Sheval Limited

Asheborough House Care Centre - Saltash

Inspection report

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

Overall summary

This was an unannounced inspection on 27 and 30 October 2015. Asheborough House Care Centre – Saltash provides nursing and residential care for up to 31 older people who require support in their later life or are living with dementia or mental ill health.

There were 28 people living at the service at the time of our inspection. The home is on three floors, with access to the lower and upper floor via stairs, a lift or chair lift. All bedrooms have wash hand basins. There are shared bathrooms, shower facilities and toilets. Communal areas include three lounges, and one dining room. There is a garden for people to use when they wish to.

The service had not had a registered manager since August 2015; however an application for a new manager was in process. A registered manager is a person who has registered with the Care Quality Commission to manage

Summary of findings

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.

At our last inspection in October 2014 we told the provider to take action to make improvements to how they ensured staff were formally supervised, and to how they assessed and monitored the quality of the service people received. The provider sent us an action plan confirming how improvements were going to be made. During this inspection we looked to see if these improvements had been made. We found they had not all been completed.

People received care and support from staff who were kind and caring, and treated them with respect. Relatives told us they were happy with the care their loved ones received. People and their relatives told us there were enough staff. However, on the first day of our inspection we were told by staff, and observed, there were not enough care staff on duty. Some people did not receive their breakfast until 11.30am and some people were still being assisted out of bed at 12 noon. People who required assistance at lunch time, were not always given it or had to wait whilst others finished their meal, before being supported. Social activities did not always take place which meant people did not have much to occupy their time.

People did not live in an environment which promoted the principles of good dementia care because of poor signage and a lack of colour contrast. Although the environment was clean and free from malodours, people were not always protected by effective infection control procedures because staff did not always display knowledge of infection control practices.

People were supported to eat and drink enough and maintain a balanced diet. The chef was knowledgeable about people's individual nutritional needs. People who required assistance with their meals were supported in a kind way. People's care plans provided details to staff about how to meet people's individual nutritional needs. People who were at risk of losing weight were not always effectively monitored; however the manager took immediate action to resolve this.

People felt safe. The manager and staff understood their safeguarding responsibilities and had undertaken training. People were protected by safe recruitment procedures as the manager ensured new employees were subject to necessary checks which determined they were suitable to work with vulnerable people.

People were not always protected from risks associated with their care because staff did not have the correct guidance and direction about how to meet people's individual care needs. Accidents and incidents were not robustly analysed to help prevent them from occurring again. People had personal evacuation plans in place, which meant people could be effectively supported in an emergency.

People's mental capacity was assessed which meant care being provided by staff was in line with people's wishes. People who were deprived of their liberty had been assessed. The registered manager and staff understand how the Mental Capacity Act 2005 (MCA) and the associated Deprivation of Liberty Safeguards (DoLS) protected people to ensure their freedom was supported and respected. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. People's consent to care and treatment was obtained, and staff asked people for their consent prior to supporting them.

People did not always have care plans in place to address their individual health and social care needs. People's care plans were not always reflective of the care being delivered. People were not involved in the creation of their care plan. Nursing records were not always reflective of people's care plans. People's changing care needs were not always communicated to help ensure prompt action was taken. External health professionals did not have any concerns and explained they were contacted appropriately when required.

People were cared for at the end of their life. Nursing staff had good links with GPs to help ensure people's care was effectively co-ordinated. People's end of life care and resuscitation wishes had not always been recorded so

Summary of findings

staff would know what to do at the end of a person's life to ensure they received the care they wanted. The manager told us she would be making improvements. People's medicines were managed safely.

People's confidential and personal information was stored securely and the manager and staff were mindful of the importance of confidentiality when speaking about people's care and support needs in front of others.

People and those who mattered to them were encouraged to provide feedback about the service they received. People told us if they had any concerns or complaints they felt confident to speak with the staff or manager. People received care from staff that had been given training and supervision to carry out their role. Staff felt the manager was supportive. Staff felt confident about whistleblowing and told us the manager would take action to address any concerns.

The provider did not have effective systems and processes in place to ensure people received a high quality of care and people's needs were being met. The Commission was not always notified appropriately, for example in the event of a serious injury. The manager had an ethos of honesty and transparency. This reflected the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment.

We recommend the provider considers research and published guidance in relation to the design of the care home environment and its connection in providing an enhanced level of care for people living with dementia.

We found 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 the 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?

