Cepen Lodge Limited

# Cepen Lodge

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

This inspection took place on 5 and 6 October 2016 and it was unannounced. At the previous inspection which took place in October 2014 we found the home was not maintaining accurate records. We made a requirement notice on Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010.We found improvements were made to meet the requirements we made at the previous inspection.

Cepen Lodge provides residential care for up to 63 older people. The first floor is designated for people living with a diagnosis of dementia.

A registered manager was 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.

Risks were assessed and action plans developed on minimising risks. A Malnutrition Universal Screening Tool (MUST) was used to assess people's potential risk of developing malnutrition. However the action plans developed as a result of the MUST were not consistently followed by staff to support people with poor nutrition. Charts used to monitor fluid intake were not consistently completed. This meant fluid intake charts did not provide staff with an audit trail of people's deterioration. The registered manager told us through the Provider Information Return (PIR) this was to be addressed.

Risks were assessed for people with poor mobility and at risk of falls. Moving and handling risk assessments were developed which gave staff guidance on the number of staff and the equipment needed for each manoeuvre. Waterlow assessments were undertaken to assess people's risk of pressure ulcers and action plans included the equipment used to prevent skin damage. Repositioning charts were used to monitor that people were moved regularly and were not exposed to prolonged pressure on the same body area.

Although the premises were clean we noted strong odours at times and in different places within the home. The registered manager said there had been housekeeping staff vacancies which were now filled and staff were to start working at the home once their induction was complete. We were also told new equipment was to be purchased and some remedial action to the property was to take place.

Care plans were not consistently person centred. People's likes and dislikes and preferred routines were not always included within the care plans. People's life history was not always documented. Care plans were reviewed but they were not always updated where there were changes in people's needs.

People told us they liked living at the home and they felt safe. The staff were knowledgeable about the safeguarding of vulnerable adults from abuse procedures. The staff were able to list the types of abuse and the expected action for alleged abuse.

Medicine systems had improved since the last inspection and were effective. Staff said medicine errors and where there were omission of signatures on medicine administration records (MAR), were rare. Staff signed MAR charts to indicate when medicines had been administered. Protocols were developed for the administration of "when required" (PRN) medicines.

People and relatives said overall there was enough staff on duty but at lunchtimes more staff was needed to support people with their meals. The registered manager said activities coordinators were available to assist people with their meals.

Staff attended training which increased their skills and insight into people's needs. Mandatory training set by the provider was attended by the staff. Staff said there were opportunities for vocational qualifications. Appraisals were annual and as a result of the discussions on areas of special interest, lead roles were assigned. For example, staff were assigned to take the lead on nutrition. One to one meetings took place to discuss performance but not to discuss personal development.

People were able to tell us the decisions they were able to make. Members of staff were knowledgeable about the principles of the Mental Capacity Act (MCA). MCA assessments were in place for specific decisions. Records were clear where Lasting Power of Attorney were appointed. Deprivation of Liberty Safeguards (DoLS) applications were made to the supervisory body for people under continuous supervision.

People told us the staff were caring and respected their rights. Members of staff knew it was important to build trust to people and to show them they mattered. We saw good interaction between people and staff. Relatives told us the staff were good and cared for their family member.

The views of people were gathered. Relatives meetings were held regularly with the registered manager and deputy manager.

Staff said the registered manager was approachable. They said the expectations were high but they were appreciated for the work they did.

Quality assurance systems were in place which included internal audits. Where there were shortfalls action plans were developed on how improvements were to be made to meet set standards and the necessary action was taken to implement change.

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 consistently safe.

We found strong odours at times and in places within the home.

Staff knew the actions needed to minimise risks identified and risk assessments were developed but action plans were not always followed. For example, fluid intake charts were incomplete for some people.

Sufficient levels of staff were deployed to meet people's needs.

Staff knew the procedures they must follow if there were any allegations of abuse.

Systems of medicine management were in place to ensure people received them safely.

### Is the service effective?

**Good**

The service was effective

People were assisted by staff to make day to day decisions. People's capacity to make specific decisions was always assessed.

People's dietary requirements were catered for. People were offered a choice of meal at all mealtimes.

Members of staff attended mandatory training set by the provider. This training increased staff skills and knowledge on meeting people's needs.

