Mr David Lewis & Mr Robert Hebbes

Normanhurst EMI Home

Inspection report

De La Warr Parade
Bexhill On Sea
East Sussex
TN40 1LB

Tel: 01424217577
Website: www.normanhurst.com

Date of inspection visit:
28 June 2016
29 June 2016
04 July 2016
05 July 2016

Date of publication:
07 September 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?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 28 and 29 June and 4 and 5 July 2016. It was unannounced. We inspected Normanhurst EMI Home at the same time as we inspected the service's sister homes, which were next door. There were 16 people living at Normanhurst EMI Home when we inspected. People cared for were all older people who were living with dementia. They were also living with a range of other care needs, including arthritis and heart conditions. Most of the people needed support with their personal care, mobility and nutritional needs. The registered manager reported they provided end of life care at times. No one was receiving end of life care when we inspected.

Normanhurst EMI Home provided accommodation over three floors, with a passenger lift to support people in getting between each floor. Lounges and a separate dining room were provided on the ground floor. The home was situated close to the sea-front in Bexhill on Sea.

Normanhurst EMI Home had a registered manager. 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. The registered manager was also the registered manager for Normanhurst Care Home, which was next door to Normanhurst EMI Home. The providers for the service were Mr David Lewis and Mr Robert Hebbes. They owned Normanhurst Nursing Home and Normanhurst Care Home.

Normanhurst EMI Home was last inspected on 3 January 2014. No issues were identified at that inspection.

During their audits of service provision, the provider had not identified a range of areas. Their audits had not identified that people did not consistently have care plans developed in relevant areas or that some documentation was not completed, to ensure people received consistent care. The provider had also not identified that parts of the home environment did not follow guidelines on supporting people who were living with dementia or a disability. There was a lack of audit of staff supervisions, to ensure relevant areas were identified. The provider had not identified that although care staff provided activities to people, they had not been trained in this area. Recruitment systems were not audited to ensure that all staff folders included all required information and the provider's policies were consistently followed.

Some staff had not been trained in their responsibilities under the Mental Capacity Act 2005. People's assessments in relation to the Mental Capacity Act 2005 were not decision specific and did not ensure the requirements of the Act were followed. Deprivation of Liberties (DoLS) applications were made, however there was a lack of best interest decisions documentation where people needed to have their liberties restricted in some way, for example by the use of restrictions such as stair gates.

Some areas for supporting people with meals did not consistently follow guidelines on for people who were living with dementia. There were a wide range of meals offered to people. People commented favourably on

the meals service. Where people needed support with their food and drinks, they were helped in the way they needed.

A few areas of risk for people such as personal evacuation plans (PEEPs) did not identify all areas of risk. Other areas of risk were identified and regular checks were maintained in relation to ensuring people's safety.

Staff fully engaged with people when they supported and cared for them. Staff were responsive to people and consistently supported people in the way they needed, including supporting them in remaining as independent as possible.

Staff supported people in taking their medicines safely, this included when people needed skin creams applying or where people were prescribed medicines on an 'as required' basis. There were appropriate systems for the storage of medicines. Staff had effective systems for liaison with external healthcare professionals where people needed support.

Staff showed a clear understanding of how to protect people from risk, including risk of abuse and followed relevant guidelines to reduce risk to people. People said there were enough staff on duty to meet their needs.

We found two breaches of the HSCA 2014 Regulations. 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?

Requires Improvement

The service was not always safe.

Some assessments of risk for people did not include relevant information to reduce people's risk. However most areas relating to risk were addressed appropriately.

The provider's own systems for recruitment were not being consistently followed.

Medicines management was safe. People were safeguarded from risk of abuse and there were enough staff deployed to meet people's needs.

Is the service effective?

Requires Improvement

The service was not always effective.

Systems to ensure the requirements of the Mental Capacity Act 2005 and Deprivation of Liberties Safeguards (DoLS) were not being consistently followed, and some staff were not aware of their responsibilities.

The provider had not ensured the parts of the home environment followed current guidelines for people who were living with a dementia or a disability.

Systems to ensure staff were supported in their roles were not consistently followed. Staff were largely supported by the provider's training plan.

People generally received the support they needed with their diet and fluids. People commented favourably on the meals.

People's healthcare needs were met and referrals were made to relevant healthcare professionals to support people when needed.

Is the service caring?

Good

The service was caring.

People were supported by staff in the way they needed to be.