Requires improvement

The service was not always safe.

People were not always protected from risks associated with their care and documentation relating to this was not always reflective of people's individual needs.

People's accidents and incidents were not robustly analysed to help prevent them from occurring again.

People lived in an environment free from odour; however, infection control practices were not always followed.

There were not always enough staff to meet people's needs.

People told us they felt safe.

People received their medicine safely.

Staff knew what action they would take if they suspected abuse was taking place.

Safe recruitment practices were in place.

Is the service effective?

Requires improvement

The service was not always effective.

People were protected by the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) as the staff and manager understood the legislative framework. People's consent was obtained prior to being supported or assisted.

Staff had the necessary knowledge, skills and training to meet people's needs.

People had their health needs met. People's changing care needs were referred to relevant health services.

People did not live in an environment which promoted the principles of good dementia care. However, the manager was receptive to our feedback and was considering action.

People liked the meals provided. People who were at risk of losing weight were not always effectively monitored; however the manager took immediate action to resolve this.

Is the service caring?

Requires improvement

The service was not always caring.

Summary of findings

People were cared for at the end of their life. Nursing staff had good links with GPs to help ensure people's care was effectively co-ordinated. End of life care plans were not always in place for every person, which meant people's wishes at the end of their life may not be carried out as they may not be known by staff.

People, their friends and family were encouraged to be involved in making decisions about their care.

People told us staff were kind.

Staff spoke fondly of people and knew people well.

People's privacy and dignity were respected.

Is the service responsive?

Requires improvement

The service was not always responsive.

People were not involved in the design and implementation of their own care

plan which meant care planning documentation was not reflective of their wishes.

People's care plans were not individualised and did not always give guidance and direction to staff about how to meet people's care needs.

People's care plans were not effectively reviewed to help ensure people's changing care needs were documented.

People's independence and social life was not always promoted which meant people had very little to occupy their time.

People could raise concerns and complaints. People felt confident action would be taken.

Is the service well-led?

Requires improvement

The service was not always well led.

People did not receive a high standard of quality care because the systems and processes for quality monitoring were ineffective in ensuring people's individual needs were safely met.

The provider had not always notified the Commission of significant events which had occurred, in line with their legal obligations.

The manager worked in partnership with external professionals to help ensure people's health care needs were met and a co-ordinated approach was taken.

Asheborough House Care Centre - Saltash

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.

We visited the home unannounced on 27 and 30 October 2015. The inspection team consisted of two inspectors, a specialist nurse advisor of older people's dementia and mental health, and one expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed information we held about the home. We reviewed notifications of incidents that the provider had sent us since the last inspection and previous inspection reports. A notification is information about important events, which the service is required to send us by law.

We also contacted two GP practices, the local authority service improvement team, a speech and language therapist, a continuing health care nurse, and Healthwatch Cornwall for their views.

We spoke with seven people living at the service and five relatives/visitors. We also spoke with seven members of care staff, a laundry assistant, a mealtime assistant, the chef, a kitchen assistant, a maintenance man, a cleaner, the deputy manager and manager.

Some people were unable to verbally communicate with us to give us their views about the service, so we observed how people responded and interacted with staff. We observed care and support in the lounge and dining rooms, and watched how people were supported during breakfast and at lunch. We spoke with people in private and looked at 10 care plans and associated care documentation. We pathway tracked four people who lived at the home. Pathway tracking is where we follow a person's route through the service and capture information about how they receive care and treatment. We also looked at medicine administration records (MARS), as well as documentation relating to the management of the service. These included policies and procedures, audits, staffing rotas, five staff recruitment files, training records and quality assurance and monitoring paperwork. We assessed and reviewed the safety and cleanliness of the environment.

Requires improvement

Is the service safe?

Our findings

People's falls and accidents were recorded. However, the information about people's accidents and falls was not robustly recorded and effectively used to identify themes, to help keep the person safe, and prevent it from happening again. For example, one person had fallen in July 2015; however the provider's audit had not identified this therefore action had not been taken to reduce the risk of a fall reoccurring.

People had risk assessments, which gave guidance to staff about how to minimise associated risks related to people's individual care needs. However, when risk assessments were in place, they had not always been updated and reviewed effectively. One person had fallen and sustained a fracture in July 2015, the person's care plan had been reviewed in August 2015, but there had been no recognition of the fall, and no care plan or risk assessment subsequently put into place.

