Stephen Oldale and Susan Leigh

Eboracum House

Inspection report

177 Park Grove
Barnsley
S70 1QY
Tel: 01226 203903
Website: emyvalecarehome.co.uk

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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?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

The inspection took place on 6 May 2015 and was unannounced which meant that people did not know we would be inspecting the service before we visited. We last inspected this service in July 2014 and found that the service was not meeting the requirements of four of the regulations we inspected at that time. These were in relation to safeguarding procedures not being followed, people's needs not being effectively responded to, staffing levels and ineffective quality assurance. An action plan was subsequently received from the provider setting out how the service intended to address these issues.

Eboracum House provides accommodation for up to 18 older people who have personal care needs and may be living with dementia. There were 15 people living at the home at the time of our inspection.

There was a registered manager employed at the service. 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.

Summary of findings

We saw that medicines were not managed in a safe way. Some information in people's medication administration records was incomplete. We saw dates of birth and room numbers missing on some medication administration records and contradictory information recorded about allergies. We observed that medicines were not administered in line with good practice. This meant there was a risk that people did not receive safe care and treatment in respect of medicines.

The registered manager had applied for deprivation of liberty safeguard authorisations for some people at the home and was aware of the requirement for these. However we saw that a decision where a person had medicines administered covertly had not been made in accordance with the Mental Capacity Act 2005.

People and relatives we spoke with were positive about the care they received and about staff who supported them. We witnessed positive and caring interactions between staff and people. People were treated with respect and dignity. Staff demonstrated familiarity with people's preferences and wishes. Care records were in place for people and these were reviewed at regular intervals. However we saw that two people had a lack of information in place to inform how they needed to be supported.

Staff demonstrated knowledge of safeguarding procedures and received training in safeguarding. Incidents were monitored for referral on to other agencies where required to prevent and reduce potential reoccurrence.

Since our last inspection, a part time activities co-ordinator role had been introduced. Activities were available to provide and encourage stimulation for people. Relatives said they had seen an improvement in activities and one told us they would still like to see more activities. Peoples' nutritional needs were accommodated and people were supported to access healthcare professionals and maintain good health.

Recruitment processes ensured new staff were assessed as suitable to work at the service. Staff received supervisions although all appraisals had not yet been completed. Staff told us they felt supported by the registered manager.

People who used the service and relatives we spoke with felt there were enough staff available The registered manager felt current staffing levels were appropriate and said a new call bell system had improved efficiency. Staff we spoke with told us they felt staffing levels were suitable for the needs of the people there.

Feedback was sought by the registered manager by way of relatives and residents meetings which were incorporated into social events. There was a complaints procedure in place and people and relatives told us they would feel comfortable to address any concerns with the registered manager. Quality assurance systems were in place which identified areas for improvement but these required more detail in some areas to be suitably effective.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Some areas of the service were not safe. People were at risk of unsafe treatment because medicines were not managed in a safe way.

Individual risk assessments were in place in order to minimise and manage risks to people. People told us they felt safe at the home.

Staffing levels were sufficient to meet people's needs and the registered manager said these could change if required. Staff knew how to identify and report abuse and unsafe practice. A recruitment process was in place to assess staff as being suitable to work at the service.

Requires improvement

Is the service effective?

Some areas of the service were not effective. The registered manager had applied for deprivation of liberty safeguard authorisations for some people at the home and was aware of this legislation. However we saw that some decisions were not made in accordance with the Mental Capacity Act 2005.

Staff received supervisions but appraisals had not yet been completed for all staff at the service.

Peoples' nutritional needs were accommodated and people were supported to access healthcare professionals and maintain good health.

Requires improvement

Is the service caring?

The service was caring. Comments from people and their relatives and observations showed that staff were kind, caring and patient in their interactions with people.

Staff offered choice and explanations to people whilst providing support. Care records contained information about people outside of their care needs to help staff to form positive relationships and engage with people.

People were treated with dignity and respect and encouraged to maintain their independence when they were able to.

Good

Is the service responsive?

Some areas of the service were not responsive. In the main, care plans detailed people's needs and preferences but some records lacked this information for people.

People and relatives told us about activities that took place and an ancillary staff member also had a role as activities co-ordinator.

Requires improvement

Summary of findings

Relatives told us that if they had any concerns they would tell the staff or registered manager and said they felt their issues would be dealt with. The service's complaints procedure was on display. There were no complaints at the time of our inspection.

