Opus Care Limited

Ashford Nursing Home

Inspection report

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Date of inspection visit:
16 May 2016
17 May 2016

Date of publication:
11 July 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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 16 and 17 May 2016 and was unannounced.

Ashford Nursing Home is registered to provide nursing; personal care and accommodation for up to 22 people .There were 16 people using the service during our inspection; who were living with a range of health and support needs. These included; diabetes, catheter care and people who needed to be nursed in bed.

Ashford Nursing Home is a large detached house situated in a residential area just outside Ashford. The service had a communal lounge available with comfortable seating and a TV for people. There was an enclosed garden to the sides and rear of the premises.

A registered manager was in post. A registered manager is a person who has registered with the care Quality Commission to manage the service. 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.

Ashford Nursing Home was last inspected in May 2015. They were rated as 'Requires Improvement' at that time and we asked the provider to send us an action plan about the changes they would make to improve the service. At this inspection we found that actions had been taken in some areas, but work was still needed in others.

Risks to people had generally been assessed and minimised but medicines had not always been recorded or stored appropriately. Fire safety had been addressed through training, drills and alarm testing. Maintenance had been carried out promptly when repairs were needed.

There were enough staff on duty but the registered manager was contracted to carry out management duties for only 12 hours per week. This had led to a lack of oversight in some areas of the service. Recruitment processes were not sufficiently robust to make sure that applicants were suitable for their roles and some refresher training was overdue. Staff had received regular supervision to measure their competency.

Assessments and decisions had not consistently been carried out within the principles of the Mental Capacity Act (MCA) 2005. People's health care needs were supported and documented. Assistance to eat and drink was provided when needed and people enjoyed their meals.

Staff were caring and considerate and people and relatives praised them throughout the inspection and in telephone conversations following it. People were offered hand massages, hairdressing and one-to-one chats with staff to help prevent them becoming isolated. Care plans were person-centred and staff knew people's personalities and preferences well.

Complaints had been properly documented, and recorded whether complainants were satisfied with the responses given. People and relatives said they knew how to complain if necessary and that the registered manager was very approachable.

Records had not been maintained appropriately and it was often difficult to find information about people's care quickly or in one place. Audits had not always been effective in highlighting shortfalls which meant there was a risk that safety issues would not be addressed promptly.

Staff felt appreciated and involved and said they were supported by the registered manager.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the end of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Medicines had not always been recorded or stored correctly.

Recruitment processes had not been sufficiently robust to ensure the suitability of applicants.

People felt safe and staff knew how to recognise and report abuse.

Assessments had been made to minimise personal and environmental risks to people.

Is the service effective?

Requires Improvement

The service was not always effective.

People's rights had not consistently been protected by proper use of the Mental Capacity Act.

Staff had received training and supervision to help them provide effective support but refresher training was needed in some cases.

People received support and encouragement to eat and drink and specialists were involved when necessary.

Is the service caring?

Good

The service was caring.

Staff delivered support with consideration and kindness.

People were treated with respect and their dignity was protected.

Staff encouraged people to be independent when they were able.

Is the service responsive?

Good

The service was responsive.

People and relatives were given the opportunity to make complaints or raise concerns and these were properly recorded and responded to.

People were provided with the opportunity to engage in activities.

Care plans were person-centred and documented individual preferences.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Records were not always easily accessible and were not always accurate.

Systems were in place to assess the quality and safety of the service but these had not always been effective.

Staff said there was a good atmosphere and open culture in the service and that the registered manager was supportive.

Staff were aware of their responsibilities to share any concerns about the service.

Ashford Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 16 and 17 May 2016 and was unannounced. The inspection was carried out by two inspectors and one specialist nurse advisor. Before our inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the home, including previous inspection reports. We contacted the local authority to obtain their views about the care provided. We considered the information which had been shared with us by the local authority and other people, looked at any safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

We met with ten of the people who lived at Ashford Nursing Home. Not everyone was able to verbally share with us their experiences of life in the service. We therefore spent time observing their support. We spoke with five people's relatives. We inspected the home, including the bathrooms and some people's bedrooms. We spoke with six of the care workers, the cook and the registered manager.