### Is the service caring?

**Good**

The service was caring.

People benefitted from a person centred culture and the staff were committed to providing a service which put people at the centre of their care and treatment.

People were supported by a team of staff who they were able to

build trusting relationships.

## Is the service responsive?

**Requires Improvement**

The service was not fully responsive

The care plans in place were not consistently person centred. People's likes and dislikes and preferred routines were not always part of the care plans. Life stories were not always included within the care plans. Care plans were reviewed but they were not always updated as people's needs changed.

Activities were taking place and people were able to participate in group and individual activities.

People were aware of the complaints procedure and felt able to raise their concerns with the registered manager

## Is the service well-led?

**Good**

The service was well led.

Systems were in place to gather people's views.

Members of staff worked well together to provide a person centred approach to meeting people's needs.

Quality assurance systems to monitor and assess the quality of service were in place

# Cepen Lodge

**Detailed findings**

## Background to this inspection

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

This inspection took place on the 5 and 6 October 2016 and was unannounced.

The inspection was completed by one inspector. The provider completed a Provider Information Return (PIR) which was received subsequent to the inspection visit. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.' We also reviewed information we held about the service, including previous inspection reports and notifications sent to us by the provider. Notifications are information about specific important events the service is legally required to send to us.

During the visit we spoke with six people, two relatives, and seven staff including an agency worker, the head of care, the regional manager and the registered manager. We also spoke with community nurses and the pharmacist sent their feedback about the service by email. 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 spent time observing the way staff interacted with people who use the service and looked at the records relating to support and decision making. We also looked at records about the management of the service.

Requires Improvement

# Is the service safe?

## Our findings

Systems introduced for managing risk were not consistently completed by the staff. Monitoring charts were used to assess people's nutritional intake and to provide an audit trail of position changes to prevent pressure to the same body part for extended periods of time.. Monitoring charts gave an overview of the person's current needs and included records of weekly weight and repositioning. The fluid intake charts did not give staff this overview. The charts did not always include the person's daily expected target intake. Where the target intake was recorded we noted some people were not having the targeted fluid intake and for others the monitoring charts were incomplete. For example, the fluid intake chart for one person included the target daily intake of 1275 mls and on the 1 October 2016 there was no entry, on the 2 October 2016 the intake of fluid was 700mls and the fluid intake on the 3 October 2016 was 600mls. A member of staff said at handovers staff were told about people whose fluid intake was poor. This member of staff said "we encourage people to drink between meals. Make sure people always have fluids close to them". This meant records did not provide an audit trail on how staff were informed about people's poor intake of fluid.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Risks were assed for people with a history of falls, moving and handling needs and for poor nutrition. The risk assessment for one person with a history of falls described the steps staff must take to reduce the risk of falls For example, to ensure the person had appropriate footwear and to ensure staff assisted the person with walking. The falls diary listed the frequency of falls and made reference to an updated care plan. The associated moving and handling risk assessments for this person included the possible causes of poor mobility for example, unable to maintain their balance and muscular spasm. The types of techniques, the equipment and the staff needed for each manoeuvre were included in the action plan. The risk assessment action plan for another person at high risk of falls included low level bed and sensor mat.

Staff knew the actions needed to minimise identified risks. A member of staff said potential risks to people were assessed. They said risks were reviewed regularly to ensure actions taken were appropriate to the risk. Another member of staff gave us examples on the actions taken to manage risks. They said two staff assisted with moving and handling and ensuring people at risk of poor nutrition had sufficient fluid intake. A third member of staff said training from district nurses was delivered on prevention of pressure damage and at the training the staff were given guidance on identifying deterioration of people's skin integrity. A member of staff told us Speech and Language Therapist (SaLT) referrals were made for people at risk of choking and guidance on blended diets was provided to reduce the risk of choking to the person.

Malnutrition Universal Screening Tool (MUST) were used to assess people's potential of malnutrition. The nutrition care plan for one person detailed the assistance needed from staff with eating and drinking. The MUST score given to this person showed they were at high risk of poor nutrition. The action plan for this person included fortified drinks, monitoring their food and fluid intake and weekly weights.