People's privacy, dignity, involvement and independence were respected.

Staff were consistently polite and respectful to people.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Some people's assessments and care plans did not always ensure they were responded to in a consistent way.

Staff, who often led on activities, had not been supported in following guidelines on activities provision. The activities manager regularly reviewed what people had been involved with.

There were systems for people to raise complaints and staff supported people in giving opinions about how the service responded to them.

Is the service well-led?

Requires Improvement

The provider's systems did not always ensure relevant action was taken in relation to people's quality of life and welfare, and all relevant records maintained.

The provider and registered manager were open to developing new areas, to help improve service provision.

Staff commented on the effective teamwork in the home and felt they were listened to by managers.

Normanhurst EMI 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.

The inspection took place on 28 and 29 June and 4 and 5 July 2016. It was unannounced. The inspection took place over four days because we inspected Normanhurst EMI Home's sister services – Normanhurst Care Home and Normanhurst Nursing Home at the same time. We did this because some services like cleaning, catering, training and human resources were managed centrally for all three homes. The inspection was undertaken by three inspectors.

Before our inspection we reviewed the 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 safeguarding alerts which had been made to us 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 seven of the people who lived at Normanhurst EMI Home and observed their care, including the lunchtime meal. We spoke with one person's relative. As some people had difficulties in verbal communication, we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We inspected the home, including some people's bedrooms, bathrooms and toilets. We spoke with three visiting professionals, including a healthcare worker. We also spoke with nine of the staff, including a domestic worker and training manager. We met with the registered manager and one of the providers.

We 'pathway tracked' four of the people living at the home. We looked at people's care records in detail, asked for their views on how they found living at the home and made observations of the support they experienced.. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

During the inspection we reviewed records. These included staff training and supervision records, 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 said they felt safe in the home. The provider had systems to promote the safety of people. However some of these required improvement

People had a personal emergency evacuation plan (PEEP). These did not outline a range of factors which could place them at risk, such as whether they were living with memory loss or anxiety, or if they had a disability such as difficulties with vision and hearing, all of which could affect them if they needed to be evacuated in an emergency. The PEEPs were not dated to ensure they were regularly reviewed over time and as people's conditions changed. We discussed this with the registered manager and provider at the end of the inspection and they agreed to review the plans.

The registered manager confirmed that when people fell, there was no system for monitoring and reviewing their condition over the next few hours and days after their accident. This is relevant because underlying injuries to frail and older people may not be apparent immediately after an incident, but may become evident during the next hours, or day or so later.

The safety of the home was regularly monitored in other areas, for example maintenance of lifts to ensure they worked safely, the monitoring of water temperatures to ensure they were within safe levels and fire safety checks. Accommodation was provided in the home over first and second floors. There were regular checks on the functioning of window restrictors to ensure people were not placed at risk from falling out of windows on the first and second floors.

Some people had difficulties with mobility and needed support, such as using a stick. Where people needed assistance they were helped by staff in a safe way. Every person had a clear assessment and care plan in relation to their mobility. These were regularly reviewed, including when people's needs changed. Where people chose to walk independently, staff encouraged them to be independent but supported them in a discrete, sensitive way to ensure they were safe. For example, if a person decided to suddenly sit down on a particular chair. Staff also ensured people could walk across the sitting rooms and along corridors as they wished, and made sure any trip hazards were quickly moved out of the person's way. All areas which could present risk to people who preferred to walk about, like the kitchen, were secured so people could not put themselves at risk by going into such areas.

Some systems for recruitment of staff required improvement to ensure staff had been employed in a safe way. Some documents included in the provider's policy for assessing prospective staff's suitability for employment, for example, the prospective employee's health questionnaire, were not on recent employee's files. We asked the registered manager about this. They reported they did not currently have systems for following up with new employees to ensure all such relevant documentation was returned to them in a timely manner. The procedure used by the provider involved interview assessment forms, but most had not been completed, to ensure there was clear evidence of why the prospective member of staff had been judged to be safe to work with people. As the provider was not auditing compliance with its own recruitment and selection processes, they could not ensure all staff were being consistently recruited in a safe way.

All other systems for safe recruitment of prospective staff were followed. This included checks with the Disclosure and Barring Service (DBS) to check prospective staff were safe to work with people, two references and a previous employment record.