People who were at risk of pressure ulcers did not always receive consistent treatment. For example, one person's care plan detailed they were "very high risk of pressure damage". The person had a diagnosis of diabetes, therefore good foot care was essential to prevent any further problems. The person's care plan detailed they had skin damage to their toe and it was being dressed daily, and to minimise the risk of pressure damage they should sit on a pressure relieving cushion. However, the person was sat in a chair with no pressure relieving equipment in place. We saw an open wound on the person's toe which had been bleeding. We informed the nurse in charge who redressed their toe and encouraged the person to elevate their legs. The manager told us it was difficult for some people to understand the importance of their health and at times people did not wish to have any treatment. However, people's care plans did not reflect this, or address the potential risks associated with people's care needs not being met.

Staff respected people's choice to take risks. For example one person did not want to use the wheelchair foot plates, so staff respected this and minimised the associated risks.

We found risk assessments were not always in place as necessary, updated, and reviewed effectively. Risk assessments were not always reflective of people's individual needs. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the first day of our inspection we were told by staff, and observed, there were not enough care staff on duty. We observed people having breakfast and lunch. Some people did not receive their breakfast until 11.30am and some people were still being assisted out of bed at 12 noon.

People's individual needs were not always being met because there were not sufficient numbers of staff deployed. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On our second day of inspection, staffing levels were improved and there was an obvious contrast to the quality of care being provided. People were given time to make choices, staff were less hurried and people were supported in line with their care plans. The manager told us at times of unplanned sickness or annual leave, they faced some staffing challenges; however, pro-active action was always taken to call in extra staff. The manager used a staffing tool to help ensure there were enough staff to meet people's individual needs. People were supported by both general nurses and mental health nurses. This staffing mix helped to ensure people received nursing care, reflective of their individual needs.

People were not always protected by effective infection control procedures; although the environment was clean and free from malodours, there was no toilet paper in some bathrooms and staff did not always display knowledge of infection control practice. For example, one member of staff handled a full catheter bag with no protective gloves; this posed a risk to both the person and themselves. Slings for hoists were used for more than one person, which posed an infection risk if they were not properly washed in between different people using them. There was no system in place to determine the frequency of washing. The manager spoke with staff and organised training to ensure action would be taken to monitor the washing of slings.

People had personal evacuation care plans in place, which meant in the event of a fire emergency services would know what level of care and support people may need.

Requires improvement

Is the service safe?

People's medicines were effectively managed to ensure they received them safely. The provider's auditing tool used to highlight areas for improvement did not cover the management of homely remedies, but immediate action was taken to include this.

People approached staff and spoke with them with ease. One family member told us, "I know my relative feels safe because […] now never talks about wanting to go home". On our arrival one person was asking a member of staff why we had been asked to sign the visitor's book. The member of staff explained to the person, the importance of checking identification badges to help keep people safe.

People were protected by staff trained and knowledgeable about how to protect them from abuse and harm.

Information about how to report concerns was displayed. Staff felt confident the manager would take action, but were also aware of other agencies they could contact. There was a whistle blowing policy in place to protect staff should they have to report poor practice or professional conduct.

People were supported by suitable staff who were recruited safely. Recruitment procedures were in place and records showed checks were undertaken to help ensure the right staff were employed to keep people safe. The provider had a disciplinary policy and procedure in place which had been used to deal with employee misconduct.

Requires improvement

Is the service effective?

Our findings

At our last inspection in October 2014 we told the provider to take action to make improvements to how they ensured staff were formally supervised. The provider sent us an action plan detailing how they would make improvements. At this inspection we found the provider had made improvements.

People received care from staff that had the knowledge and skills to carry out their roles and responsibilities effectively. New staff completed an induction programme. The manager was aware of the new 'care certificate'. The care certificate is a national induction tool which providers are required to implement, to help ensure staff work to the desired standards expected within the health and social care sector. Staff were asked by the manager to complete and update training applicable to their role, for example dementia training and manual handling. Some care staff told us they had not undertaken training in pressure area care or continence care, but liaised with nursing staff when they were concerned. They told us training would be helpful.

Staff told us they felt supported by the manager and deputy manager, and received supervision that included observations of their practice, and an annual appraisal. Supervision and appraisal is a process by which a person reflects on their work performance and identifies training and development needs. Staff described the supervision process to us and told us, "I had one last week or the week before. [The deputy] assessed me… and a nurse watched me hoisting" and "They ask how we're doing and any issues, it is helpful".