We 'pathway tracked' eight of the people living at the service. This is when we looked at people's care documentation in depth, obtained their views on how they found living at the home where possible and made observations of the support they were given. This allowed us to capture information about a sample of people receiving care.

During the inspection we reviewed other records. These included three staff training and supervision records, three staff recruitment records, medicines records, risk assessments, accidents and incident records, quality audits and policies and procedures.

Requires Improvement

Is the service safe?

Our findings

People told us they liked living in the service and felt safe. One person said, "I'm absolutely safe here-if I need anything staff always come". A relative told us, "I just don't have to worry about [My relative], the staff are magnificent and we trust them".

Medicines had not always been managed safely. There were a number of gaps on medicines administration records (MAR) where staff had not signed to show when people had been given their medicines. Some of these gaps dated back several weeks. Although checks made during the inspection showed that people had received their medicines, the signature gaps had not been picked up by staff or the registered manager before we highlighted them. There was a risk that any missed doses would not be quickly identified, investigated and put right if necessary.

Controlled drugs (CDs) had been recorded in a special register and two staff signed this each time CDs were given to people. However, on one date a person's CD dose had not been entered up in the morning, even though a stock-check found that it had been given. This created a risk that staff might think the person had not received their dose and give them another. Some entries on the MAR had been handwritten by staff. A number of these were difficult to read and some had not been signed by two staff to confirm that the entry had been made accurately; as is best practice.

Records of when people had their prescribed creams applied were inconsistent. Staff and the registered manager told us that care staff applied creams but nursing staff checked that this had happened. There were two places were creams applications were recorded; on the MAR and also on a separate creams sheet. One person's cream had been prescribed for application twice a day. The MAR documented that this happened every day from 21 April to 15 May 2016, but a cross-check with the creams sheet showed that the records did not match. The creams sheet had gaps which indicated that the cream had only been applied once a day on six occasions in that same period.

Some people had been prescribed thickening granules to help them swallow drinks. The granules can present a choking risk if ingested when dry. Pots of thickener were stored in people's bedrooms. Although the risk to people was low because they were mainly nursed in bed and unlikely to be able to reach the granules, the registered manager confirmed that some people had children to visit them. Neither staff nor the registered manager knew about the dangers associated with thickeners and no assessment had been made of the potential risks. The registered manager removed the thickening granules to safe storage during the inspection.

The lack of consistent recording, administration and safe storage of medicines is a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

MAR charts contained photos to help staff ensure the right people received their medicines. Staff checked people's details before taking them their medicines and then ensured that they had been swallowed them before leaving people. Any allergies were noted and people and relatives said they received their medicines

regularly. The temperature of a medicines fridge had been regularly monitored to make sure medicines were stored in a suitably cool environment.

Staff recruitment practices were not always robust. We looked at six staff files in order to assess how the provider carried out checks to ensure that they were employing people who were suitable for their roles. All files contained application forms; however two of them did not have full employment histories or an explanation of gaps in employment. Each staff member had a Disclosure and Barring Service (DBS) check in place before they started work. DBS checks help employers to make safer recruitment decisions. References had been sought for applicants to ensure that they were of good character and would be suitable for the position. Where people were unable to provide prior employment references, education and personal references were received instead. Not all references had been verified however. For example; one employee's reference differed from that supplied on their application form and did not match their stated work history. Another reference had been accepted from a person who was not in a position to comment about the applicant's work record or suitability. The provider could not be assured about applicants' past performance and aptitude.

The lack of a thorough recruitment process is a breach of Schedule 3 of Regulation 19 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

All staff files viewed contained proof of identification which included documents such as passports, driving licences, birth certificates, and proof of address, along with a photograph of the staff member. All nursing staff had been checked to ensure that they had a current and valid registration with the Nursing and Midwifery Council.