Is the service well-led?

Requires improvement

The service was not well led as improvements were required as to how it operated. Although audits were completed in a range of areas, some of these were not of a level to effectively identify areas for improvement.

Incidents were monitored routinely and referrals made to other agencies and organisations are required.

People and staff spoke positively about the registered manager. Team meetings took place where staff could discuss information relevant to the service and share good practice.

Eboracum 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 took place on 6 May 2015 and was unannounced which meant we did not inform anyone beforehand that we would be inspecting. The inspection team consisted of two adult social care inspectors.

Before our inspection, we reviewed the information we held about the home and contacted the commissioners of the service to obtain their views. This information was reviewed and used to assist with our inspection.

After our last comprehensive inspection in July 2014, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches we identified. We undertook our inspection in May 2015 to check that they had followed their plan and to confirm whether they now met legal requirements.

During our inspection we used different methods to help us understand the experiences of people living at the service. These methods included informal observations throughout our inspection. Our observations enabled us to see how staff interacted with people and see how care was provided.

We spoke with seven people, and three relatives of people, who lived at the home. We spoke with the registered manager, the operations manager, two care workers, the cook and a domestic worker. We reviewed the care records of five people and the personnel files of two members of staff. We looked at a range of other documents, including medication records, training records and records relating to the management of the home. These included audits and meeting minutes.

Requires improvement

Is the service safe?

Our findings

People in the home told us they felt safe. One person told us, "I couldn't manage at home. I feel safe here and the staff are all nice." Relatives also told us they felt their family members were safe. Comments included, "I can go to work with reassurance now", "I've never seen any dangerous situations here" and "We feel he's safer here [than at home]."

We saw areas of unsafe practice around medicines. We saw that the treatment room where medicines were kept was located in an area of the home which meant the medicine trolley could not be taken out whilst medicines were being administered. This was due to steps on the corridor preventing access to the main part of the home. We observed a staff member administer medicine to a person one at a time. They took the medicines from the treatment room to where the person was located and then completed the medication administration record (MAR) chart on return to the treatment room. Due to this arrangement, there was a risk of errors occurring with incorrect administration or inaccurate record keeping. This was because there was an increased risk that the staff member could be distracted on their way to or from administration, or were required in an emergency. The time taken between administration and documentation was also extended due to this arrangement which further increased these risks.

We noted that protective gloves were available in the treatment room. We saw that the staff member did not wear protective gloves when they administered medicine as is good practice. The staff member carried medicine with their fingers in the medicine pots and handed tablets to people which they then swallowed. This practice increased the risk of the spread of infection and did not promote effective infection control.

We looked at a sample of nine people's MAR charts. We saw examples of where these were handwritten which increased the risk of incorrect or omitted information being recorded when these were transcribed. For example, we saw one medicine which should have been taken 30 minutes prior to food yet this instruction was not documented on the accompanying MAR chart. This lack of information did not ensure medicines were administered for the best effect. We saw that some people were prescribed PRN (as required medicines), however information was not recorded to inform staff as to when these should be given. Clear PRN guidance is important so that there is consistent information to follow to ensure that people are given medicines safely.

We also saw that other important information was omitted in the medication records. There were no photographs of the people who used the service. Of the nine MAR charts we looked at we saw three did not contain the person's date of birth and several did not state the person's room number. This increased the risk of medicines being administered to the wrong person. One person's care plan stated that they were allergic to aspirin yet the information in the person's medication administration records stated that they had 'no allergies'. The lack of complete and accurate information further risked medicines being administered in an unsafe way.

We saw medicine audits that had been completed however these had not identified the areas of concern we identified which evidenced they were not suitably effective. Our findings showed that medicines were not managed in a way to ensure people's safe care and treatment. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People who used the service and relatives we spoke with felt there were enough staff available. One person told us, "They're [staff] pretty decent at coming. They don't take long." A relative said, "There are always staff about. They seem to cope really well with the demands of people." The registered manager told us that there were two care staff on duty, at least one of who was a senior, at all times. She told us that staffing levels were monitored and if it was determined that another staff member was required, then this could be implemented. The registered manager felt the current staffing levels were appropriate. Staff we spoke with told us they felt staffing levels were suitable for the needs of the people there.