The provider ensured people were supported with taking their medicines in a safe way. This included secure storage of medicines, full records of medicines received into the home, given to people and disposed of from the home. There were clear systems where people were prescribed skin creams, including body charts to inform staff of where creams were to be applied on the person's body and records to show how often they had been applied. All limited life medicines such as eye drops were dated on opening and disposed of by the expiry date. Where people were prescribed 'as required' (prn) medicines, they had an individualised protocol which stated what the medicines was for and when it should be administered. For example, one person was prescribed a prn medicine for pain. Their protocol stated clearly what the medicine was for and records showed when they might need to take it. This ensured the effect of the medicine for the person could be assessed. Another person needed their prn medicine on a regular basis. They had been referred back to their GP because of this, and staff were waiting a decision about how the person's symptoms could be more effectively managed.

Medicines were administered safely. The member of staff carefully checked the medicines administration record (MAR), before taking the medicine to the person. They remained with the person while they took their medicine, discretely checking with the person that they had swallowed their medicine. Staff then signed the MAR once they were sure the person had taken the medicine. People were not rushed to take their medicines and staff took the time to explain what the medicine was for. Staff were kind and patient even if they needed to repeat the information several times.

Staff had a good understanding of how to protect people from abuse. Normanhurst EMI home specialised in caring for people who were living with dementia. Some of the people could present a risk of abuse to other people living there, due to certain behaviours which could challenge. We discussed with staff how they reduced risk to people from the other people living in the home. Staff were aware of these risks and actions to take to reduce them. For example one member of staff told us about a person who might show behaviours which could challenge others. The member of staff emphasised the importance of knowing this person as an individual and signs they showed so they could prevent risk to others, before the occurred. Staff were aware of how to report concerns about people being at risk of abuse, including to the local authority. The training plan showed all staff were trained in awareness of safeguarding people from abuse when they started employment, and were regularly updated in the area during their employment.

There were enough staff on duty. One person told us "Staffing's fine." Staff were available to support people throughout the day when they needed it. There were always two members of staff in the sitting room and usually more. Staff told us they felt there were enough care workers to support people on a day to day basis. They also said they knew they could go to the registered manager if they felt they needed more staff. For example they said if a person was unwell or presented particular support needs relating to their behaviours which may challenge, they were confident the registered manager would take action to ensure there were additional staff on duty. They told us about times when this had happened in the past.

Requires Improvement

Is the service effective?

Our findings

People received effective care in some areas, particularly with their diet and fluids and ensuring appropriate referrals were made when they had additional healthcare needs. However other areas required improvement.

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. 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. We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

The entrance to the home was locked and people could not go in or out on their own. There were stair gates on each floor and people could not go upstairs without supervision from staff. We asked staff about such restrictions on people's liberties. Staff were not aware devices such as stair gates could restrict people's liberties. Deprivation of liberties safeguards (DoLS) applications had been made for people and people had DoLS care plans. People had care plans relating to DoLS in their individual folders, however these stated only that a DoLS application had been made. They did not give consideration about how their care could be delivered in a least restrictive way to meet their needs.

People's mental capacity assessments were generic, not decision specific and did not include areas such as the locked doors and use of stair gates. None of the people's records showed best interests meetings had taken place to ensure their care was being provided in their best interests and in the least restrictive way possible.

MCA and DoLS training were included in the home's training plan. However many of the staff we spoke with had not received this training. Staff appeared to be unsure about the application of the Mental Capacity Act 2005 (MCA) in practice. One member of staff told us "We do internal capacity assessment for things such as clothes and we try and get next of kins to sign things as sometimes we cannot get information from the resident." Staff were unsure about the legal status of people's next of kin or if people had a lasting power of attorney (LPA) in place in relation to health and welfare. Staff we spoke with thought documents like powers of attorney might be held centrally, but they were unsure. We discussed the MCA with the registered manager and she agreed this was an area for development.

Staff did show a clear understanding of offering people choice in their daily lives and they knew people as individuals, but they did not complete separate assessments of capacity to reflect what they knew about people.

