Parkfield Health Care Limited

Adel Grange Residential Home

Inspection report

Adel Grange Close
Adel
Leeds
West Yorkshire
LS16 8HX

Tel: 01132611288

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Our inspection took place on 21 March 2016 and was unannounced. At our focused inspection on 24 June 2015 we found the provider had followed their action plan to address shortfalls in relation to breaches of Regulations 12, 17 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adel Grange is a residential home for thirty people, situated in North Leeds. On the day of our inspection there were 27 people using the service. The building is listed and retains many original features. Some alterations have been made to make the home more accessible.

Communal accommodation consists of two lounges and a spacious dining room. Most bedrooms have en-suite facilities and are accessed by a passenger lift. There are some rooms available on the ground floor.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found the provider had an inconsistent approach to assessment and recording of the risks to people. Some care plans contained detailed risk assessments, however we saw some care plans where risks had not been identified, meaning staff would not be aware of how to ensure the risks to people were adequately mitigated.

Safeguarding was understood by staff, although the provider had not ensured training in this area was kept up to date. We saw records which evidenced some concerns were escalated to external bodies when needed. Accident and incident recording was mainly good, however we found two falls had not been recorded or reported.

Appropriate background checks were carried out before new staff began working in the service. We saw there was no system in place to ensure staffing levels were matched to the current care and support needs in the service. People who used the service, their relatives and staff all expressed concerns that staffing levels were not adequate.

We found the provider was managing people's medicines safely and kept training in this area up to date, however there was a lack of ongoing checks of staff competency in the administration of medicines and other areas of training.

There was an inconsistent approach to the obtaining of consents from people who used the service. Not all care plans evidenced the provider was undertaking assessments related to the Mental Capacity Act 2008. Where people's relatives had given consent there was a lack of evidence best interests decisions had been made.

Staff were supported in their roles with regular supervision, however appraisals had not been kept up to date. We saw there was a plan in place to address this. Staff training was not kept up to date in all areas, and the registered manager told us the provider did not provide support to ensure the training programme was adhered to.

We saw people were supported to have access to a wide range of health professionals.

We observed the lunchtime service and saw it was relaxed, with people assisted to make choices in a patient and caring way. One person was supported to eat their meal and we saw the staff member did not provide this support in a caring way.

There was good feedback about staff from people and their relatives, however we were told that agency workers were not always effective in their roles. Our observations of staff practice evidenced some staff worked in a kind and person-centred way, however this was not consistent. We saw several incidences of staff not being mindful of appropriate behaviours or the feelings of the person they were supporting.

We found people's care plans lacked person centred information relating to their preferred lifestyles, likes and dislikes. Care plans were not always updated to reflect people's changing needs. Synopsis care plans used by staff did not always contain sufficient guidance to enable them to provide responsive care and support.

There was a programme of activities in place, however the activities co-ordinator was not always available to lead these. They had not been supported to be effective in this role with any training, and there was no budget available to them.

We received consistently positive feedback about the registered manager. They told us they did not always have effective support from the provider to maintain effective leadership in the service.

We looked at maintenance records and the reports from the registered manager's monthly walk-rounds, however not all items were actioned. The registered manager told us the provider did not always respond to these reports in a timely manner.

The registered manager undertook a range of audits but these were not always kept up to date.

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

Inadequate

The service was not always safe.

The provider had systems in place to ensure people's medicines were managed safely, although the registered manager agreed records relating to creams and ointments needed to be improved.

People who used the service, their relatives and staff members told us there were not always enough staff on duty. There was no system in place to calculate staffing levels to ensure they reflected the care and support needs of people who used the service.

Not all care plans contained risk assessments relating to people's care and support needs.

Is the service effective?

Requires Improvement

The service was not always effective.

The provider was not assessing people's capacity to make decisions in accordance with the Mental Capacity Act (2005), and we saw an inconsistent approach to gaining consent.

Not all staff had completed all mandatory training, and we saw refresher training was not always kept up to date.

We saw evidence people had access to healthcare professionals when they needed to.

Is the service caring?

Requires Improvement

The service was not always caring.

People told us staff employed by the provider were caring, but gave poor feedback about agency staff who worked in the service.