A new call bell system had been implemented since our last inspection. The registered manager told us this had improved the service and response times for people at the home. We saw that people had access to call bells to summonstaff assistance. As this was a computerised system, the registered manager told us she was able to look at specific periods to monitor waiting times, for example in response to any complaints. This information could then be used to inform whether any changes were required.

Requires improvement

Is the service safe?

Staff we spoke with were able to describe different types of abuse and said they would report any suspected or witnessed abuse to the registered manager. There was a safeguarding policy in place at the service and information was available on display for staff to refer to. We saw evidence that staff had received training in safeguarding.

We looked at five people's care records. Two of the people were spending a period of respite in the home and the registered manager told us that their care plans were not as comprehensive as people who lived there permanently. We noted there were risk assessments in place for the people who lved at the home permanently and these had been reviewed and updated at regular periods. For the two people who accessed the service for respite, the information was not as detailed in order to identify and manage risks. One person had no risk assessments in place. We fed this back to the registered manager who said they would review these accordingly to ensure information was captured accurately.

Staff we spoke with told us they had had to provide reference details and have a DBS (Disclosure and Barring Service) check in place prior to starting their role. The Disclosure and Barring Service helps employers make safer recruitment decisions by providing details of any criminal records a person may have. This ensured that staff employed were assessed as suitable to work at the service. We looked at the personnel files for two members of staff. We saw references in place but we only saw evidence of a DBS check in place for one person. The other staff member had been employed at the home for a number of years and we were told did have the equivalent of a DBS check undertaken when they commenced employment. As we could not see evidence of this and the staff member could not locate their check, the registered manager and operations manager agreed to submit another check to ensure they held accurate information about the staff member.

We saw personal emergency evacuation procedures in place for people which gave information about how they were to be supported in the event of an emergency. There was an emergency action plan in place to provide guidance to follow in the event of an emergency. A current fire risk assessment was in place and regular fire checks took place. During our inspection we saw a maintenance person who worked for the provider undertake various safety checks around the home.

We spoke with a domestic worker who told us they could manage their duties in maintaining cleanliness of the home. They showed us where cleaning materials and solutions were kept in a locked cupboard. They said that personal protective equipment was always available along with necessary cleaning items and they had responsibility for ordering these. Our observations of the home were that it was generally clean. We did notice some malodours within the home at various times throughout the duration of our inspection.

Requires improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA 2005) is legislation designed to protect people who are unable to make decisions for themselves, and to ensure that any decisions are made in people's best interests. The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act (MCA) 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. A training matrix showed that care staff had completed training in the MCA 2005 and DoLs within the last two years. Care staff we spoke with were able to provide an understanding of the act. MCA and DoLS were included as a topic for staff supervisions.

Nine DoLS applications had been made to the 'Supervisory Body' at the time of our inspection. The registered and deputy manager told us they were still awaiting decisions for these and knew to notify the commission once a decision was made by the supervisory body.

The registered manager told us one person who they believed lacked capacity was administered medicine covertly due to their refusal to take this. We looked at this person's medication administration record and saw the following handwritten information by a staff member '[Name] medication can now be covert. GP is aware of this due to telephone discussion.' There was no capacity assessment in place to show that the person could not make the decision to take this medicine themselves. Nor was there any evidence to show what attempts had been made to involve the person in the decision and whether any less restrictive alternatives had been considered. No evidence of any best interests discussions were in place to show this was the most suitable method of the person to take their medicine. The registered and operations manager said they would follow this up with the staff member and the person's GP to ensure suitable processes were in place.

Our findings showed that the arrangements in place for obtaining consent for decisions did not follow the principles of the MCA 2005 where people lacked capacity. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care staff we spoke with told us they received an induction when they commenced employment at the home. Staff told us they felt they had suitable training for their roles. We saw a training matrix in place which the registered manager used to identify what training staff had and when this was due to be updated. The matrix showed staff received training in a number of areas which included dementia awareness, pressure care and diabetes. The registered manager told us that all staff were undertaking refresher training via e-learning and we saw notices on display reminding staff to register for this. This showed that staff had opportunities to undertake training to equip them with the required skills for their roles. However we found that a member of the ancillary staff had not had received training at Eboracum House although they had training from a previous role. We fed this back to the registered manager to ensure the staff member was suitably trained for their role and any duties they were undertaking.