People who were at risk of losing weight were not always being effectively monitored. For example, one person's care plan detailed in September 2015 they should be assisted with their lunch and weighed on a weekly basis. However, on the first day of our inspection the person was not supported at lunch time and the person had not been weighed on a weekly basis. By the second day of our inspection the manager had taken immediate action to address this.

People who were unable to stand or sit on scales had their weights monitored, by the use of the Malnutrition Universal Screening Tool (MUST). This tool is used to measure a person's weight by a calculation of a person's body mass index (BMI). People had food and fluid charts in place if there were concerns about how much a person was eating and drinking. The manager liaised with professionals, such as GPs and speech and language therapists when professional guidance was required.

On the first day of our inspection, the atmosphere at breakfast and at lunch time was disorganised and a lack of staffing meant some people were not adequately supported. For example, some people did not know what to eat or how to use their cutlery. People who required assistance were not always given it or had to wait whilst others finished their meal, before being supported. Staff were trying to assist people, and at the same time trying to assist others. People were not always given a choice of drink or choice of meal. One person waited for their dessert for an hour after they had eaten their main meal.

People's individual needs were not always being met because there were not sufficient numbers of staff deployed. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the second day of our inspection, because of an increase in staffing, mealtimes were better organised, and staff had time to offer people choices and support them effectively. Comments such as "would a spoon be easier for you" and "you haven't eaten very much, would you like some help with this", demonstrated staff had time and were observant to people's individual needs. The management were receptive to our feedback, recognised the impact of reduced staffing and appreciated what had occurred on day one, had not been good enough.

People enjoyed the meals, one person told us, "oh yes the food is always lovely". Relatives comments included, "I've seen my relative at meal times and they always eat the lot" and "Dinner always smells gorgeous". The chef told us she was in discussion with the manager about changing the menu to incorporate more choices for people.

People living with dementia were not supported or empowered by their environment, this affected people's stimulation and independence. For example, there was limited and restricted space for people to walk from room to room, and there were no distinguishing colours or pictures on bathroom doors to help people find them.

People's mental capacity was assessed which meant care being provided by staff was in line with people's wishes.

Requires improvement

Is the service effective?

The legislative framework of the Mental Capacity Act 2005 (MCA) was being followed. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant.

People who were deprived of their liberty had been assessed, which meant their human rights in this respect were protected. The deprivation of liberty safeguards (DoLS) provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. However, there was no reviewing system of DoLS applications in place, to help make sure people's liberty was not being unlawfully and unnecessarily restricted. The manager took immediate action by implementing a monitoring system to address this. The manager and staff had an understanding about the principles of the MCA and DoLS.

People's consent was obtained prior to staff providing support, for example, a member of staff asked one person if they would like an apron on. The person replied that they did not, and this was respected. Other comments such as "would you like me to help you with your lunch" and "can I take this off you now", demonstrated staff sought people's consent to care.

People's changing care needs were referred to relevant health services. People's care records demonstrated a variety of health care professionals were contacted as necessary, for example, psychiatrists, dementia liaison nurses, opticians, chiropodists, and speech and language therapists. A GP visited twice weekly to help ensure people's health care needs were met with a consistent approach.

We recommend the provider considers research and published guidance in relation to the design of the care home environment and its connection in providing an enhanced level of care for people living with dementia.

Requires improvement

Is the service caring?

Our findings

People's end of life care and resuscitation wishes had not always been recorded so staff would know what to do at the end of a person's life to ensure they received the care they wanted. The manager told us she would be making improvements. Nursing staff worked closely with GPs when people were at the end of their life, to help ensure a co-ordinated approach was taken.

People's end of life care and resuscitation wishes had not always been recorded. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People received care from staff who were kind and caring. People told us, "If I was at home I'd die, but not here, I live" and "I've been here two years and everybody is lovely". A relative commented, "people are spoken to as capable adults" and "everyone seems to have time".

People's family and friends were welcome to visit, one relative commented, "I can come and stay and have lunch". However, when people did not want visitors this was respected too. Another relative told us, the home "feels normal, a sense of normality and homeliness".

Staff spoke with people in a kind way, and enjoyed humour together. Compassion was shown by staff towards people, by placing their arm around the person. One person showed their appreciation by kissing a member of staff on the cheek. A member of staff told us, "I love it here; it is a privilege to be here and to care for them". Another member of staff told us, "They are all individuals. Care is hard and they all have different needs……You get to know a person and observe their behaviours. Some people need a cuddle… others can't bear to be touched".