There were enough staff on duty to meet peoples' assessed needs. People and relatives said that staff responded to call bells and requests for assistance promptly. One person told us, "I never have to wait long when I want something" and a relative commented "Staff can't do enough for residents and they always find time to have a chat".

The registered manager explained that staffing numbers were determined by looking at each person's individual needs and working out how many staff and which skills mix should cover each shift. There were five health care assistants working in the mornings, four in the afternoons and two at night. In addition, one registered nurse was on duty during both day and night shifts. Rotas showed that the registered manager worked as the only nurse on duty on many occasions. She told us she was contracted by the provider to work 24 hours per week as a nurse and 12 per week in her role as registered manager. We spoke with the registered manager about how she was able to separate the roles; for example, how would she deal with a management query when working as a nurse; or a nursing issue when working as a manager. She explained that 12 hours per week was not sufficient to carry out her management duties and she therefore worked many extra, unpaid hours to compensate for the shortfall.

Staff we spoke with demonstrated they understood abuse, could describe the forms it could take and how to report it both within and outside of the service. They said they would have no hesitation in reporting any concerns they might have and one staff member told us ," It's our duty to keep people safe". There was an up to date safeguarding policy in place and posters around the service reminded staff and visitors of the need to speak up about any suspicion of abuse or neglect.

Accident and incident report forms had been appropriately completed by staff. Action plans were put in place to help prevent recurrences. For example; a detailed risk assessment had been made about a person who often refused help, but was prone to falls as a result. This gave staff clear guidance about how to

respect this person's wishes while doing everything possible to keep them safe.

Other assessments had been made about different risks to people, for example of choking, hot food and liquids, mobility and pressure wounds. These gave staff directions to support people in ways which minimised the risk to them. One person had an assessment about pain which documented the reasons why pain relief might be needed, the signs of pain to look out for and that staff should report any significant or prolonged pain to nursing staff. Another person was at risk of choking and the assessment set out the position in which the person should eat and drink together with guidance about allowing them plenty of time to swallow between mouthfuls.

People lived in a safe environment. Maintenance records showed that any reported repairs were dealt with quickly by an employed handyman. For example; we saw that broken bed rails had been fixed on the same day they were reported. Hoisting equipment had been regularly safety-tested and water temperatures had been recorded to ensure they were at safe levels for people.
Fire alarms were tested weekly and fire drills were practiced monthly. The alarms were tested during one day of our inspection and we observed that staff reassured people and followed evacuation routes as described in the provider's fire policy. There was clear signage throughout the service to identify escape routes and 'Fire information for visitors' was displayed in the entrance foyer. Staff had received fire safety training and refreshers and were confident about their roles in the event of an emergency. The service had a business continuity plan; which detailed that people would be evacuated to another of the provider's local nursing homes, should the need arise.

Requires Improvement

Is the service effective?

Our findings

People told us that they enjoyed the meals on offer. One person said, "The food is usually good and there's enough of it for me". Another person told us, "You get a choice of food, they come round and ask us what we want, it's always ok .I've always got a jug of water, they fill it up for me."

We checked to see whether people's rights had been protected by assessments under the Mental Capacity Act 2005 (MCA). The Mental Capacity Act is to protect people who lack mental capacity, and maximise their ability to make decisions or participate in decision-making. Capacity assessments had been carried out if there was a question about people's ability to make a specific decision. However, where bed rails were in use, there had been no discussions documented to show that any alternatives had been considered when people lacked capacity to agree to them. There had been no assessment to show that their use was in the best interests of the people concerned. The registered manager said that best interest processes had not been carried out. The principles of the MCA had not been followed in these cases.

The failure to act in accordance with the principles of the MCA is a breach of Regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staff had received training about the MCA and were able to describe how they helped people make day to day decisions by offering them visual choices. We observed that staff sought verbal consent from people when delivering support by asking, for example; "Can I open your curtains for you or would you prefer to leave them shut?" Guidance for staff about the MCA was on display as a prompt to consider people's rights and wishes. Meetings of a staff meeting evidenced that staff had been reminded to ask people if they would like to wear food protectors at mealtimes, even if those people could not verbally communicate their decision.