Supervisions and appraisals are meetings designed to support, motivate and enable the development of good practice for individual staff members. The registered manager told us staff had at least three supervisions each year and this could be increased if required. Care staff we spoke with said they received regular supervisions. However, one staff member outside of the care team said they had received one supervision only in the period of a year. We saw that appraisals had not yet been completed for all staff. The registered manager was working through these with an aim to have completed all within the next three months. All staff told us they felt supported and could go to the registered manager at any time if they needed to.

We asked people for their views on the food at the home. One person told us about their preferences. They said they liked the food and told us, "I've said to them [staff] I don't like sausage or mushroom and they don't fetch me them." When we asked how people knew what meals were on offer, one person said "They always put a note up downstairs." They were referring to a menu board that was on display outside of the dining room. Relatives described the food as "lovely." One relative said of their family member, "He always used to have a good appetite so they always gave him more. He always had two puddings."

We observed people eating their lunchtime meals in the dining room. Some people chose to eat in the lounge or the conservatory. Tables were set neatly with table cloths and napkins were available. People ate independently at their

Requires improvement

Is the service effective?

own pace but staff were present and checked on people regularly to provide encouragement and offer further drinks or food. We saw that several people in the dining room chatted amongst each other. Staff offered people choices of meals and provided people with their chosen preferences. We noticed that although music was playing in the background in the dining room, the radio station was one that played current pop and dance music. It was not apparent that the people who used the service had chosen the station.

Although people enjoyed their meals, one of the desert options was a crumble which we saw several people struggle with. One person opted to use a knife and fork to eat theirs as they were unable to break it with their spoon. Another person said, "You can't break it. It's just gone that bit over [in the oven]." We felt this could have had potential to dissuade people from eating their meals and fed our observations back to the registered manager.

We spoke with the cook and saw information was available in the kitchen showing the dietary needs of people, for example if people were diabetic or had any allergies and people's preferences. The cook told us that people did not have to have what was on the menu and if they wanted something different this could be accommodated.

People were weighed at monthly intervals or more frequently if required. Assessments were in place to monitor and review people at risk of malnutrition. The registered manager told us food charts would be used where people required these to document eating habits to identify any nutritional concerns and implement necessary actions. Care plans were in place for nutritional needs and staff were able to state what support people required with meals.

People were supported to maintain good health and access healthcare services when required. We saw in care records where people had been referred to other professionals. This included referrals to the district nurse, GP and memory team amongst others. People we spoke with told us they got treatment when required. One person said, "I've had the doctor out twice. I tell [registered manager] and [deputy manager] and they'll phone up". Relatives told us they were always kept updated about their family member's health needs. One told us, "I'm kept in the loop all of the time."

Some redecoration had taken place since our last inspection. There were new blinds and flooring in the conservatory and a corridor of the home had been designed to be a sensory corridor to make the environment more 'dementia friendly'. The operations manager told us they were starting to incorporate memory boxes to locate outside people's rooms and were working with people and relatives as to what to include in these. The registered manager showed us a number of bedrooms that had been redecorated and we saw new furniture in the lounges. This showed that actions had been taken, and were still in progress, to improve the environment for the people who used the service.

Good

Is the service caring?

Our findings

We asked people whether they liked the home. All people spoke positively about the staff and the care they received. Comments included, "I think they need a medal, they look after me really well", "It's nice here, I like it", "All the time I've been here it's been alright", "It is very nice, staff are ok, no problems at all", "Staff are lovely" , "It's lovely, no faults whatsoever" and "They're [staff] all very nice."

Relatives told us, "Hand on heart, we are very pleased and very satisfied with the care our [family member] is getting", "When we found this home it was a 'Eureka' moment ", "Lovely staff. Always have banter with my [family member]. They're all nice" and "Staff are very very caring and respectful. One relative told us about a family member that had lived in the home who had recently passed away. They said, "They [staff] were brilliant with [my family member] when they died. Really supported me too, brilliant." Several letters, written since our last inspection, were on display in the reception area praising the home and the care that staff provided. One said, 'The care is second to none.'

Feedback we received from a professional involved with the home stated, "All staff members were polite and extremely helpful."

