviour, communication and their daily lives.

Each person had an individual care plan which contained information about the support people needed. We found that people had input into the care plans and choice in the care and support they received. Care plans were signed by people to ensure they agreed with the information in their care plan. Care plans we reviewed had a personal profile outlining the person's support needs, next of kin, identity and religious beliefs. Care plans also contained information such as the person's medical history, health information, communication and care needs. These plans provided staff with information so they could respond to people positively and in accordance with their needs. There was a 'life story sketch' for people providing information on their background and upbringing and a section on "what would you like staff to know about you in order to make you feel comfortable" listing significant events that were important to them.

There was a key worker system in place. A key worker is a staff member who monitors the support needs

and progress of a person they had been assigned to support. In most cases reviews were undertaken regularly with people, which included important details such as their current circumstance and if there were any issues that needed addressing. However, we found the key worker section for three people's records we looked at was incomplete. People and staff told us that people were involved in care planning and reviews. One relative told us, "I signed and have a look at care plans."

There was a daily log sheet and staff handover record, which recorded key information about people's daily routines such as behaviours and the support, provided by staff. Staff told us that the information was used to communicate between shifts on the care people received during each shift.

There were procedures in place to handle complaints. The policy provided people who used the service and their representatives with clear information about how to raise any concerns and how they would be managed. People and relatives knew how to make complaints and staff were able to tell us how they would respond to complaints.

Requires Improvement

Is the service well-led?

Our findings

People told us they enjoyed living at the home. One person told us, "I enjoy living here" and another person commented, "I like it here." Staff told us they enjoyed working at the home. One staff member said, "I enjoy working here." A relative told us, "He does like it here." We observed people interacted well with each other, chatting and laughing. Staff told us the culture within the home was like a family.

The service had some systems in place for quality assurance and continuous improvements. The registered manager undertook spot checks to ensure high quality care was being delivered and people were being treated with respect. We saw that audits were carried out in medicines and an audit was undertaken by a service manager from another service on October 2015 that highlighted areas that required improvements under the CQC's five domains. The systems in place enabled the registered manager to identify and address shortfalls and continually improve the service for people if required. However, we did not see documentary evidence that audits were being carried out on people's and staff records such as care plans, risk assessments and supervision that would have helped identify the issues we found during the inspection.

We did not see evidence that the service had a quality monitoring system which included surveys for staff, people and relatives. Quality monitoring systems are important to ensure staff, people and relatives are able to provide feedback about the service in order to make required improvements and identify best practises to ensure high quality care is being delivered.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

Monthly staff and residents meetings enabled people who used the service and staff members to provide a voice and express their views. Resident meeting minutes showed people discussed food, privacy and staff approach. Comments from people included, "Carers are good" and "Hope they let me stay." Staff meeting minutes showed staff discussed call bells, respect and about the people living at the service.

Both staff and people were positive about the registered manager, one person commented, "She is lovely, she is really helpful." One staff member commented, "She is good, she is excellent." Relatives were happy with the management at the home. One relative told us, "She is lovely, really good, terrific."

Staff told us that they were supported by the registered manager and were comfortable to contact the registered manager when needed. One staff member told us, "She is very supportive" and another commented, "She is the best manager."

The service's vision and values was to provide high quality care and to be fair and equal, treating everyone with respect. Staff told us that vision and values were communicated in staff meetings and supervisions.

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 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	Assessments of the needs and preferences for care and treatment were not carried out in full for people that used the service to cater for their emotional and social needs. (Regulation 9(3)(a))

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	Care and treatment was not always provided with the consent of the relevant person as the registered person was not always acting in accordance with the Mental Capacity Act 2005. (Regulation 11(1)(3))

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The service provider was not providing care in a safe way as they were not doing all that was reasonably practicable to mitigate risks to service users (Regulation 12(2)(b))

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs
Treatment of disease, disorder or injury	In order to reduce the risk of harm from malnutrition or unexpected weight loss the

service should ensure that they appropriately record diets and take action at the right time to keep people in good or the best of health.(Regulation 14(4)(a))

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Quality monitoring systems were not in place to encourage feedback from people and relatives about the quality of care for the purpose of continually evaluating and improving services. (Regulation 17(2)(e))

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The service provider was not providing care in a safe way as they were not doing all that was reasonably practicable to ensure the safe management of medicines (Regulation 12(1)(2)(a)(b)(g)

The enforcement action we took:

Warning Notice