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 are called the Deprivation of Liberty Safeguards (DoLS).The registered manager had made applications for DoLS for 12 people, but these had not yet been considered by the supervising authority.

Staff had received training in a range of subjects in order to perform their roles safely and to provide the right care and support to meet people's needs. However, updates had not always been maintained within the required timeframes. For example, 13 out of 24 staff had not updated their knowledge of infection control within the past 12 months and six had not updated their knowledge of manual handling in the past year. However, the service was clean throughout and staff followed correct procedures to maintain hygiene, such as wearing gloves and aprons to deliver personal care and washing their hands frequently and thoroughly. Our observations showed that staff supported people to move safely and in line with best practice. Some staff had completed training in additional areas that were relevant to the needs of the people in the home, such as dementia and communication training. Upcoming DoLS training was advertised on a staff notice board.

Records of supervisions showed that staff received regular one- to-one sessions where they could discuss their performance, their workload, training, working relationships and people's changing needs. A matrix enabled the registered manager to identify who had received supervision and when it was next due. Staff confirmed that they had meaningful supervisions and that these were effective in supporting them in their roles.

We recommend that the provider arranges suitable refresher training for staff.

At our last inspection we found that skin wounds had not always been managed and documented appropriately. At this inspection we saw that wound assessment charts were in use and that people's wounds were reviewed every three to five days as is best practice. People had been appropriately referred for specialist advice from a Tissue Viability Nurse and staff received regular updates about wound care and the best dressings to use. Photos had been taken of some wounds, which tracked their improvement and staff were able to confidently describe how people's wounds were managed and cared for.

Catheter care had been provided where necessary and in line with best practice guidelines. Catheters were monitored for blockages, leakage or any signs of infection. People's fluid intake and output was recorded and bags were changed regularly. People confirmed that catheter bags were emptied frequently and that staff cleaned catheter sites at least twice daily.

People living with diabetes were monitored by staff and referred for blood sugar monitoring when needed. Some people took blood thinning medicines and there was clear information about blood test results and when they were next due. Care plans guided staff to be vigilant of any bleeding or injuries experienced by people taking these medicines; as they prevented clotting. Risk assessments about supporting people to move reminded staff to do so safely to avoid the risk if skin tears and the associated risk of severe bleeding.

Referrals had been made to speech and language therapists when people had difficulty in swallowing; and their advice had been followed in thickening people's drinks and providing pureed or soft meals. Dieticians had been involved when there had been any concerns about weight loss or people's appetites. Advice had been put into practice by providing people with milky drinks or special food supplements. People's food and fluid intake was recorded daily, and staff told us that they would make nursing staff or the registered manager aware of any concerns about people's eating and drinking.

People's records showed that they had regular visits from GPs and nurse practitioners to help keep them well. The service also received input from a Community Matron and on occasion, the palliative care team. A chiropodist made regular calls to attend to people's feet and nails and optician and physiotherapist visits had been documented.

People were given plenty of drinks throughout the days of our inspection. A trolley with hot and cold drinks was taken around by staff at intervals and, in between, people had other drinks provided to them. Some people needed staff to support them to eat and this was done gently and in a relaxed way. Staff described the meal and helped people to eat at their own pace; while being encouraged by staff. Special cutlery and plate guards were used by some people to make eating easier for them. A relative told us, "Staff never rush Mum. She sometimes takes a long time to eat, but they're patient and kind and they chit chat with her all the time".

The cook was knowledgeable about people's food preferences and information about this was kept in the kitchen. He explained that the provider liked homemade meals to be served and that cakes were made in-house to serve to people with tea at 3pm. The menu was rotated every four weeks and people had two

choices for lunch and tea each day. A cooked breakfast was on offer and people could ask for alternatives at any time. One person said that they liked to have an omelette sometimes, even when it was not on the menu for that day. They told us, "They never mind and will do one for me especially." The cook was able to tell us about catering for diabetic diets and how foods could be enriched with cream and milk powder to make them more calorific if people needed to maintain or put on weight.