Safety systems were in place to protect people in the event of an emergency. Personal Emergency

Evacuation Plans (PEEP) gave staff guidance on the assistance people needed for safe evacuation from the building. The fire risk assessments were reviewed in May 2016 and remedial action was taken from the recommendations made. Checks of fire alarm systems were carried out regularly and portable appliance tests (PAT) were annually.

While we did not cover the prevention and control of infection on this inspection we spoke to the registered manager about the strong odours present at times in places within the home. Relatives also mentioned the odours present at times within the home. The registered manager said there had been shortages of housekeeping staff and new staff had been recruited. These staff were undertaking their induction whilst their checks were being processed. New equipment to better manage infection control was to be purchased.

The staffing rotas showed the registered manager and head of care were supernumerary and worked office hours. On duty each day was one "senior" on each floor and ten care assistants working across three floors. At night there were two "seniors" on duty with three care assistants. Relatives said during meal times more staff were needed. The registered manager said activities coordinators were available to support with mealtimes. During the inspection we saw activities staff supporting staff to assist people with their meals. We observed meals times were calm and people were not rushed to eat meals.

The Community Nurse told us the staff were seen with people and interacting with them. One person told us as the rotas were organised in "patterns" and they had the same staff deliver personal care in two week rotation. Another person told us the staff were good and they "look after me". Staff said there was sufficient staffing levels to meet people's needs.

The people we spoke with said they felt protected from abuse. One person said the staff made them feel safe. staff were aware of the safeguarding of vulnerable adults from abuse procedures. These staff knew the signs of abuse and the actions they must take for suspected abuse. A member of staff said there was an expectation that staff should follow safeguarding procedures. They had responsibilities towards keeping people safe from abuse and harm.

We spoke with the pharmacist that had involvement with medicine management at the home. The pharmacist told us "I was delighted to visit in October and find that an extensive reorganisation had taken place, where each floor had a designated lead to deal with medicines. This meant the job of reordering monthly medications was streamlined and shared between three members of staff rather than one. They said the involvement of a regular GP has meant people medicines were reviewed more frequently".

A person said "they [staff] take my pulse every day before they give me my medicine. They see to everything. My memory is going and I can't remember if I had my medicine. I ask and they will know if I was given my medicines. Previously there was no system. I was running out of cream. They have a system now and they are adhering to it." Another person said "the staff bring me my insulin and I inject myself".

A member of staff said there had been medicine errors but this had been resolved and were happening much less frequently. They said communication between staff had improved and staff had more assistance with ordering medicines. Another member of staff said medicine systems had improved, medicine errors were more occasional and there were less missing signatures. Medicine profiles in place described the purpose of the medicine and the direction for administration. Medication Administration Record (MAR) charts were signed by staff following the administration of the medicines. Protocols were in place for when required medicines (PRN). PRN protocols for pain relief gave staff the direction for administration, the maximum dose within 24 hour period and guidance on how to identifying the person was in pain.

Good

# Is the service effective?

## Our findings

New staff were provided with an induction when they started work at the home. A member of staff said their induction was helpful and included class based training. This member of staff described the process they followed. For example, new staff were "paired with experienced staff". Another member of staff said the induction prepared them for the role for which they were employed. They said new staff were assigned with a mentor to shadow and to approach for guidance.

Staff said annual appraisals were taking place with the registered manager. One to one meetings with a line manager were taking place to discuss issues of concern but not to discuss personal development. Staff told us one to one meetings were based on staff performance. A member of staff said their one to one meeting had not taken place recently but there were group meetings which occurred to discuss performance issues such as medicine errors. Another member of staff said one to one meetings were not taking place and it would be beneficial for staff to discuss personal development with a line manager. The registered manager told us one to one meetings were mainly based on performance and the responsibility of the role.

Staff were supported to develop their skills and insight into people's needs. A member of staff said the quality of the training offered was good. They said staff attended dementia and mandatory training set by the provider which included food hygiene, safeguarding of vulnerable adults from abuse and Mental Capacity Act 2005 (MCA). Another member of staff told us there were opportunities for vocational qualifications. They said opportunities were available for them to register for vocational qualifications.

The registered manager told us there were three staff that had train the trainers certificates working at the home. This meant the staff had access to training on "site". The analysis of training undertaken showed staff attended mandatory training set by the provider which included Health and Safety, fire awareness, food hygiene, moving and handling, infection control, Mental Capacity Act (MCA) 2005 and safeguarding on vulnerable adults. Staff also attended training in behaviours that challenge, care planning and medicine competence training.