We saw some positive interactions between staff and people who used the service, however this was not always the case. We made several observations of staff not being mindful of people's

dignity and feelings.

People's care plans lacked information relating to their hobbies, interests, likes and dislikes.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans lacked evidence of the involvement of people and their relatives.

Care plans were not always updated to reflect people's changing needs. Some care plans lacked guidance for staff to help them provide appropriate care and support.

The part-time activities co-ordinator had an enthusiastic approach, although we found they had not received any training to support them in this role. There was no budget to support the activities programme.

Is the service well-led?

Requires Improvement

The service was not always well-led.

People who used the service, their relatives and staff gave positive feedback about the registered manager. Staff told us the registered manager listened to their feedback and acted appropriately.

There was a programme of audit in place, however this was not robust enough to effectively drive quality in the service.

We saw the registered manager identified improvements needed in the service during a monthly walk-round, however the provider did not always respond to these in a timely manner.

Adel Grange Residential 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.

Our inspection took place on 21 March 2016 and was unannounced. The inspection team consisted of four adult social care inspectors.

Before our inspection we reviewed all the information we held about the service, including notifications from the provider and previous inspection reports. We did not send a provider information return before the inspection. 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.

During the inspection we reviewed the care plans of seven people and looked at other documents relating to people's care and the general running of the service. We spoke with six people who used the service, three visiting relatives and a visiting professional. We also spoke with the registered manager, the deputy manager, the chef, the activity organiser and four members of care staff.

Inadequate

Is the service safe?

Our findings

At our focused inspection of Adel Grange on 24 June 2015 we rated this domain as Inadequate. We found the provider had followed their action plan to address shortfalls in relation to Regulation 12 (g) (safe care and treatment) and regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Although we found the provider was now meeting legal requirements, we required evidence of a longer term track record of consistent good practice before we reviewed the rating.

We looked at the care plans of seven people and found an inconsistent approach to recording of risk assessments. Where risk assessments were present in care plans we found they were comprehensive, regularly reviewed and relevant plans were in place to reduce the risks to the person. Three care files contained no risk assessments, meaning staff had no guidance to help them mitigate any risks associated with those people's care and support needs. One person whose care plan contained no risk assessments had sustained injuries requiring hospitalisation three days before our inspection, and another fall three weeks prior to that. Their care plan contained no falls risk assessment or related care plan. We brought this to the attention of the registered manager who told us the care plans which contained no risk assessments were for people who had were using the service on a temporary basis, although two of the people had been living at Adel Grange for periods of several months. The registered manager agreed the risk assessments should have been in place.

This constituted a breach of Regulation 12 (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with expressed some concerns about the level of staffing in the home. Comments included, "There are not enough staff at night" and "People are always waiting for service at night." Visiting relatives we spoke with gave similar feedback. One visitor told us, "They could do with some more staff, the carers have a lot to do." Another said, "A few more staff would help."

Staff also told us they felt they were not always deployed in sufficient numbers to provide safe care and treatment. One member of staff told us, "We don't always have enough staff, especially at night. I'm never sure who to go to first if alarms go off."

Other members of staff told us how staffing levels impacted on their jobs. One member of staff said, "I have made mistakes in the past with medicines because I have had to do one thing whilst also keeping an eye on people in the lounge. There is too much to do at once." Another told us, "We can be rushed if there is a lot to do when we get people up, if their room is a mess then we need to clean it as well as help them get up. If it's really bad the cleaner will do it, but night staff tend not to have chance."

The service is arranged across more than one floor with a number of internal doors and corridors, meaning staff would need to move around the home regularly to ensure people who used the service were safe. The registered manager told us they had five care workers including one senior member of staff on shift each

day, and two care workers and one senior at night. Care records we looked at evidenced there was a high dependency for care and support. One member of staff told us they had to 'watch the lounge' if care staff were busy elsewhere. They said when this happened and people wanted to go to the toilet they could not help as they were not care staff and had to wait or go and find care staff to assist.