During our observations, we saw that staff were kind and caring when they interacted with people. They communicated with people in ways to suit their needs. Staff demonstrated familiarity and knowledge of people's preferences and dislikes. When staff assisted people, they explained what they were doing and offered friendly patient encouragement throughout. This meant people had time to do things at their own pace and they were not rushed. Staff used touch in an appropriate and comforting manner and were caring in their approach. We saw people chose where they spent time within the service. Some people spent time in their rooms and other people liked to sit in communal areas. People were offered choices by staff.

We saw positive interactions between staff, visitors and people in the home. For example, we saw some relatives visit their family member and we saw and heard humorous interactions between the relatives, their loved one and other people in the room. A staff member came around to offer hot drinks and cakes. Staff told us they got on well with people's relatives and also said this was a good way of finding out more about people and therefore to promote positive relationships.

People told us their privacy was respected and observations showed people were encouraged to be independent by staff where they were able to be. One person said, "I do what I can but they help me when I need it" and "They treat me with respect." We observed staff knocking on people's doors although we did see staff walk into one person's room without knocking. The person told us staff did usually knock first. We did not see or hear staff discussing any personal information openly or compromising privacy and we saw people's privacy was maintained, for example when they received assistance with personal care.

People said they felt comfortable talking to staff and we saw advocacy information on display in the entrance to the home. An advocate is a person who is able to act in the interest of someone and put forward views on their behalf.

Requires improvement

Is the service responsive?

Our findings

Care staff demonstrated an understanding of people's personalised tastes and needs and their preferred routine. They told us discussions with people and involvement with families guided them as to how people liked to be supported. One staff member told us, It's a homely home. You get to know people really well, we get to know their likes and dislikes." One person told us about their preferred morning routine. They said, "I've always been like that at home." They described how staff responded to their routine and accommodated them with this. We spoke with this person's relative who told us, "My [family member] has their own routine, [staff] let them take their time. They've been really good." Another relative told us, "We have regular chats about [my family member], to see if any changes are needed." This showed that staff were responsive to people's individual needs.

We looked at the care records of three people who lived at the home permanently and we found that these had been reviewed and updated regularly. Any changes in care needs had been documented for staff to follow. Two people who were currently in the home for a period of respite had limited information available. The registered manager told us that a 'respite care plan' should be in place. One person had been at the home for a month but there was no respite care plan in place. Another person had a 'respite care plan' however it was not always clear how they were to be supported. We saw the person had been assessed as 'at risk' of falls but there was no guidance in place as to how this was to be managed. We fed these findings back to the registered manager who said they would implement appropriate care plans.

We saw care records captured information about people's life histories however this varied as information was omitted in some records. One person told us, "I filled a form in about my life, my family, where I got married and where I was born and that." The registered manager told us that some people's relatives were encouraged and requested to complete this information where none was in place. One relative told us about staff, "They know all [my family member's] life story." Such information is important to give a holistic view of the person as well as providing information for staff to engage and interact with people in ways to stimulate them and form positive relationships and shared interests.

At our last inspection we saw there was a lack of stimulation and activities available for people. The registered manager told us that the cook now also worked as an activities co-ordinator for a period of time during their shift. The cook told us they "played it by ear" as to what people wanted to do during that time as this changed dependant on people's wishes. Staff told us they tried to encourage activities when they were able, for example by playing games such as dominoes and draughts.

We asked people about activities in the home and they told us, "They [staff] do games and activities but I like to go in the conservatory and watch TV. Staff will come and have a natter." During observations we saw one person looked through a magazine with the owner and both chatted about the content. Another person who became restless was provided with a sensory blanket which was intended to provide stimulation. We saw some handmade Easter decorations on display. One person told us "I helped to make those."

One relative told us, "They've started to have more activities, making things. My [family member] will sit and have a go. They made Easter bonnets, it was nice. They have had a question and answer session. I've become more aware of the activities and [activities person/cook] is brilliant, a natural." Another told us, "Our [family member] never joins in activities but we'd like them to. They had a Vera Lynn sing-along and had an Easter party." Another relative said, "I see different activities but would like to see a little bit more of them."

No people or relatives we spoke with had any complaints to make about the service. One person told us, "I would tell them if I wasn't happy." Relatives said, "I could go to [registered manager] about anything. She will sit and listen". The service's complaints procedure was displayed in the reception area of the home. An easy read format was also available on display. There were no complaints at the time of our inspection.

Requires improvement

Is the service well-led?