People did not have individual, decision specific mental capacity assessments on how their freedom may be

restricted or what least restrictive practice could be implemented. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider's statement of purpose stated that one of their aims was to provide a 'hotel setting' for people to live in, and also that 'We treat people as individuals.' Despite such statements, some areas of the home environment were not supportive for the people living there, particularly those who were living with dementia or disability. For example there was no signage when a person came out of the lift to direct them to lounges, their rooms or other facilities, like toilets. The floor and wall colouring was similar on all floors, so different floors could not be distinguished from each other. Bedroom doors showed people's name but there were no pictures or memory boxes to help orient people. Some carpets were of a flecked design. Flecked design carpets have been identified as inappropriate and a risk factor for people who are living with dementia and visual difficulties. Most people had the same bed throw on their beds. This would make it additionally difficult for people to identify their room and did not support their individuality. We queried with a member of staff whether this was people's personal preference but they said they were put on by housekeeping staff and did not relate to people's choice. There are a wide range of guidelines available about appropriate environments for people who are living with dementia or a disability. Such guidelines had not been considered in the provider's audits or action plans developed so the home environment met the needs of people living there. This is an area which required improvement.

Most people ate their meals in the dining room. One person told us "The food's very nice." The dining room was a light and pleasant area, however due to the need for the number of tables and chairs, assisting people to get in and out of their seat or across the room, could be difficult. The menu was provided in written format and staff also offered people verbal choices about the meal. We asked staff about best practice in supporting people who were living with dementia with choice at mealtimes. They said they had tried picture cards in the past but had not found them effective in helping people make choices. Other methods such as showing people plated up choices were not used. People were not served their meal table by table. This meant on two the tables, one person had finished all of their meal before the other people had been served. Staff told us this was because some people became impatient for their meal and found it difficult to wait. The provider had not considered the wide range of guidelines on supporting people who were living with dementia in relation to mealtimes.

Many of the people were frail and needed support with their diet and fluids. Some areas lacked consistency in approach. One person had particular needs relating to their dementia, so they ate and drank variable amounts on a day to day basis. Their condition was being monitored and the staff supported the person to ensure they did not become risk of dehydration or malnutrition. However, what staff told us was not included in the person's care plan to ensure all staff would know how to staff support the person in the same way. The lack of a care plan about this matter meant regular review of the support they needed could not take place.

Other people were regularly assessed for nutritional and dehydration risk. Where other people were assessed as being at risk, a care plan was put in place to identify how their risk was to be reduced. Staff monitored people's dietary and fluid intake to ensure they received enough to eat and drink. People were supported with their meals when they needed it. Where people needed support to eat, staff sat with them, engaging them with the meal and general conversation. Staff did not rush people who needed assistance. One person had behaviours associated with concentrating to eat their meals. This was clearly documented in their care plan, including the specific ways staff were to support the person at mealtimes. We saw staff followed this person's care plan to ensure they ate the meal they wanted.

Staff said they were supported in providing effective care as there was a training and supervision

programme. One member of staff told us enthusiastically about their dementia training. Another member of staff described recent training in how to support people who had mobility difficulties. The provider's training plan included relevant areas to ensure staff were supported in caring for people effectively, this included fire safety and infection control. Records of training were maintained. Where a member of staff did not attend mandatory training, the provider had systems ensure this was followed up and action taken within their policies and procedures. Staff told us they were supervised regularly and could raise issues with their manager if they needed to.

A training manager was in charge of inducting staff into their roles. The home's induction programme followed national guidelines on the inducting of new staff into their roles. This training manager knew all the staff who had recently been employed and was aware of staff who needed additional support, for example because they had not worked in a caring role before. This training manager was flexible in their approach to supporting new employees, this included supporting staff who worked only on night duty.

Several people had additional healthcare needs. Staff supported people with these needs and made referrals to people's GPs or other healthcare professionals when needed. One person had a dressing on their hand. The reason for this person's dressing was clearly documented in their records. All of the staff we spoke with knew why the person needed the dressing. Records showed people were referred to their GP or other healthcare professionals, such as the community psychiatric nurse when needed. Referrals had been made to speech and language therapists where a person had difficulties in swallowing. We met with a district nurse who confirmed staff followed any instructions they gave and contacted them whenever relevant, about people's healthcare needs.

Good

Is the service caring?

Our findings

Staff showed a caring approach to people, taking into account their individual needs. We observed staff supporting people both during our SOFI and at other times. Staff responded to people quickly if they indicated they needed assistance. Staff empathised and engaged with people when they supported them. Staff made eye contact with people when they talked with them. They checked back with people about what they wanted, making sure they had fully understood what each person wanted before starting to help them. They also verified with the person that they had understood how they were going to support them, before they started assisting them. There was lots laughter and banter when people and staff talked with each other, and both people and staff clearly enjoyed these engagements with each other. One person was enjoying gently teasing a member of staff, which the member of staff responded to in a relaxed way, laughing with the person about what they were saying.