We discussed this with the registered manager who told us dependency levels were high. We asked them how staffing levels had been determined and they acknowledged there was no tool used to calculate safe staffing levels within the home, although they said they were looking to put one in place which would include a dependency tool. From feedback we received and our observations, we considered there were insufficient staff deployed to meet people's needs. There was also no evidence to show people's dependencies and the layout of the building had been taken into account to ensure staffing levels were safe. This was a breach of the Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safeguarding records showed six safeguarding referrals had been made since January 2015. Referrals showed the actions taken in response to the allegations, although we found two of these safeguarding incidents had not been notified to the Commission as required. We also found an entry in the daily records for one person which showed they had alleged staff had been hitting them. There was no evidence to show what had been done in response to this allegation. We discussed this with the registered manager who told us they had not made a safeguarding referral as they had spoken with the person about the allegation and they had said it didn't happen, although the registered manager was not able to show us a record of this discussion. The registered manager said they had also discussed the allegation with healthcare professionals in a recent review of this person's care and it had been agreed that additional support would be provided to staff in how best to manage this person's behaviour.

Staff we spoke with had a good understanding of safeguarding, knew the reporting procedures and said they would have no hesitation in informing external agencies if they felt matters were not being dealt with properly.

People we spoke with told us they or their relatives felt safe at Adel Grange. One person said, "I feel safe here, the carers understand everybody's problems." A relative told us, "[Name of person] settled well and made friends here."

We looked at the records relating to accidents and incidents in the home for the three months before our inspection, and found that not all had been recorded. For example, we saw two falls in two days recorded in one person's daily notes, but could not find any evidence of an accident form having been completed for these. Where accident forms had been completed and reviewed we saw information relating to who had investigated and the outcome, together with an indication as to whether the incident had been notified to the CQC and local authority as appropriate. On one form we saw the registered manager had written, 'Will speak to night staff' as a required action, however we were unable to find evidence that this had happened.

We looked at the recruitment records of two members of staff. We found the provider had followed safer recruitment practices by taking references and making checks with the Disclosure and Barring Service (DBS). The DBS is a national agency which holds information about criminal records and assists employers identify potential employees who are barred from working with vulnerable people.

We looked at how medicines were managed and observed a senior staff member during the morning medicines round. The staff member was calm and efficient and followed good practices to ensure medicines were administered safely. Some medicines were prescribed with special instructions about how they should

be taken in relation to food. We saw there were arrangements in place to make sure these instructions were followed.

The staff member told us one person received their medicines covertly, which means the medicines were disguised or hidden in food or drink to ensure they were taken. There were clear instructions on the medicines administration record MAR as to how these medicines should be given, as well as recorded agreement in the person's care file to show this person lacked capacity and the decision to give medicines covertly had been agreed in the person's best interests with the person's GP, social workers and family.

The registered manager told us all the senior staff had received medicines training which they said was updated annually. The trainee deputy manager confirmed they had received medicines training in the last month. The registered manager said medicine competency checks were not completed, but was willing to put these in place

We found the records for the administration of topical medicines such as creams and ointments were incomplete. The staff member told us these were administered by care staff when they were delivering personal care and the care staff signed the topical medicine administration record (TMAR) which was kept in the person's care file. We looked at the TMARs for four people and none had been completed correctly. For example, one person was prescribed an emollient for dry skin which was to be applied twice a day, yet from 7 March 2016 to the date of the inspection it had only been signed as administered once daily on six occasions. We raised this with the registered manager they said they were confident staff were applying the creams but agreed the recording needed to improve.

Some prescription medicines contain drugs that are controlled under the Misuse of Drugs legislation. These medicines are called controlled drugs (CD). We found these medicines were kept securely and records were completed correctly. We checked the stock balance of one CD and it was correct.

Requires Improvement

Is the service effective?

Our findings

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

Care plans evidenced an inconsistent approach to obtaining consents. For example, we saw a number of consents including consent to care and treatment, immunisation and photography which had been signed by relatives. One of the care plans we looked at contained a mental capacity assessment and details of a best interests decision, the others did not evidence why the person using the service had not signed consents. We saw in one care plan that family members had signed to express a preference which their relative disagreed with. Although the provider had recognised that the person using the service had capacity to make the decision and was respecting their wishes, their care plan had not been updated to reflect this. We discussed this with the registered manager during the inspection and they agreed to change the information in the care plan.

We concluded this was a breach of Regulation 11 Need for consent of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA

The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We looked at arrangements in place in respect of this and whether any conditions on authorisations to deprive a person of their liberty were being met.