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.

MCA assessments were undertaken to ensure people were able to make specific decisions. Assessments included the people consulted, the person's ability to retain the information or understand the consequences of the decision. A best interest decision was then taken based on the assessment. For example, one person lacked capacity to make complex decisions about their care and treatment but was able to make day to day decisions. Records were clear where lasting power of attorneys were appointed and the recorded the nature of the appointee for example, care and treatment.

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 authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and the registered manager told us applications for people under continuous supervision were made to the supervisory body. Keypads were used on entry and exit doors to alert staff people leaving the building were accompanied.

We saw that for some people Do Not Attempt Resuscitation (DNAR) orders which the GP had signed after consultation with family and the person were in place. Members of staff were aware of the guidance and of the people with DNAR orders in place.
One person told us they were able to make their own decisions. Another person said they were able to make their own decisions and they were not subject to continuous supervision. This meant they were able to leave the home without staff support.

A member of staff said consent was gained from people before tasks were undertaken and gave examples on the types of decisions people made. They said "the staff know it's their [people] decision. People were given options of meals and encouraged to decide what they wanted to wear". Another member of staff said people made day to day decisions which included meal choices and what people wore.

A member of staff said there were people who at times were resistive to personal care. They said strategies were in place which included giving people time to accept personal care and other staff offering to their assistance. Another member of staff explained the strategy in place for one person. They said "we try and talk to him. We worked out that two staff are the best. We explain the task, one [staff] talks the other [staff] does the task".

People's dietary requirements were met. Individual food passports listed the person's likes, dislikes and preferred meals size. Catering staff said they catered for people that were served blended and high calorie meals and for people with diet controlled medical conditions.

People told us there were choices of meals. One person told us "staff know I can't eat onions". Another person said the food was good and stated "I have what I like". A third person said "I don't like it but I eat it. You are asked to make a choice from two options".

The member of staff with a lead role in nutrition for people living with dementia explained their role. They said the role included looking at areas for improvement, assessing adapted cutlery and how people with dementia were able to recognise the food served.

The eating and drinking care plan gave staff guidance on enabling one person to make meal choices. Meals were to be prepared separately for one person with an irregular sleeping pattern. This meant the person was served with freshly prepared meals

One person told us their health was good and they were able to request GP visits. Another person told us they had a recent illness, "the staff were excellent" and the GP prescribed antibiotics.

Reports of professional's visits showed people had access to the relevant healthcare services. For example, people had regular visits from NHS services such as an optician and dentist. GP visits to the home were regular and the Community Liaison Team were supporting staff with people's ongoing healthcare needs where appropriate.

We spoke with a community nurse who visited the service frequently. The community nurse said the staff were helpful and "took on board and followed" the guidance given. It was also stated that "overall the impression of the home is good. Staff are friendly. The staff know the people and are aware of their character".

Good

# Is the service caring?

## Our findings

The people we spoke with said they liked the staff and liked living at the service. The comments from one person included "the staff were ok" and they were "well looked after. If you call them [staff] at night they come straight away. They give me milk and the pain goes away". A relative told us the staff made contact by phone when their family member was awake as their sleeping pattern was irregular. They said "XX is up if you want to visit." One person said there were carers meetings and their family members attended. Relatives meetings were regular and well attended by relatives.

One person said they had daily visits from relatives which occurred in their bedroom. Another person said their visitors were welcome at the home.

While the property was well maintained the property was not adapted on the floor where people living with dementia were accommodated. The registered manager told us in the Provider Information Return (PIR) "we are aware that the environment on the dementia floor could be created on a more dementia friendly layout. Discussions are taking place to clarify that changes can be made."

The staff received a number of compliments from relatives about the care and treatment they delivered to their family members. For example, a person that received short term care thanked the staff for their care and treatment.