Our findings

There was a registered manager in place at the home who had commenced employment the day before our last inspection. Staff, relatives and professionals spoke positively about the registered manager. One person who lived at the home told us, "[Name] is the manager. She's really good, she's lovely. I've met [name of operations manager] and [name of owner] too and they seem nice. They always introduce themselves." Another person told us, "I would gladly recommend this place." During our inspection we observed the registered manager, operations manager and owner spend time around the home and interact with people who lived there.

Relatives said about the registered manager, "She's brilliant and I do like the changes she is making. It makes you aware of what was lacking before. There wasn't much activity and there is more delegation now", "She's really good, professional", "Her door is always open. Got a very good relationship with [the registered manager]" and "She's really good. We can go to her anytime and talk."

Staff were equally as positive about the registered manager and one staff member told us, "She's the best manager I've worked for." Another told us the registered manager was "definitely approachable." Staff told us they could talk to the owner also when they were present. Some commented that they "loved their job."

A professional from the local authority who had been working with the registered manager to improve the service told us, "The manager has been very agreeable to work with and took all improvements on board." Another professional involved with the home said they had no concerns with the service or the people who used it. The comments we received indicated an open culture at the home with accessibility to the registered manager by all people involved with the service.

Since our last inspection, the registered provider had introduced a new role of operations manager. We met the operations manager who had commenced employment in March 2015. They explained their responsibilities for monitoring the service and told us of work that had been undertaken and work that was still to be implemented, acknowledging there were still improvements required to the service. They told us they had no concerns with the registered manager who they described as "A pro-active, fantastic manager."

We saw a 'monthly manager's audit' and evidence that some areas had been identified for follow up actions and were being progressed. For example it had identified that the blinds in the conservatory needed replacing and we saw that this action had been completed. We saw other changes around the home, such as a new call bell system and more activities, which showed that improvements were being made.

However, the audit system still required improvement as several audits were not comprehensive enough to effectively identify areas for improvement. For example, we saw a document titled 'care plan' audit from March 2015. This stated that a care plan had been checked and all risk assessments were up to date. It did not detail which care plan had been audited and there was no information listed to show exactly what had been checked within the care plan. Another audit of a first aid box said 'stock checked and in date' but no details of what the stock was being checked against. The operations manager acknowledged the lack of detail within these and told us they would be implementing comprehensive audit tools to use in future for all areas. The next day they sent us the new documentation for care plan audits which was designed to fully explore any gaps or areas for improvement.

We saw that comprehensive policies and procedures had been introduced since our last inspection which were next due for review in March 2016.

Staff told us team meetings took place and told us they were kept updated about any information relevant to the service and their roles. We saw the last team meeting minutes from January 2015. Various issues were discussed which included the new call bell system training, record keeping and team working. The registered manager told us that she started work early each morning which allowed her to see night staff each day. This meant that she was able to have contact with all staff and was accessible to them and could also see how the service operated at night.

Relatives told us about meetings and events they were able to attend at the service with people who lived there. The registered manager told us these were incorporated as part of social events. We saw minutes of these meetings from

Requires improvement

Is the service well-led?

2014 and the latest one in April 2015. We saw there was discussion around changes and improvements to the home. Some of the comments captured from people were, “We are pleased with the improvements in the home”, “Been a long time coming” and “I love all the new chairs in the rooms.” Relatives told us they were kept updated about changes at the service and would feel confident to put forward their views. We saw service information on display at the home’s entrance, for example the home’s statement of purpose, feedback from relatives and information about activities and meals within the service. Feedback forms were available for visitors to complete to provide their views of the service.

We saw annual satisfaction surveys from February 2015. These had been completed by, or with, people at the home, and their relatives. The findings within these were positive and some comments from these were displayed in the entrance area. We did not see any evidence that the views of staff and stakeholders had also been sought in this way for the same period. This meant that some relevant views were not being captured. This could lead to other areas of needs for improvement and good practice not being highlighted.

The registered manager had oversight of all incidents at the service. These were monitored on a monthly basis to identify any themes and trends and to look for ways to reduce potential risks. The registered manager was aware of their obligations for submitting notifications in line with the Health and Social Care Act 2008.

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 How the regulation was not being met: Care and treatment of service users was not always provided with the consent of the relevant person. Where people lacked capacity to do so, the registered person did not always act in accordance with the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Care and treatment was not always provided safely as medicines were not being managed in a proper and safe way.