Solent View Care Home Limited

Solent View Care Home

Inspection report

41-43 Victoria Grove
East Cowes
Isle of Wight
PO32 6DL
Tel: 01983290348

Date of inspection visit: 24 & 27 July 2015
Date of publication: 16/09/2015

Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Inadequate

Overall summary

This inspection took place on 24 and 27 July 2015 and was unannounced. During the inspection, we followed up on breaches of regulations we had identified at a previous inspection on 22 September 2014. These related to: care and welfare; safeguarding; assessing and monitoring the quality of service; and notification of incidents. We set compliance actions and the provider sent us an action plan telling us they would meet the requirements of the regulations by 28 February 2015.

At this inspection, on 24 and 27 July 2015, we found action had been taken and some improvements had been made, but the provider was still not meeting all fundamental standards of care and safety.

The home provides accommodation for up to 19 people, including people living with dementia. There were 19 people living at the home when we visited.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.

Staff had received training in safeguarding adults. However, we identified three occasions when a person with dementia care needs had been abused by other people living in the home. The incidents were not reported to the local authority, in accordance with local safeguarding protocols, or to CQC as required by law. This meant action was not taken to ensure an effective protection plan was put in place to safeguard the person from further abuse.

Records showed that people who were asleep at medicine rounds did not receive important prescribed medicines. There was a lack of information about medicines that people were prescribed "as required" and a medicine that should be given before food was sometimes given with or after food. There was also a lack of information to help staff identify when people who could not verbalise their pain needed pain relief.

People's safety was compromised in some areas. Required actions from fire safety risk assessments had not been completed and staff were not able to take appropriate safety measures in the event of a fire. Three staff members were not able to open side gates in the event of a fire, as they did not know the code to the key safes. First floor window restrictors were not in place to protect people from falling. This compromised people's safety.

Staff sought verbal consent from people before providing care, but did not follow legislation designed to protect people's rights and ensure decisions taken on behalf of people were made in their best interests.

The provider had introduced a series of audits and had improved their quality assurance systems. However, these had not picked up the issues we identified relating to the quality and safety of the service provided. The registered manager and head of care had not ensured their practice was up to date. They were not familiar with current regulations and relevant guidance, although people and staff praised the management of the home, describing them as "approachable". There were good working relationships with external professionals.

People were attended to promptly and there were enough staff to meet people's needs at most times. The provider was reviewing the staffing levels in the evenings, following a recent reduction from three to two staff at these times. The process used to recruit staff was safe and appropriate checks were conducted before new staff started working at the home.

Individual risks to people were assessed, documented and managed effectively, including risks to people of developing pressure injuries or being scalded.

Records showed most staff were suitably trained, apart from one member of night staff who had not been trained in safe moving and handling techniques.

Most people were satisfied with the quality and choice of food. They received a choice of suitably nutritious meals and were appropriately supported to eat and drink. People had access to healthcare services, including doctors, nurses and specialists.

People were treated with kindness and compassion. Interactions between people and staff were positive, friendly and respectful. When people became upset, they were comforted by staff who knew them well and were skilled in giving reassurance. Their privacy was protected and staff made sure people were compatible before they were invited to share double rooms.

People received personalised care from staff who supported them to make choices and were responsive to their needs. Care plans were detailed and reflected people's current needs. These were reviewed regularly in consultation with people and their families.

An activity coordinator supported people to engage in a range of activities suited to their individual needs, including group and one-to-one sessions. Feedback was sought from people and action taken to address any concerns.

We identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have taken at the back of the full version of the report.

Following the inspection we discussed our concerns with the Isle of Wight Council's safeguarding adults team.

Summary of findings

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action.

Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

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?
The service was not safe.

The provider did not respond appropriately to incidents of abuse. People did not always receive their medicines as prescribed and when needed.

Staff could not open side gates in the event of a fire. First floor window restrictors were not in place to protect people from falling.

People told us there were enough staff to meet their needs. Recruitment procedures were safe.

Inadequate

Is the service effective?
The service was not always effective.

Staff did not follow legislation designed to protect people's liberty and rights.

Most staff were suitably trained and received appropriate support to perform their roles effectively.

People received a choice of nutritious meals and were supported to eat and drink enough. They had had access to appropriate healthcare.

Requires improvement

Is the service caring?
The service was caring.