Staff were quick to respond if people needed support. One person stood up suddenly and walked briskly across the room. This was quickly noticed by a member of staff who knew the person well and what they wanted, when they suddenly stood up. On another occasion a person suddenly started coughing. A member of staff quickly supported them, offering them a tissue and asking if they would like a drink. When the person's cough had stopped, they looked relaxed and showed no signs of having been distressed about the cough afterwards, although they had looked alarmed at the time.

Many of the people were living with continence needs. Staff ensured people's dignity was maintained and completed continence assessments. They also assisted people to use the toilet at regular intervals during the day. Where people had complex continence needs, they were referred to the continence advisor. All people who had continence needs had an individual care plan, which staff followed.

Some of the people had additional needs relating to pain. Many of the people could not inform staff of when they were feeling pain. We talked with a member of staff who told us about how a person showed by their body language that they were in pain. The person had a clear care plan which included what the member of staff had told us. The person's care plan was regularly reviewed to ensure they remained pain-free.

Staff encouraged people to be as independent as possible. A member of staff said a key area was knowing people as individuals, and what each person could do. One person was very variable in their condition, some days they were able to walk but on other days they needed assistance to move. Staff supported this person to remain as independent as possible on days when they were able to move. When people found standing up from a chair difficult, staff supported and encouraged them to remain independent in doing this. Staff did not rush people in any way and encouraged them when they stood independently.

People were supported to make choices about what they did during the day. Staff always offered people choices about what they wanted to drink and listened to what they said. This included where people had difficulty in communicating verbally. For people who had such difficulties, staff looked at their facial expressions or gestures so they could support them in making choices. A member of staff told us "Remember they are adults not children."

Staff said they were keen to ensure people received the care they needed, and although they were living with dementia, people needed to be treated as individuals. One member of staff said "It's their quality of life that matters." People's care records were completed in a supportive tone, describing people's actual care needs and how they responded when they were supported. Judgemental words or phrases were not used in any people's records when describing any behaviours which may challenge.

Requires Improvement

Is the service responsive?

Our findings

Staff were responsive to people's individual needs, including their dementia care needs. However improvements were required to ensure people's engagement needs were fully met.

An activities manager was employed across all three homes. They were mainly based in the care home, but also provided some support to this home. When the activities manager was not available, activities were led by members of staff. Staff told us they were not sure of what activities were beneficial to people and tended to ask people what they wanted to do, which several people could not always respond to. Staff did not use a planned, individual approach to ensure each person's needs were being responded to. The activities manager did maintain activity sheets. These were ticked to show people's attendance, or not at activities. The information did not include evidence of benefit of engagement to people or otherwise to support development of individualised plans for people. As the activities manager was based in the sister home, these records were not always available to staff to support them in developing individual care plans for people.

The provider had not ensured that all people who were living with dementia were responded to in a consistent way. One person spent periods of time when they were awake and active, followed by periods of time when they spent most of their time asleep. This affected their daily life, particularly when they spent several days asleep. Some staff said the person could be asleep for several days, other staff said it was much less than this. Staff also varied in their reports about how long the person might spend awake. Although the person had a daily record completed, there was no information on the actual duration of periods when the person was awake or asleep. Staff therefore did not have the full information they needed to support assessment of the person's varying needs during such periods, and to ensure appropriate care planning. Other people's documentation was much clearer. A person had a clear statement about the triggers which caused them to show behaviours which may challenge. They had a care plan which related to this assessment. This clearly outlined how staff were to support the person when they showed these behaviours. Staff followed this care plan.

Many people had difficulties in communication, including in speaking, understanding and processing of speech. Some people used non-verbal ways of communication like gestures or facial expressions. These people's care plans were clear and outlined each person's individual need. They documented how staff were to appropriately support the person. Staff followed these care plans when they supported people. People's care plans documented their strengths and emphasised positive matters, rather than concentrating only on matters which could present issues. For example a person needed some support with their personal care. Their care plan detailed the areas they were able to do for themselves, as much as the areas they found difficulty with.

People's relatives were supported in coming and out of the home as they wanted. Staff were welcoming to people's relatives. Staff were readily approachable to discuss any matter which people's relatives wanted to raise with them. People's relatives told us they enjoyed their visits and appreciated the flexibility of the home's visiting arrangements. They said staff told them of all relevant matters and discussed changes in

people's care plans when needed.