Staff described the methods used to build trust. Staff told us they spent time with people, they discussed their likes and dislikes which helped to develop relationships. A member of staff told us inclusion helped prevent isolation. For example, they introduced people to each other and encouraged them to discuss shared interests. Another member of staff said there was a casual approach towards people, the staff made eye contact when they communicated with people and offered assistance before undertaking tasks. The third member of staff said "we listen and give people time. I never rush people. I give them time. I ask them. I take my time to hold their hands. I ask them how they are. They can trust you and they don't have to do something they are not ready to do. I treat people as individuals".

We saw members of staff enabling people, whose preferences they knew, to make choices. For example, we saw members of staff asking people to make meal choices for the following day. For one person the member of staff said "the last time we had fish fingers you didn't eat it. What about a salad"? A member of staff said people were asked about their preferences.

We observed staff show concern for people in a caring and meaningful way. On one occasion we saw one person who had lost their way and position themselves at risk of harm. We saw a member approach the person and offer assistance. The member of staff said "Let me help you." On another occasion during lunchtime we saw a member of staff approach one person. The comments from the staff in the dining room included "do you want to have a lay down and eat later," "XX let us take you to your room. Can you stand ? You are a bit sleepy."

People's rights were respected. A member of staff said people's rights were promoted and was achieved by offering choices. Another member of staff gave us examples on how to staff respected people's privacy and dignity. They said staff closed bedroom doors when they provided personal care, they knock before entering bedrooms and staff respected some people's preference for staff to wait outside the toilet.

Requires Improvement

# Is the service responsive?

## Our findings

One person said their health had improved because of the quality of care they had received and were leaving the service to live with family. Another person said their personal care was delivered by the staff in their preferred manner. A member of staff said "care plans tell us about people. We ask people what they like. I make mental notes for example the times they get up. We listen to what families tell us."

While staff knew people well the care plans we viewed were not consistently person centred. Care plans lacked people's likes and dislikes and preferred routines. Life stories were not always documented. Reviews of care plans were taking place but the care plans were not always updated where people's needs changed.

The registered manager told us care plans were to improve and they were to include more guidance on how people wanted their care to be delivered. The personal care plan for one person although described the assistance needed from staff and included the gender preference of staff to deliver their care, lacked detail on the person's preferences for example, how they wanted their care delivered. The care plan also lacked detail on the aspects of care the person was able to manage for themselves.

Medicine care plans in place included some detail such as the prescribed medicines including "when required" (PRN) medicines. The person's preference on how their medicines were to be administered was included in their care plan.

An eating and drinking care plan for another person was more detailed and included their preference on where they ate their meals. The care plan stated the person had good appetite and preferred to have their breakfast in their bedroom and all other meals in the dining room.

The personal care plan for one person was detailed and individual to the person. For example, the plan included the aspects of care the person was able to manage for themselves, the assistance needed from staff and their likes and dislikes such as "likes to wear a shower hat."

The care plan for one person with additional mental health needs included the comments the person was likely to make and how staff were to respond to the comments. However the care plan lacked detail on the mental health condition and the signs and symptoms of deterioration.

A member of staff said the care plan formats had been reviewed which were better and there was more "cross referencing" and reduced repetition. Another member of staff told us senior staff developed the initial care plans and staff reviewed the care plans daily. They said while there were opportunities to read care plans there were daily handovers where information about people's current needs was passed onto them. Daily reports were completed by the staff which included observations of the staff, the meals people ate and personal care delivered.

The activities coordinator told us monthly activities programme were developed. Similar activities took place for the ground and second floor and separate activities were arranged for the middle floor. For

example, arm chair exercise, visits to pubs and entertainers. They said some people preferred not to participate in group activities but would attend entertainment and other people preferred to have one to one time with activities coordinators. Trips were organised for example, to Bristol Zoo and Butterfly World. The people at the service were assisted to choose a charity each year and money to support the charity was raised by the staff. The coordinator also said the activities were becoming repetitive and providing more meaningful activities was being considered.

We observed activities taking place for five people in a lounge of the home. People were supported with signing by the activities coordinator and chair exercises. In the afternoon there was an entertainer for a sing along which people from all floors attended.

The complaints procedure was on display on each floor. One person told us initially they discussed concerns with family members. Another person said "I have no moans about the place. I would recommend it to anyone". A relative told us they had complained about the care their relative was receiving and the attitude of specific staff. They said the registered manager investigated the complaint and responded appropriately and was resolved to satisfactory level.