People were treated with kindness and compassion. They received comfort and reassurance when upset from staff who made them feel listened to.

Staff were skilled at building positive relationships with people and people's privacy was protected.

People were involved in planning their care and family members were kept up to date with any changes.

Good

Is the service responsive?
The service was responsive.

People received personalised care that was responsive to their needs. Care plans were detailed and reviewed regularly to ensure they met people's individual needs.

An activity coordinator supported people to engage in activities suited to their interests.

People's view were sought and action was taken to address any concerns.

Good

Is the service well-led?
The service was not well-led.

Inadequate

Summary of findings

The provider did not notify CQC of incidents of abuse. Fire safety deficiencies had not been addressed.

A series of audits had been introduced but had not been effective in ensuring compliance with the regulations.

The registered manager and head of care were not up to date with current regulations and best practice.

There was a clear staffing structure in place and staff felt valued. There was an open and transparent culture within the home.

Solent View 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 24 and 27 July 2015 and was unannounced. The inspection team consisted of an inspector and an expert by experience 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, the registered manager completed 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. We also reviewed information we held about the home including previous inspection reports, the provider's action plan and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with nine people living at the home and two family members. We also spoke with the registered manager, the head of care, six care staff, the activities coordinator, the cook, the cleaner and the maintenance person. We looked at care plans and associated records for seven people, staff duty records, staff recruitment files, records of accidents and incidents, policies and procedures and quality assurance records. We observed care and support being delivered in communal areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Following the inspection we received feedback from the local authority commissioning unit, a community nurse, a consultant from the Memory Service and the local authority team responsible for assessing applications to restrict people's liberties.

Inadequate

Is the service safe?

Our findings

At our inspection on 22 September 2014 we found not all staff had been trained in safeguarding adults from abuse. The provider had not responded appropriately to incidents of abuse between people living at the home by reporting them to the local authority safeguarding team. We set a compliance action and the provider sent us an action plan saying they would be meeting the regulations by 28 February 2015.

At this inspection we found staff had received training in safeguarding adults. They said they would have no hesitation in reporting abuse to the management and were confident senior staff would act on their concerns. However, we identified three occasions when a person who was unable to give valid consent had been sexually abused by other people living in the home and the management had not responded appropriately. The person's doctor had been contacted, who referred the person to a consultant psychiatrist. A plan had been put in place to protect the person. However, the plan had not been effective in preventing further abuse and the local authority had not been notified of the incidents in accordance with local safeguarding adults protocols. This meant they were not able to investigate the incidents and ensure an effective protection plan was developed to safeguard the person from further abuse.

The continued failure to respond appropriately to incidents of abuse was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When the above person saw a consultant from the Memory Service, they were prescribed a new medicine. However, medication administration records (MAR) showed the person had not received this medicine on five occasions in the two weeks prior to our inspection. Staff told us this was because the person was asleep at the time of the medicine round. The consultant had asked staff to monitor and report back to them about the effects the medicine had had on the person. They told us staff had not done this, so they had not been able to review its effectiveness. We also identified other medicines that this person and other people had not been given due to them being asleep at the medicine round, including heart medicines. This put people's health at risk. The provider's medicines policy did not include guidance about what to do if a person was asleep at the time of the medicines round. We discussed this with the registered manager, who agreed that the medicines should have been given later, when people were awake.

Staff were aware of how and when to administer medicines to be given 'as required' (PRN), for example to relieve anxiety. However, recorded information about when these should be administered was not sufficient to ensure people received them in a consistent way. Where a variable dose was prescribed, there was no information available for staff about what dose to give. One medicine, which should be given half an hour before food, was often given with or after food, so may not have been effective. Some people who were living with dementia were unable to communicate when they were in pain. Information was available to help staff identify when these people needed pain relief, but this was generalised and an assessment tool was not being used to assess people's individual need for pain relief.

At our inspection on 22 September 2014, we identified that staff had not received fire safety training and personal evacuation plans had not been developed for people. At this inspection we found staff had been trained in fire safety and personal evacuation plans were in place. However, three staff members did not know the code needed to access keys to the side gates of the home. In the event of a fire, they would not have been able to unlock the gates and evacuate people through this route.