Two people who used the service had an approved DoLS in place, and we saw the registered manager had applied for a DoLS for a person who was expressing a wish to leave which would have put them at risk of harm. There was evidence a best interests decision had been made involving the person's family, health professionals involved in the person's care and senior care staff.

Staff we spoke with understood DoLS and were aware of which people who used the service had a DoLS in place. They told us they could access information about any conditions connected with the DoLS if they were unsure.

Staff told us they had regular meetings or 'supervisions' with senior staff to discuss their performance. Staff we spoke with told us they gave and received honest feedback about their performance and discussed their training needs. We did not see evidence of regular appraisals taking place, however the registered manager had a plan in place to ensure these were undertaken in the current year.

We looked at evidence of the training provided for staff to support them in their roles. The registered manager had a log of training which had been carried out and the frequency at which it should be refreshed. We saw some staff training had not been kept up to date. For example, seven out of 22 staff had no record of training in safeguarding, and this included two senior care assistants. The provider's records stated this training should be refreshed every two years, however seven staff's most recent training was outside this frequency. This meant only eight staff had up to date training in safeguarding. Training in other areas such as infection control, MCA and DoLS and fire safety had also not been refreshed for all staff within the stated timescales. The registered manager told us they did not always get the support they needed from the provider to keep training up to date, and in addition we saw there were no records of checks on staff competency which would have demonstrated training had been effective.

We spoke with the staff member who was responsible for organising activities for people. We asked what training they had received to help them carry out this role and they said none. They said they had done their own research on the Internet but felt some training would be helpful as they found it difficult sometimes to know how to motivate people.

We spoke with the registered manager who told us they had asked the provider for support to deliver the full range of training needed, but no action had been taken by them.

This was a breach of Regulations 18 (2) (a) Staffing of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Care plans evidenced that people had access to healthcare services when they needed them. We saw records relating to input from a range of professionals including speech and language therapists, dieticians, occupational health therapists and GPs. A visiting relative told us, "[Name of person]'s healthcare needs are always met – they have got a chiropodist in for her, and they always get a doctor if people aren't well."

The lunch service in the main dining room was relaxed. Large print menus were on the tables, and staff asked if people needed any more assistance to understand what was on offer. People were asked for their choice of main meal by table, and this was served immediately. Staff were patient and supportive, and people had time to make choices. Food looked hot and people said they enjoyed it. Staff asked people if they would like more and offered a choice of desserts.

One person was being supported to eat their meal. They occasionally asked the staff member for a drink, but the staff member did not offer any engagement with the person as they assisted them.

Requires Improvement

Is the service caring?

Our findings

People who used the service gave some good feedback about staff. Comments included, "The staff are good to me," and "The staff sit and comfort people who are upset." Visiting relatives were complimentary about the staff and the atmosphere in the home. One relative told us, "The staff are fantastic, proper caring people. It's not just a job, they enjoy giving care." Another relative said, "They are always welcoming, it's like a big family."

Staff described ways in which they were mindful of people's privacy and dignity. These included knocking on people's doors before entering their rooms and ensuring people were covered as much as possible and curtains were closed when carrying out personal care.

People's care plans lacked information about their lifestyles, hobbies likes and dislikes which would be of assistance to staff in forming meaningful relationships with people who used the service, however we observed a number of interactions which evidenced staff knew people well.

We saw people generally looked well presented, with evidence personal care had been attended to.

We saw some positive care interactions between people and staff. We saw staff crouching down so they were at eye level with people when they were talking. We saw one person was distressed and the staff member was speaking calmly and quietly giving reassurance. The staff member said, "I know what will cheer you up. Shall I bring you your photos. I'll just go and get them." The person clearly enjoyed looking at the pictures

We received some less positive feedback about agency staff. One person who used the service told us, "They use too many agency staff, they don't know what to do. They just stand around, they're not effective." A relative said, "Agency staff tend to just sit and watch." A member of staff told us, "Clients don't always like the agency staff. I always tell [the registered manager] if this is the case."