Good

Is the service caring?

Our findings

People and their relatives gave us positive feedback about their experiences. One person told us, "I'm very happy here. The girls [staff] are so thoughtful and they look after me splendidly". Another person said; "Of course, I'd rather be at home, but this is the next best thing and I'm grateful for it". A relative said, "Everyone is so kind and approachable. I can visit whenever I like and the welcome is always the same-friendly, caring and thoughtful". Another relative commented, "I can't fault the care Mum's had at Ashford Nursing Home. I never have to worry about her and I often turn up at different times to find staff sitting and chatting with Mum".

We observed the interactions between staff and people throughout the days of our inspections. Staff knocked on bedroom doors and called out before they entered. There were signs on people's doors to remind staff to respect people's personal space and we saw that staff did so consistently.
People's bedroom doors were closed by staff when they were delivering personal care; to protect people's dignity. Staff used people's preferred names and spoke with them respectfully. People knew staffs' first names and used them, and we witnessed some warm and affectionate exchanges.

People were greeted kindly by staff who approached them confidently, gaining the person's attention and speaking clearly to them. People responded positively to staff by showing their awareness with recognition and smiles, even when verbal communication was impaired. One person liked to sit out in their chair with their bedroom door open so that they could see out into the corridor. We noticed that staff acknowledged and spoke with this person each time they passed their door. A relative told us; "[Relative] absolutely loves the staff. She smiles whenever they come in the room and that gives me real reassurance".

Records showed that care plans had been discussed with people and their next of kin, if they wished. One person explained a particular aspect of their care to us; which they said staff had talked through with them to make sure they understood. Formal consent to care and treatment had been signed so that people knew what to expect. There was evidence of discussions with people and their loved ones about Do Not Attempt Resuscitation (DNAR) orders, any hospital admissions and people's past life histories and preferences. One relative told us, "I've been involved in [Relative's] care right from the start. The staff and manager keep me informed of any changes or anything I need to know about".

People were encouraged to be as independent as possible. Although most people were nursed in bed, staff gave them the opportunity to wash their own hands and face, for example, and to choose their clothing. Staff told us how important it was for people to retain even a little independence. They said that special cutlery and plate guards helped some people to eat without assistance and that giving people choice made people feel involved. One staff member said, "People like to help themselves if at all possible. It's our job to encourage them but always be on-hand if we're needed".

There was no one receiving end of life care at the time of the inspection. However records had been made about people's wishes, where known. Care files clearly noted if people had a DNAR order in place and this was also recorded in staff handovers. This helped to ensure that people's end of life choices were respected.

We heard that the service had links with the hospice community palliative care team who had offered advice and support in the past for people who had received end of life care. Contact details for the palliative care team were available at the nurses' station. We spoke with nursing staff who knew about the palliative care team and how to contact them if needed. They told us that they had received training to use specialist equipment to deliver monitored doses of medicine and that this equipment was available to them. There was a range of other equipment such as pressure relieving mattresses, hoists, slings and special beds to provide people with comfort and care at the ends of their lives.

Good

Is the service responsive?

Our findings

People and relatives told us they knew how to complain if they needed to. However, one person said, "I've got no complaints at all about the staff or anything here" and another commented," I've never needed to complain but I know I could speak to someone here if I needed to". A relative said, "Really, there's nothing to find fault with; it's a lovely home and we've never had to complain".

At our last inspection, minor complaints and concerns had not been recorded. At this inspection we saw that full records had been maintained about any complaint or concern raised. This included details of investigations and the outcomes of the complaints. In addition, the registered manager had documented whether complainants had been satisfied with the outcomes. Complaints and concerns could be tracked to show that they had been fully addressed.