The Health and Safety Executive (HSE) provides guidance to care home providers about the risks of people falling from windows. This recommends that control measures, such as window restrictors are fitted to windows which people could fall through and are at a height that could cause harm. We found some windows, in people's bedrooms on the first floor of the home, did not have restrictors in place and could be opened fully. This put people's health and safety at risk.

The failure to ensure people received medicines as prescribed and when needed; the inability of staff to open fire safety gates; and the failure to protect people from the risk of falling through windows were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe and there were enough staff to meet their needs at all times. One person said, "I love it here. I don't have any worries at all."

Inadequate

Is the service safe?

We observed people being attended to promptly throughout the inspection. The provider determined the staffing levels by seeking feedback from people and staff on a regular basis. The staffing levels from 4:00pm to 10:00pm had recently been reduced from three to two care staff. The registered manager told us this was as a result of feedback from staff who felt they could manage with fewer staff. They said the needs of people living at the home had reduced and some tasks that care staff used to perform in the evenings had been moved to other times. Two people, who had been on respite care, left the home during the inspection, thereby reducing the number of people being cared for to 17.

We received mixed views from staff about these changes. Three members of care staff told us the new staffing levels were adequate; but three told us they did not think they were safe. They felt people at risk of falling could not be monitored effectively and two people occasionally displayed behaviour that was inappropriate or challenging to staff. One staff member said, "It was cut because it went quiet and it was OK for a while, but people are becoming more needy now." However, another member of staff told us "The reduction in numbers is fine as residents are less demanding now." The registered manager was in the process of reviewing the new arrangements and assured us the number of staff in the evening would be increased if this was necessary to ensure people's safety.

Records showed the process used to recruit staff was safe and helped ensure staff were suitable to work with the people they supported. Appropriate checks, including references and Disclosure and Barring Service (DBS) checks were completed for all staff. DBS checks identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. Staff confirmed this process was followed before they started working at the home.

The risk of people falling while mobilising around the home was assessed. Where needed, fall saving equipment was in people's reach at all times and staff encouraged people to use it correctly. Before people were bathed, the temperature of the water was checked and recorded to prevent people from being scalded. Pressure relieving cushions and mattresses were in place to protect people from the risk of developing pressure injuries.

Requires improvement

Is the service effective?

Our findings

At our inspection on 22 September 2014 we found staff were not following Mental Capacity Act, 2005 (MCA) or protecting people's rights by following Deprivation of Liberty Safeguards (DoLS). We set a compliance action and the provider sent us an action plan saying they would be meeting the regulations by 28 February 2015.

At this inspection we found staff sought verbal consent from people before providing care, but did not follow MCA or its code of practice. The MCA provides a legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision should be made involving people who know the person well and other professionals, where relevant. Some people living at the home had a cognitive impairment. Decisions had been made about people's care, the administration of medicines and the use of bedrails to stop them falling out of bed. However, people had not had their capacity assessed in relation to these decisions, and relevant people, such as family members, had not always been consulted to make sure the decisions were in people's best interests. Staff had received training in MCA but were not clear about who was responsible for conducting capacity assessments.

The provider had introduced a 'consent to care' form which some people had signed to indicate their agreement with the care and support detailed in their care plan. However, where people had not signed the forms, there was no evidence they had agreed to their care. In one case, the form had been signed by the relative of the person who did not have legal authority to make decisions on behalf of the person. In another case, the form had been signed by a person who was registered blind who told us they were not able to read it. The registered manager had completed a best interests decision on behalf of one person in relation to their ability to consent to intimate relationships. However, the MCA excludes such decisions from being made. This showed a lack of understanding of the MCA and its code of practice.

The continued failure to follow the MCA and its code of practice was a repeated breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. The local authority DoLS assessor had sent the provider information about a Supreme Court Judgement which widened and clarified the definition of a deprivation of liberty and given advice about when applications were required. However, DoLS applications had not been made for any of the people living at the home. We identified two people that the Supreme Court Judgement may have applied to, for whom applications should have been considered. They were not permitted to leave the home without being accompanied by staff and were subject to constant supervision and control whilst in the home as they were at risk of harming themselves or others. Their liberty was being restricted without the relevant legal authority.