In contrast we saw some staff practices which showed a lack of awareness of dignity and respect. We saw one staff member often kissed people after they spoken with them which was done in a kindly way, however it suggested the staff member was not aware of professional boundaries and that some people may not welcome this intimate contact. On one occasion we saw a person was dozing in a chair in the lounge. A staff member came into the room with a person in a wheelchair. They tapped the person in the chair on the shoulder while at the same time removing the pillow from behind them saying, "I need this." The person said, "I like that (meaning the pillow which was being removed)' and the staff member said, "It's for (person in the wheelchair), not you" and left the room with the pillow and the person in the wheelchair.

We saw the registered manager walking through the lounge with a person to the dining room. The person had a clothing protector on which was torn and their trousers had a very large wet patch on the front and back. The inspector alerted the registered manager, who was not aware, and they immediately took the person to get changed. However, although the wet patch was evident this had not been picked up until we

drew it to staff's attention.

In the afternoon we spoke with one person who was unshaven. We asked them if they wanted a shave and they said yes and asked us if we could arrange it. We asked one of the care staff who took the person out of the lounge. The person returned a short time later still unshaven. The person told us they had not wanted that staff member to assist them. We spoke with the registered manager who arranged for the person's personal care to be attended to. After the person had been shaved they were very happy and asked us to touch their face to feel how smooth it felt.

We concluded the above examples constituted a breach of Regulation 10 Dignity and Respect of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service responsive?

Our findings

People who used the service did not always feel involved in writing or reviewing their care plans. One person told us, "They do ask for information but I don't know exactly what they use it for." One relative told us about their experience. They said, "[Name of person] has been here well over a year. They have just started to talk to me about the care plan. I have never signed it but I have asked to have a look at it." Care plans did not evidence the involvement of people or their relatives, although we did see some evidence of regular review.

Care plans were not always updated to reflect people's changing needs. For example in one care plan we saw instructions relating to a person needing their meals adapting for texture and consistency to minimise choking risks. The registered manager told us a speech and language therapist had visited the person some months before our inspection and we saw their assessment stated the person could resume a normal diet. Another person's malnutrition universal screening tool (MUST) had not been completed since December 2015. Weight records showed the person had lost over a kilogram since the last MUST assessment.

In another care plan we saw the person was at risk of urinary tract infections, and the guidance for staff was to record the person's fluid intake. There was no information in the care plan which specified how much the person needed to drink, what staff should do if the person did not drink sufficient fluid and no indication of likely symptoms which may alert staff to the presence of an infection. Although fluid charts had been completed, we saw entries did not show how much the person had drunk each day. Entries used generalised phrases such as 'good diet and fluids,' and 'ate and drank a fair amount.'

The registered manager told us people had two care files, one known as the 'synopsis' was used by care staff and the other larger file was kept in the office and not accessed by care staff. The registered manager told us they wrote and updated all the care records with assistance from the trainee deputy manager. They also told us staff were unlikely to read these due to their length and complexity.

The synopsis contained a care plan summary which provided an overview of individual care needs, however we found more information was required to reflect the information provided in the main care files and to ensure staff knew what support each person needed. For example, in one care plan we saw reference to the person exhibiting 'unpredictable behaviour', but there was no information to enable staff to help the person appropriately.

We found daily records focussed on people's physical care needs and did not reflect how people had spent their days.

We concluded the above evidenced a breach of Regulation 9 Person centred care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans in the larger files contained information about how people preferred their physical care needs to be met. There was evidence to show specialist advice was sought when required. For example, an occupational therapist and physiotherapist had assessed one person's seating and how they were

transferred by staff to determine if any specialist equipment was needed.

There were no activities taking place during our inspection, although we saw from the activity plan on display that there should have been a domino tournament on that day. A member of staff told us, "There need to be more activities. Today there won't be any activity because there is a lot of cleaning to do. The staff member that does activities spends more time cleaning at the moment."

We spoke with the activity organiser who also had another role as housekeeper. They told us they were employed for activities 20 hours a week. The staff member was very enthusiastic about this role and we saw they interacted with people well. They told us how they had made 'twiddle blankets' for people, which are blankets with attachments, and different textures which people living with dementia can feel and play with. We did not see any of these in use during our inspection and the activities organiser said they did not know where they had gone.