Staff said they would refer any complaints to the registered manager. A complaints protocol was on display in the foyer; which gave contact details for external organisations which might help if people were dissatisfied with the response to their complaint. Thank you cards and compliments had been kept by the registered manager. One of these read; 'Thank you for [Relatives's] care. I wouldn't have wanted then to be anywhere else'. Another said, 'You are to be congratulated for doing a really good job of making a home for [Relative]; where they were very happy and felt safe'.

A selection of activities were available to those people who wished to take part. The service had an activities coordinator working part-time. Most people were being nursed in bed or chose to stay in their bedrooms. We asked the activities coordinator how they provided people with things to do and prevented people from becoming socially isolated in these circumstances. She explained that people who were able to read newspapers or magazines were provided with them and that she read to people who needed support with this. Other people enjoyed crossword and other puzzles and she ensured that people had a supply of these. Another person liked to knit for charity and the activities coordinator delivered the finished items for this person. People who were able to speak with us said that they had enough to keep them occupied and enjoyed their one-to-one time with staff most.

The coordinator completed a monthly activities board which showed manicures, hand massages and taking board games in to play with people. 'Chat topics' such as the Queen's 90th birthday were listed to give care staff ideas for subjects to talk about with people. Individual records were kept to show what each person had participated in each week. A relative told us, " Mum isn't able to join in with any formal activity, but staff often sit and talk to her or give her a hand massage; which is lovely for her".

The activities coordinator told us that a number of people were unable to communicate verbally. However, she had learned what they liked through their non-verbal responses and by speaking with families and visitors about what people had enjoyed when they lived in their own homes. For example; one person loved dogs and had them to visit during the inspection; which gave them obvious pleasure. Another person preferred their own company and to watch TV. We observed that staff made conversation with this person about what they had been watching and engaged them like this.

Care plans were person- centred and had been developed around individual needs and preferences. Detailed information about people's life histories had been compiled on forms entitled; 'Getting to know me'; and staff were able to tell us about people's different personalities. Some people had 'Memories' albums full of photos and keep-sakes which staff used as conversation starters, and reminded people of happy times and achievements.

People's choice about whether to have baths or showers was documented in care plans along with other information about how they liked their care to be delivered. For example; one care plan noted the position the person favoured when lying in bed. Another care plan recorded that the person liked to wash themselves but tired easily so staff should offer to support them if they wished; to make sure they were clean all over.

Assessments about any particular risks to people had been written to take account of the individual support needed. For example, an assessment about assisting a person to move using a hoist, noted that they experienced involuntary limb movements and that staff should take extra care to make sure the person did not injure themselves. There were individual hoist sling records in place which identified the type and size each person needed to be secure when lifted.

People who were at risk of developing pressure areas had been provided with special air-flow mattresses. These had been set to people's individual weights and a record was maintained to show these were checked regularly. Staff repositioned people according to their own specific needs and whether they were able to move themselves in bed or a chair. We observed that staff referred to care plan information when necessary and that care plans had been regularly reviewed and updated.

Requires Improvement

Is the service well-led?

Our findings

The lack of consistent management oversight of the service had an impact on the quality of service people received. Although a registered manager was in post, they spent the majority of their hours on shift, and this left little time to undertake management tasks to assure the delivery of high quality care. People and relatives told us that the registered manager was "Approachable" and "Kind". Relatives said they always felt welcome when visiting and that staff and the registered manager always greeted them with a smile. Staff said that they enjoyed working in the service and that they felt valued by the registered manager. They described an open culture where they were encouraged to speak out with any concerns or ideas to improve the quality of the service being provided. All staff we spoke with felt supported by the registered manager but some said they worried for her because "She works so many hours and misses out on her family life".

The registered manager explained that she was only contracted for 12 hours per week to manage the home. She worked in the role of nurse, for which she is qualified, for another 24 hours each week. The registered manager told us that this was not sufficient time to allow her to have proper oversight of the service. We saw evidence of this during the inspection where we found records to be disjointed and spread out, some refresher training overdue, medicines poorly managed in some respects, best interest decisions not carried out and auditing ineffective. Although the registered manager said that she worked many extra unpaid hours, she had still been unable to keep on top of all of her management duties. This was impacting on the service as the lack of oversight had created the opportunity for mistakes to happen; even though people had received appropriate care to date.