The continued failure to follow deprivation of liberty safeguards was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Training records showed most staff were suitably trained and had completed a wide range of courses relevant to their roles. However, one member of night staff, who had been employed for six months, had not been trained in safe moving and handling techniques. This put them and people they were supporting, at risk of harm. Other staff praised the quality and availability of training. They told us that they could ask for any training that would benefit people and the management would try to provide it. For example, six staff had requested, and were currently following, a training programme in end of life care. In addition most staff had completed, or were undertaking, vocational qualifications in health and social care. Staff had recently received tissue viability training from a specialist nurse to help prevent people's skin from breaking down. A community nurse told us this had been successful and had led to a reduction in skin breakdown. They said, "Staff notify us early [of signs of skin breakdown] and follow our advice".

Staff were well-motivated and told us they felt valued and supported. They received regular supervisions and yearly appraisals. Supervisions provide an opportunity for

Requires improvement

Is the service effective?

managers to meet with staff, feedback on their performance, identify any concerns, offer support, and discuss training needs. One staff member said, "[Supervisions] are really good. We talk about my work and develop an action plan".

All but one person were satisfied with the quality and choice of food. One person said, "The food is good and there's plenty to eat." Another person said of the cook "She does try to find out our likes and dislikes. She makes lovely dumplings as she knows I like dumplings". Care plans included nutritional plans, which the cooks were aware of and followed. People were offered a choice of suitably nutritious meals appropriate to the seasons and ingredients used were of a high quality. Alternatives were offered if people did not like the menu options of the day. For example, one person requested a salad and received this. Drinks were available throughout the day and staff prompted people to drink often. People were encouraged to eat and staff provided appropriate support where needed, for example by offering to help people cut up their food. One person declined their lunch even after being offered support and encouragement. Staff then refrigerated the meal so it would be available if they chose to have it later. Special diets, including high calorie supplements were available for people who required them. People received portion sizes suited to their individual appetites. Staff monitored the food and fluid intakes of people at risk of malnutrition or dehydration and took prompt action when people started to lose weight.

People were supported to maintain good health and had access to appropriate healthcare services. Healthcare professionals such as doctors, community nurses and chiropodists were involved in people's care where necessary. Records were kept of their visits as well as any instructions they had given regarding people's care.

Good

Is the service caring?

Our findings

People were treated with kindness and compassion. One person told us “I love it here; they’re really good to me.” Another person said of the staff, “They've all been very good here".

Comments made by people in a recent survey by the provider included: “Since I’ve been here there’s been nothing but kindness and caring”; and “[The staff] are all very kind”. A third person said, “The care is very kind; they can't do enough for you." Two people told us that if they woke in the night, staff offered them a hot drink and a snack, which they appreciated.

Interactions between people and staff were positive, friendly and respectful. Staff smiled as they went about their work and used touch appropriately. When people became forgetful or upset, they were comforted warmly by staff who understood them well and were able to empathise with their situation. Staff used facial expressions, body language and touch to reassure people and make them feel listened to. Details about people’s lives and background were recorded in their care plans and staff used this knowledge to help build positive relationships. For example, they knew one person liked a particular type of music and had obtained some of this to play to the person. Staff spoke fondly of the people they cared for and said they developed “a good bond” with them.

Some people found it reassuring to carry a comforting object around with them. Staff told us they washed the items when people were asleep, to ensure they always had them with them when they were awake. When supporting people with visual impairments, staff took time to explain things they were unable to see clearly. For example, at meal times, staff described the food and named the people who were sat around them. This showed consideration and understanding for people.

A care manager told us of two occasions when people with complex dementia care needs had been distressed and anxious on admission, but had quickly settled down and become calm. In one case, they said the registered manager had “worked magic” in encouraging a person to accept the help they needed. They told us the registered manager “went out of his way to buy food that would keep [the person] happy” and they were “very grateful for his skills”. The care manager also praised staff, saying they were “impressed by how thoughtful they were about [the person’s] needs, and how quickly they got to know them”.

We heard conversations between staff members and people, where they talked about each other’s families and interests, showing they knew people and their backgrounds well. People’s bedrooms were personalised with photographs and items important to them. Staff used these as prompts to promote conversation and learn more about people. This helped build positive relationships.

Staff ensured people’s privacy was protected by speaking quietly and making discreet use of blankets or screens, so people’s dignity was not compromised. When they received treatment from visiting health professionals, this was carried out in the privacy of their rooms. All bedrooms had locks which people could use if they chose to and staff knocked on people’s doors and waited for a response before entering. Two bedrooms were shared rooms and staff described how they ensured people were compatible before being placed together. People in the shared rooms told us they were “very happy” with the arrangements.