People who required the use of moving and handling equipment were reassured at all times to alleviate anxiety. Comments such as "I am going to put this around your waist, it is to help you stand" and "you are going to go up into the air, but we are going to be right with you" helped people to feel more comfortable with the actions which were being carried out.

People who showed anxiety and unrest were shown patience by staff who frequently answered people's questions, by taking a kind and interested approach. Staff recognised when it was the right time to walk away and leave a person to be on their own, as their presence was making them feel uneasy. A comment such as "are you alright…I'll come back in a minute and give you some time to calm down" demonstrated awareness of people's individual personalities.

People who were unable to effectively communicate because of their dementia or mental illness had documentation in place called, "This is me" or "About me" to help staff be aware of a person's life history. Although this documentation was inconsistently completed staff were knowledgeable about people and of the little things that mattered, for example, what people's previous occupation had been. A relative told us, staff had been prompted to ask questions about their loved one's past, because of phrases and sentences they had been repeating. The information had then been used and included in the person's care plan, to help staff support the person in a meaningful way.

People's dignity was promoted and staff tactfully supported people with personal care. A relative commented, "people are treated with dignity…allowed to keep their dignity". People's privacy had been compromised because locks on some bathroom doors did not work; however, by the second day of or inspection this had been rectified. People were able to express their own sexuality and staff were non-discriminatory and respectful of people's own choices.

People's care plans did not always show their contribution and involvement or their relatives/representatives. The manager told us because of people's complex health and social care needs, it was sometimes difficult to include their written views and verbal feedback. However, the manager explained by working as a team, the staff ensured people were always involved in their care. Staff were observant of any triggers which made a person happy or sad and people's care was adapted as necessary. People's friends and families were encouraged to provide feedback at any time, and there was a suggestions box in the main entrance.

Requires improvement

Is the service responsive?

Our findings

People's care plans were not effectively reviewed to ensure they gave guidance and direction to staff about how to meet people's individual care needs. For example, people who had skin damage had "body maps" to highlight the location of the damage and the treatment being provided. However, body maps had not been reviewed or reassessed to ensure the care and treatment was still required or effective. People's body maps were not always linked to their care plans, which meant information was not consistent and reflective of their needs. Another person's care plan detailed they required a blood sugar test be undertaken prior to meals four times a day. However, from speaking with nursing staff this was no longer needed and should have been discontinued as a problem within the person's care plan.

People and/or their families were not involved in their care plan reviews, so were unable to be actively involved in decisions about their care and treatment. The manager told us action would be taken, and by the end of our inspection a letter had been drafted to families inviting them to contribute to their loved ones care plan.

People's care records did not always demonstrate if a change in health had triggered responsive action. For example, one person had a skin problem which had been identified in August 2015, however, it was unclear if it had been reassessed as there was no documentation to support the care and treatment which had or was being provided.

People's changing care needs were not always communicated to help ensure prompt action was taken and people's care plans were effectively updated. We saw a problem with one person's skin at 9.30am and were informed by care staff that it had been shared with the nurse in charge. We spoke with the nurse at approximately 4pm and found the deterioration of the person's skin had not been communicated. The manager recognised this was not acceptable and told us she would address this with staff immediately.

People's care records in place to record when people were being regularly checked and provided with support when they were in their bedrooms, were inconsistently completed. This did not provide reassurance to the manager that people were getting regular visits by staff. For example, the records for one person who was assisted at 11.30am showed they had not been checked since 5.30am. Care documents for two people who remained in their bed for the duration of our inspection, indicated they had only been seen at 5.35am and 11.30am. People's care plans showed frequent checks were required. The manager told us and was confident people had been checked throughout the day, and explained staff had just forgotten to complete the records.

People did not always receive the care they required. Care plans did not always meet people's needs and preferences. Care plans were not effectively reviewed and reflective of the care being delivered. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People could participate in organised social activities when the activities co-ordinator was on duty. However, at the time of our inspection the activities co-ordinator was on holiday, which meant people did not participate in any social activities. People sat in lounges with the TV or music on in the background, which meant people had very little to occupy their time. The manager recognised changes needed to be made and took action to ensure social activities would continue in the absence of the activities co-ordinator.