Good

# Is the service well-led?

## Our findings

Staff told us the organisation's approach was to meet people's needs in an individual manner. A member of staff said "everyone is independent from others". A relative told us the motto was "be bright, be kind." The registered manager said the organisation's values were "be bright, be kind and make everything count". An employee of the month was introduced and nominated by staff using the values of the organisation. The registered manager also stated the use of language ensured people were respected and staff understood that they "come here for the person. We don't come to just do the job. [Staff] are the first thing people see and the last thing and for some [people] staff are their everything. Some people don't receive visitors and what [staff] give is their everything."

Relative's meetings were regular and well attended. At the most recent meeting relatives were introduced into a new initiative called "tiny noticeable things" (TNT). The registered manager said "this encourages the staff to make a tiny change to something that matters to a person to improve the quality of the service we provide i.e. offering an "after-eight" mint to someone who particularly enjoys them after lunch. Offering a resident their own sugar bowl to allow their independency as to how much sugar they take".

Effective communication systems were in place. A range of meetings were organised by the registered manager to discuss specific areas such as activities, Health and Safety and care and treatment. Staff meetings were organised into day and night staff. At the most recent day staff meeting information was shared, concerns discussed and the TNT initiative discussed. A member of staff said there were daily flash meetings where a handover from the night staff to the registered manager and "seniors" took place.

The registered manager and staff worked in partnership with other professionals to ensure people received a high standard of care and support. We saw good evidence of working in partnership with other services such as, community nurses, speech and language therapists and GPs to support people with their care and treatment.

Staff were assigned specific lead roles. Staff said during their appraisal lead roles were assigned and were based on their interests and past experiences. A member of staff said they had past experience of hospitality and their lead role included working with catering staff on meal presentation and tableware.

The community nurse we spoke with said "there was strong leadership," the registered manager was "on the ball and looked at the wider issues and bigger picture". The comments from the staff about the leadership of the registered manager included "had high standards and had high expectations from the staff, there had been improvements with the appointment of a deputy," "we are appreciated. It makes a massive difference. The residents benefit from good morale. There is a high standard." A member of staff said there was a presence from the registered manager and deputy. They said the registered manager and deputy "popped up on the floors". An agency worker assigned to provide one to one care told us "I bought the staff chocolates last week I was in awe of the staff. XX [registered manager] is professional in the way conflict [with relatives] was managed. diplomatic and sensitive to people".

The registered manager told us the staff worked hard and "gave a lot and were appreciated for what they did. The aim was to educate staff and maintain their motivation." It was stated "the staff are person centred but they don't evidence it [records] enough." There was more energy to be given into dementia specialism and it was said "the staff are excited but the environment needs to be adapted".

A member of staff told us the team worked well together. They said "if I am not sure I can ask". Another member of staff said there were improvements and the team worked well together and not as "individuals". This member of staff said senior meetings occurred on Fridays and were regular.

Quality assurance arrangements in place ensured people's safety and well-being. A whole home audit took place and where there were shortfalls an action plan was developed on how to meet the set standards. For example, medicine competency training for staff and to replace the catering temperature probe had been set as actions to complete.

Internal audits were undertaken to assess and monitor the quality of the service. Care plan audits were used to assess the content of care files and to ensure all the required information was included. Where documents were missing an action plan with timescales was developed. A comprehensive infection control audit was undertaken in June 2016. However, the odour had not been identified for action. During the inspection we noted handovers did not include poor nutrition and that monitoring charts were not consistently completed. The registered manager when we gave them feedback on the inspection agreed information on how staff ensured they were made aware of people's poor fluid intake needed improving. The provider information return (PIR) completed by the registered manager and received subsequent to the inspection visit stated "Residents who are not taking adequate fluids need to be recognised and improvement practices put in place. To do this we are going to highlight on the handover sheets every resident's intake against the recommended daily amount. We are going to implement an annual record sheet for each resident that requires their food and fluids monitored. This sheet will be user friendly and will give us a clear indication is there is an area of concern with regard fluids. We are going to develop a simple flow chart to direct staff of the actions that can be taken when a resident's fluid intake is not adequate".

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 17 HSCA RA Regulations 2014 Good governance<br><br>Records did not provide staff with up to date information on people's intake of fluid. |