We recommend that the provider considers whether the registered manager's current contracted hours are sufficient to enable her to manage the service safely and effectively.

At our last inspection, records had not been consistently completed to show the care people had received. At this inspection the situation had not significantly improved. Throughout the two days of the inspection we found it was necessary to piece together information from a number of sources to be able to evidence that people had received appropriate care. For example; when people needed to be repositioned in bed, their care plans recorded that they should be turned every three to four hours. There were charts in use to show when this had happened and they evidenced that people had been repositioned regularly during the daytime. However, the entries on these charts stopped in the evenings. We had to look at other documents such as night records to be sure that people had been repositioned as described in their care plans. Although we found that they had, the records about turning people to protect their skin were disjointed and created a risk that regular turning could be overlooked.

Care files contained a one-page summary about different aspects of people's care; including eating and drinking. The summaries for people who had their drinks thickened to help them with swallowing, did not record this. We checked staffs' understanding about thickening fluids and they were able to tell us which people had drinks like this and the consistency they were prepared to. However, the failure to include this information on the care plan summary made it possible that any new staff may miss this crucial detail.

Although catheters had been checked and changed appropriately, the documentation to support this was unclear. We had to read four separate records in order to positively establish that catheters and bags had been properly managed. Records to show when people had received their medicines, (MAR) had not always been completed; making it difficult to work out in retrospect, whether people had actually received them. Although reconciliation checks proved people had been given the medicines, it was not always possible to see this by reviewing the MAR which created the risk that staff could not immediately tell if people had medicines as prescribed to them.

Systems in place to measure the quality and safety of the service were not robust. Regular audits were carried out to identify any shortfalls in areas such as health and safety and infection control. However, not all auditing had been effective in recognising issues. Medicines audits had been carried out both daily and weekly but had failed to pick up the gaps in signatures we found during the inspection. This meant that gaps were not investigated until we highlighted them and that there was a risk that people had missed doses.

The failure to maintain accurate, complete and contemporaneous records and to effectively audit the service is a continued breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Other records on the service had documented any problems and included action plans to detail when they had been addressed. For example, an infection control audit noted that some carpets needed cleaning and this had happened. Items highlighted in health and safety audits had been transferred to the maintenance book and were signed off as completed by the handyman. Falls had been tracked by the registered manager and revised risk assessments put in place for people.
There was a daily diary in use which recorded any particular issues of note in connection with people's care; such as appointment follow-ups and whether people needed dressings changed.

At our last inspection statutory notifications about deaths had not been provided to the Commission. At this inspection we found that any deaths had been appropriately reported in a timely way.

Feedback had been sought from people when possible, and their families. 'Friends and Family' meetings were held regularly and minutes showed that relatives were pleased with the care being provided. The registered manager had acted on feedback ,for example by agreeing to family members joining their loved ones for Sunday lunch. A survey had been issued in February 2016 and the responses we read were wholly positive. One relative responded; "Mum has received excellent care here" and a person had replied, "I find the meals good".

Minutes of staff meetings showed that these were used as a forum to seek staff views but also to pass on important guidance about people's care and treatment. At one meeting, the safe positioning of people during and after eating was discussed and at another, information about how people should be supported to move was given. Staff told us that they were completely at ease in raising any concerns or ideas at these meetings and with the registered manager. One staff member told us; "It's our aim to give people the best-they deserve it". A relative we spoke with said, "It's really, really special here-Excellent staff who really mind about people's care".

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Best interest discussions and documentation had not been completed for people using bed rails.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines had not always been stored and recorded properly.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment procedures were not sufficiently robust or detailed.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Records had not been properly maintained and were not easily accessible or accurate in some cases. Not all auditing had been effective in identifying shortfalls in the quality and safety of the service.

The enforcement action we took:

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