The home had a complaints procedure, which was available to people. All formal complaints were dealt with by the provider. No formal complaints had been made recently to the provider. Staff were aware it was complex to support people in giving opinions about what they felt about the care provided. For some people staff said they talked to people's relatives. They told us about the spouse of a person, who gave them positive feed-back about how they were providing care. Additionally while staff were with people, they actively asked people to let them know how they felt their care was being provided, at the time they were supporting them.

Requires Improvement

Is the service well-led?

Our findings

People were relaxed with staff, showing by gestures, such as smiles and by approaching staff in a confident way, that their care and daily life was being managed in a way they wanted. This included the registered manager and the deputy manager, who people clearly knew as persons who were familiar to them. However we found there were a range of areas which required improvement in relation to overall management of the home.

The provider had systems to audit the quality and safety of the service, however the audit had not identified a range of areas, and action plans had not been developed to ensure service improvement. This included where people were living with continence care needs. Staff were aware there could be a period of time between the person's assessment by the continence nurse and the delivery of continence aids. During such periods the person's dignity could be compromised by the lack of suitable aids. This had not been identified by the provider in their audits and suitable arrangements made to ensure people could be treated with dignity, until they received delivery of continence aids. Other areas had not been identified. Although many of the people needed to use commodes at night, the provider's audit had not identified that for the older commodes in use, although the commode inserts were clean, they were very stained. There was no action plan for their replacement.

We asked staff about training in supporting people with activities, but although they regularly supported people with activities, we were told only the activities manager had been trained in the area. Many of the people had difficulties with engagement and needed support from staff with participating in activities. The provider had not identified this as an issue in their training plan. We looked at supervision records. Some staff supervision records had not been completed in all relevant sections. This included the page of the supervision record which listed areas for training. Some supervision records had not been dated and did not include the name and status of the supervisor. We asked about audit of staff supervision records. The registered manager reported there was no current system in place to audit such records and ensure all relevant areas had been followed through.

The provider visited the home regularly and completed a report on their visits. These reports had not identified that regular audits in key areas, including audits of systems for safe recruitment of staff were not being followed. Although the home's statement of purpose outlined their systems for working only with the consent of people, the provider's audits had not identified they were not doing so. There were systems for audit of care plans, but these were not taking place. For example a person had part of their continence care managed by a prescribed appliance. Their care plan did not document relevant matters such as the type and size of the appliance used or particular areas staff needed to observe for when supporting the person with the appliance. The provider had not identified that such information would ensure all staff, particularly those unfamiliar with the person, would know how to effectively support them with their appliance, and signs they needed to watch out for, to ensure the person's comfort and well-being.

The provider's systems to assess, monitor, mitigate risk to people and improve care did not operate effectively. People did not have accurate, complete and contemporaneous records about their care. This is a

breach of Regulation 17 of the HSCA Regulations 2010.

The deputy manager told us they had accessed a range of information and guidelines about supporting people who were living with dementia and had worked with external specialist teams to develop appropriate philosophies of care for people. We saw they used such philosophies of care when supporting people, including promoting their independence and actively reducing risk from behaviours which may challenge other people. Staff were open to the wide range of ideas about supporting people who were living with dementia, and were keen to know more to ensure people had a good quality of life. One of the members of staff said part of their philosophy of care was to promote a normal life as much as possible for people.

Staff commented on the management of the home. They said they felt part of a team and could contribute ideas, and be listened to. They said there was good teamwork and communication. Staff said the registered manager was readily available. and the deputy manager was available when the registered manager was not. Staff said they could talk to the registered manager or her deputy about "Anything," and know they would be listened to. A district nurse told us they thought the service was well run and they could find information they were looking for with ease, for example about people's weights, not like some other homes.

Although the registered manager was also registered manager of the larger sister home next door, she was regularly in the home. When she was there, she discussed key areas with people and staff, including the deputy manager, and made observations of care. She was keen to respond to issues as they arose. For example we discussed one of the reports of an accident to a person. The report of what had happened was not clear and did not outline what had happened for a person who had not been there at the time. The registered manager said they would support staff in writing accident reports in the future, to ensure they were clearly written

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People did not have individual, decision specific mental capacity assessments on how their freedom may be restricted or what least restrictive practice could be implemented. Regulation 11 (1)(2)(3)(4).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's systems to assess, monitor, mitigate risk to people and improve care did not operate effectively. People did not have accurate, complete and contemporaneous records about their care. Regulation 17 (1)(2)(a)(b)(c).