The registered manager confirmed there was no budget assigned for activities and they relied on fundraising. The activity organiser told us they had raised money which paid for some people to go on a day trip to Blackpool in 2015. There was information displayed in the home about fundraising events that were taking place now and in the future to raise money to create a cinema room in the quiet lounge.

Although some staff made every effort to engage with people there were times when we saw other staff stood in lounge areas watching people rather than engaging with them.

In the main lounge there was music playing and we heard some people singing along to the songs and other people dancing. At times there were television programmes showing on the television but no sound as the music was playing. Apart from the television and music there was little for people to do and we saw most people sat in the lounge just watching what was going on. There were no books, magazines or games, although we saw in the small lounge there were some items stored behind a settee, but these were not accessible to people.

One relative told us about their experience of making a complaint. They said, "I spoke to the deputy manager as (the registered manager) was not in the home. (The registered manager) arranged a meeting with me and sorted things out. I was happy with the way things were dealt with. I have seen improvements since. They seem to have done everything I asked, I am happier now."

Staff told us the registered manager held meetings with them to discuss any complaints received.

Requires Improvement

Is the service well-led?

Our findings

At our focused inspection on 24 June 2015 we rated this domain as requires improvement. We found the provider had followed their action plan to address shortfalls in relation to Regulation 17 Good governance of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

There were systems in place to assess and monitor the service but some of these needed to be more robust.

We found the building was generally clean and free from malodour but saw a number of areas where work was still needed. For example the bathroom equipped with a hoist was out of use, meaning people had to have showers even if this was not their preference. One person's care plan showed they liked to have a bath, yet according to their records they had received no baths or showers in March 2016. When we discussed this with the registered manager they said the person would have had a shower, it just had not been recorded. We saw the registered manager was conducting a monthly walk-round of the service and identifying items for attention, and providing information to the provider when works required their approval. The registered manager told us they did not always get a response from the provider and we saw some works had been waiting in excess of a month for action.

We looked at the servicing records relating to the premises. We saw the electrical installation certification was in date, however the gas safety checks had last been carried out in January 2015 and were therefore out of date. We also looked at arrangements in place to test fire alarm systems and carry out drills. The last test was carried out in June 2015.

Our inspection identified shortfalls which had not been addressed through the provider's own quality assurance systems. This included gaps in training as records showed staff had not received updates in mandatory subjects such as safeguarding, fire safety and infection control.

There was no staffing tool in use to determine or review staffing levels to ensure they were sufficient to meet people's needs. There was no evidence to show people's dependencies and the layout of the building had been taken into consideration.

People's care records including care plans and risk assessments were not always in place, accurate or up to date. There was lack of evidence to show how consent had been obtained or agreed.

Although we had received other notifications from the service, we had not been notified of two safeguarding incidents.

We concluded there was a lack of leadership and support from the provider to enable the registered manager to drive improvement in the service effectively. This was a breach of Regulation 17 Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home had a registered manager and we received positive feedback about them from staff we spoke

with. Comments included, '[name of registered manager] is down to earth and approachable,' and '[name of registered manager] is fair, she listens to facts and doesn't jump to judgements. I don't feel she would judge me if I took an issue to her.' Staff told us the registered manager was a visible presence in the service and regularly worked alongside them to provide care and support for people.

A visiting relative told us, "[names of registered manager and deputy] are wonderful. Easy to talk to and you can have a laugh with them."

We saw evidence of regular visits by the provider. The registered manager told us the provider made observations in the service and spoke with people who used the service.

We saw there was a programme of audit in place in the service. The registered manager conducted checks relating to infection control, medicines, health and safety, accidents and night staff.

The registered manager held regular meetings with staff to enable them to contribute to discussions about the organisation of the service. Staff told us the meetings were useful, and said they could make suggestions which the registered manager acted on.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans were not always updated to reflect people's changing care and support needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Staff did not always work in ways which demonstrated they were mindful of people's dignity.

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 ensuring people's consent to aspects of their care and support were appropriately obtained or adequately documented.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider was not ensuring people who used the service on a temporary basis were adequately safe because they had not carried out risk assessments.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a lack of leadership and support from the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was no system in place to ensure that staffing levels were adequate to meet the care and support needs of people using the service. Staff training was not kept up to date.