When people moved to the home, they (and their families where appropriate) were involved in discussing and planning the care and support they received. Care was reviewed on a monthly basis or when people’s needs changed. Any changes were discussed with people. One person said, “Oh yes, they discuss [my care plan] with me regularly”. Family members told us they were always kept up to date with any changes to their relative’s condition.

Good

Is the service responsive?

Our findings

At our inspection on 22 September 2014 we found continence care plans were not personalised. There was a lack of activity provision and there was no system in place to seek feedback from people. We set a compliance action and the provider sent us an action plan saying they would be meeting the regulations by 28 February 2015. At this inspection, we found these areas had been addressed effectively.

People received personalised care from staff who supported them to make choices and were responsive to their needs. One person said of the staff, "I'm very happy with everything they do." Another person told us "All the [staff] are OK; they look after me well." A further person told us they were free to choose where they spent their day. They said, "I can go downstairs if I want or I can stay up here if I want to".

Initial assessments of people's needs were completed using information from a range of sources, including the person, their family and other health or care professionals. A care plan was then developed to meet the person's individual needs. A care manager described the care plans they had seen as "very professional and detailed" and said people placed there had "a personalised experience". The care plans were reviewed regularly by the head of care, in consultation with people and their families (where appropriate). Records showed the reviews were effective in identifying and implementing changes promptly. A community nurse told us staff "show a lot of interest when people start to deteriorate and contact us quickly [for support]".

Care plans reflected how people wished to receive care and support and recorded people's preferences and choices. For example, they contained detailed information about when people preferred to get up and go to bed, how they liked to receive personal care and what activities they wished to take part in. People told us staff followed the care plans and respected their wishes. Staff understood people's individual continence needs, promoted their independence and supported them appropriately.

People had access to a range of activities. An activity coordinator supported people to engage in activities on weekdays. They had started to identify people's individual interests and were tailoring events and activities to meet their individual needs. For example, one person told us they enjoyed going out for trips in the home's minibus. Another person sometimes chose to help with household chores. We observed an over-sized board game in progress which, judging from people's reactions and comments, they enjoyed. If people chose not to engage in group activities, the activity coordinator spent time with them on a one-to-one basis talking about subjects of interest to them or reminiscing about their lives. A person with a visual impairment told us "Once a week somebody reads a story to me."

The provider conducted quality assurance surveys twice a year to obtain people's views about the service. The activity coordinator supported people to complete the surveys, where needed, and reported the results anonymously to the registered manager. Comments from the latest survey showed some people were dissatisfied with the laundry arrangements. The registered manager had responded to this by discussing it at recent staff meetings and reminding staff of the correct procedures. All other feedback was positive and included comments such as: "I don't think I could get better service; I'm quite content"; and "I love it here".

A complaints policy was in place and people told us they knew how to complain. One person said, "I'd just talk to the manager and he'd sort it out." Another person told us "I have no complaints about the staff at all." Records confirmed that no formal complaints had been received since our last inspection.

Inadequate

Is the service well-led?

Our findings

Providers are required by law to notify CQC without delay of certain incidents which occur. These include deaths, serious injuries, and allegations of abuse of people. At our inspection on 22 September 2014 we found the provider had not sent us notifications about incidents of physical abuse. We set a compliance action and the provider sent us an action plan stating they would ensure all relevant incidents were notified in the future.

At the time of this inspection, our records showed that all deaths and serious injuries to people had been notified as required. However, the provider had not notified CQC about three incidents of sexual abuse that were recorded in people's care records between March and June 2015. The provider was not complying with their statutory duty. As a consequence, CQC was not able to monitor incidents of abuse and take appropriate regulatory action to ensure people were safe.

The continued failure to make statutory notifications when required was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

At our inspection on 22 September 2014 we also found the provider's quality assurance processes were not effective and a fire safety risk assessment had not been completed. At this inspection we found a fire safety risk assessment had been completed by a specialist contractor in March 2015. The contractor had identified 19 'deficiencies' which required action, 16 of which were shown as 'high priority'. These included additional signage, removing coats from a lift control cupboard and ensuring external side gates could be opened without a key. The registered manager was not aware of these deficiencies, so none of them had been addressed. This compromised people's health and safety.