People could raise concerns and complaints. People told us they would speak with the manager and felt confident action would be taken. The service had a complaints policy in place which was available to people and their relatives. The complaints policy was not in a suitable format for people living with dementia, as some people were unable to understand the written words. The manager handled complaints and shared an example of how she had responded to a complaint; this had involved arranging a meeting with the person and their family to find a solution. The investigation and outcome of the complaint had not been recorded. The manager told us she recognised the importance of recording complaints but a lack of time had impacted on this. She told us improvements would be made to make sure the records were a true reflection.

Requires improvement

Is the service well-led?

Our findings

At our last inspection in October 2014 we told the provider to take action to make improvements to how the quality of the service was monitored. At this inspection we found improvements were still required.

People did not always receive a high standard of quality care because the provider did not have effective monitoring systems and processes in place in respect of reducing and monitoring risks associated with people's care, such as falls, accidents, weight loss and pressure ulcers.

There was no effective system in place to monitor the quality and detail in care plans to ensure they were individualised, properly and regularly reviewed, and up to date to give clear guidance and direction to staff about how to meet people's needs.

Infection control practices were audited to help ensure the staff were following the provider's policy and procedure, and associated legislation. Whilst the audit had helped to highlight a change of flooring required for one person, the audit had not been effective in ensuring people were protected by effective infection control procedures at all times, as we found there was no toilet paper in some bathrooms and staff did not always display knowledge of infection control practice.

The manager told us her line manager visited on a weekly basis to provide support, discuss the service and to check people's finances. However, these visits were not recorded to demonstrate what was discussed and what checks were carried out. The manager told us she would ensure a new system was introduced to help formalise these visits.

The systems in place to assess and monitor the quality of service people received were not effective. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not always notified the Commission of significant events which had occurred, in line with their legal obligations. For example, one person had sustained a fracture and had been admitted to hospital; however, we had not been notified of this serious injury. Some people were subject to approved Deprivation of Liberty Safeguards (DoLS) applications; however we had not been advised of this.

The provider had failed to notify us of all significant events in line with their legal obligations. This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

There was a clear management structure in place, and people and staff knew who to speak with. Comments included, "[…] is brilliant open to an opinion and she's very supportive, yes I think her and (the deputy) – I couldn't ask for a better manager and deputy to be honest. They are both very good and what they do nursing wise and as a manager they are brilliant!" The manager was in the process of making an application to the Commission to be registered. The manager and deputy manager were knowledgeable about people, their families and the staff.

The service was underpinned by a number of policies and procedures, made available to staff. Polices were not always reflective of current legislation and regulations. The manager took immediate action to update the safeguarding policy and told us she would speak with the provider about ensuring others were reviewed.

There was a whistleblowing policy in place which protected staff should they make a disclosure about poor practice and staff told us the manager had acted in the past, when they had raised concerns about staff conduct. Staff enjoyed working at the service and told us they found the manager approachable and supportive, comments included, "[…] is absolutely brilliant, absolutely brilliant, she has ways of saying things, she's a really good manager", and "I've been very impressed by how professional […] is. "She is great – she's very fair. She's nobody's fool! She sees exactly what's going on and is not swayed by people's opinions. She's very approachable and very flexible. She's very professional…"

The manager was open and transparent when working with external professionals; listened to advice and implemented changes as required. External professionals did not raise any concerns about the service, the staff or management.

People, their family and friends were asked to provide feedback about the service by completing a questionnaire. The results from the 2014 survey had been displayed, and it showed people were satisfied with the care they were receiving.

Requires improvement

Is the service well-led?

The manager promoted the ethos of honesty, learning from mistakes and admitted when things had gone wrong. This reflected the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Regulation 9 (1) (a) (b) (c) (2) (3) (b) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **People did not always receive the care they required. Care plans did not always meet people's needs and preferences. Care plans were not effectively reviewed and reflective of the care being delivered. People or their representatives were not always involved in the design or review of their care plans.**

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 **Regulation 12 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **Risk assessments were not always in place as necessary, updated, and reviewed effectively. Risk assessments were not always reflective of people's individual needs.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **People's individual needs were not always being met because there were not sufficient numbers of staff deployed.**

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents

The provider failed to notify us of all significant events in line with their legal obligations.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 (1) (2) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The systems in place to assess and monitor the quality of service people received were not effective.

The enforcement action we took:
We issued a warning notice.
We have told the provider they are required to become compliant with the Regulation by 9 January 2016.