The provider had introduced a series of audits and improved the way they monitored the quality and safety of the service. However, these had failed to ensure compliance with the regulations. For example, an environmental audit was conducted each month, which showed window restrictors were in place on all first floor windows. This was not the case, so the audit was not accurate. Medicines were audited each month which had helped ensure that people's medicines were always in stock and were stored safely. They had identified the need to change the times some medicines were given and addressed administrative errors in the signing of MAR charts. However, the audits had not identified that medicines were not always given as prescribed and when needed. Care plans were reviewed each month by the head of care to ensure they were up to date and met people's individual needs. However, the reviews had not identified the lack of MCA assessments or the ineffectiveness of a plan designed to protect a person from abuse. The systems and processes designed to assess, monitor and improve the quality and safety of the service provided were therefore not always effective. This had led to continued non-compliance with some regulations.

The continued failure to have effective systems in place to mitigate the risks to people's health and safety and to assess, monitor and improve the quality and safety of the service effectively were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In order to keep up to date with current practice, the registered manager attended meetings of the local care homes association, accessed circulars distributed by them and sat in on training being delivered to staff. However, we found they were not familiar with new Health and Social Care Act 2008 (Regulated Activities) Regulations introduced in April 2015 and had not accessed guidance issued by CQC to help providers meet the new regulations. They were not familiar with the latest guidance on the administration of medicines in care homes. Consequently, their medicines policy was not up to date. They were not familiar with the MCA code of practice, so were not able to ensure staff followed it.

People told us the home was well run and they were on "first name terms" with the registered manager and head of care. One person said, "I see [the registered manager and head of care] every week and any problems are always fixed." Another person said of the staff, "They all seem to work well together."

There was a clear staffing structure in place. The home was managed by a registered manager, who was supported by the head of care. Each shift, one staff member was designated 'lead person' and took responsibility for making sure people's care was coordinated and delivered effectively. Another member of staff was allocated to do the laundry, promote fluid intake and monitor people in the lounges at key times. Each member of staff also had

Inadequate

Is the service well-led?

responsibility for taking an overview of an aspect of the service, such as medicines, infection control and continence management. Their role was to keep up to date with relevant issues and promote good practice amongst colleagues. The registered manager told us the aim was to help staff develop. Staff were given protected time for this work. Staff understood their roles and responsibilities and worked well as a team.

Staff felt valued and praised the management of the home, who they described as "approachable". One staff member told us "We get all the support we need and any issues are sorted." Another said, "They often call in [out of hours] to check we're all OK." They described the home as "a happy place with a nice feeling" and "like a little family".

There was an open and transparent culture within the home. There were good working relationships with external professionals and there was also a whistle blowing policy in place, which staff were aware of. Whistle blowing is where a member of staff can report concerns to a senior person in the organisation, or directly to external organisations. Visitors were welcomed and described the home as "friendly". However, we noted there were no links with the community other than through friends and family members.

Accidents and incidents were recorded in people's individual care records, so staff can identify when a person had frequent accidents, such as falls. The head of care was also implementing a system to collate all accidents or incidents that occurred in the home, so any patterns could be identified and action taken to reduce the level of risk. The provider did not have a development plan for the home, but was considering ways to improve the rear garden to make it more accessible to people.

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	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The provider was not following the Mental Capacity Act, 2005 in ensuring service users were only treated with consent. Regulation 11(1)(2) & (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way in relation to the management of medicines and fire safety arrangements. Regulation 12(1) & 12(2)(a)(b)(g) & (h)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not take appropriate action following allegations of abuse. Service users were not protected from the risks of being deprived of their liberty unlawfully. Regulation 13(1)(2) (5)(6)&(7)(b)

The enforcement action we took:
We issued a warning notice and required the provider to become compliant with the regulation by 25 September 2015

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider was not operating effective systems or processes to ensure compliance with the regulations or to ensure practice was improved following significant events. Regulation 17(1) & 17(2)(a) & (f)

The enforcement action we took:
We issued a warning notice and required the provider to become compliant with the regulation by 25 September 2015

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The provider did not notify CQC of incidents of abuse or allegations of abuse. Regulation 18(1)&(2)(e)

The enforcement action we took:
We issued a warning notice and required the provider to become compliant with the regulation by 25 September 2015