

Laudcare Limited

Bishopsmead Lodge

Inspection report

Vicarage Road
Bishopsworth
Bristol
BS13 8ES

Tel: 01179359414

Date of inspection visit:
08 July 2016
11 July 2016

Date of publication:
13 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 8 and 11 July and was unannounced. The last inspection took place on 6 January 2015. We found one breach of the regulations of the Health and Social Care Act 2008 relating to the management of medicines. This breach was followed up as part of our inspection

Bishopsmead Lodge is registered to provide accommodation for persons who require personal or nursing care for up to 51 people. The service cares for older people, some of whom are living with dementia. At the time of our inspection there were 41 people living in the service.

There was a registered manager in place on the day of our inspection. 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.

In January 2015 we found that medicines were not managed safely. At this inspection the provider had not made sufficient improvements. This is the third inspection where we have found that the service has not managed medicines safely.

People's rights were not being upheld in line with the Mental Capacity Act 2005. This is a legal framework to protect people who are unable to make certain decisions themselves. In some people's support plans we did not see information about their mental capacity and Deprivation of Liberty Safeguards (DoLS) being applied for. These safeguards aim to protect people living in care homes from being inappropriately deprived of their liberty.

The provider had not consistently protected people against the risk of poor or inappropriate care as accurate records were not being maintained.

The provider did not have effective systems and processes for identifying and assessing risks to the health, safety and welfare of people who use the service.

The provider had not ensured that people were protected from the risk of cross infection.

Staff were not consistently supported through an effective training and supervision programme.

Staff demonstrated kind and compassionate behaviour towards the people they were caring for. We received positive feedback about the staff and people thought they were caring.

Care records that we viewed showed people had access to healthcare professionals according to their specific needs.

Relatives were welcomed to the service and could visit people at times that were convenient to them. People maintained contact with their family and were therefore not isolated from those people closest to them.

We found four 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 this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement ●

The service was not safe.

Medicines were not managed safely.

People were not adequately protected from the risk of cross infection.

Safe recruitment processes were in place that safeguarded people living in the home.

Is the service effective?

Requires Improvement ●

The service was not always effective.

Staff were not consistently supported through a supervision programme.

People's rights were not being upheld in line with the Mental Capacity Act (MCA) 2005. This is a legal framework to protect people who are unable to make certain decisions themselves.

The provider had not protected people against the risk of poor or inappropriate care as accurate records were not being maintained.

Is the service caring?

Good ●

The service was caring.

In the main we observed staff treating people with kindness.

Staff were knowledgeable about people's needs.

People and relatives spoke positively about the staff and told us they were caring.

Is the service responsive?

Requires Improvement ●

The service was not always responsive.

Care plans were not consistently written in conjunction with

people or their representative. People had not signed their care plans to indicate their agreement.

The provider had a system in place to receive and monitor any complaints. Where issues of concern were identified they were taken forward and actioned. People said they knew how to complain.

Relatives were welcomed to the service and could visit people at times that were convenient to them.

Is the service well-led?

The service was not well-led.

Systems were not operated effectively to assess and monitor the quality and safety of the service provided.

The feedback from staff members and people we spoke with was positive about the management of the service.

Staff felt well supported by the manager and viewed her as being approachable.

Requires Improvement 

Bishopsmead Lodge

Detailed findings

Background to this inspection

This inspection took place on 8 and 11 July and was unannounced. The last inspection took place on 6 January 2015. We found one breach of the regulations of the Health and Social Care Act 2008 relating to the management of medicines. This breach was followed up as part of our inspection

Bishopsmead Lodge is registered to provide accommodation for persons who require personal or nursing care for up to 51 people. The service cares for older people, some of whom are living with dementia. At the time of our inspection there were 41 people living in the service.

There was a registered manager in place on the day of our inspection. 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.

In January 2015 we found that medicines were not managed safely. At this inspection the provider had not made sufficient improvements. This is the third inspection where we have found that the service has not managed medicines safely.

People's rights were not being upheld in line with the Mental Capacity Act 2005. This is a legal framework to protect people who are unable to make certain decisions themselves. In some people's support plans we did not see information about their mental capacity and Deprivation of Liberty Safeguards (DoLS) being applied for. These safeguards aim to protect people living in care homes from being inappropriately deprived of their liberty.

The provider had not consistently protected people against the risk of poor or inappropriate care as accurate records were not being maintained.

The provider did not have effective systems and processes for identifying and assessing risks to the health, safety and welfare of people who use the service.

The provider had not ensured that people were protected from the risk of cross infection.

Staff were not consistently supported through an effective training and supervision programme.

Staff demonstrated kind and compassionate behaviour towards the people they were caring for. We received positive feedback about the staff and people thought they were caring.

Care records that we viewed showed people had access to healthcare professionals according to their specific needs.

Relatives were welcomed to the service and could visit people at times that were convenient to them. People maintained contact with their family and were therefore not isolated from those people closest to them.

We found four 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 this report.

Is the service safe?

Our findings

In January 2015 we found that medicines were not managed safely. The provider sent us an action plan telling us what they were going to do to meet the regulations. During this inspection we found insufficient improvements had been made.

Systems in place for ordering medicines did not ensure the medicines were received in a timely way. The service had experienced difficulties in obtaining repeat medication. On the day of the inspection seven medications were out of stock and not available for people. Carried forward numbers and quantities of medicines received were not recorded on the Medicine Administration Record (MAR). In some cases where they had been recorded they were recorded incorrectly. For example the received number of one medicine from the pharmacy had been documented incorrectly as the carried forward number. The poor stock control recording meant that when there had been gaps on the MAR it was not possible to discern whether it was a case of the medicine not being recorded as administered, or whether the medicine had been administered at all.

The nurse on duty was observed 'potting up' medicines on a couple of occasions. The practice of 'potting up' is considered as being secondary dispensing. Secondary dispensing is when medicines are removed from the original dispensed containers and put into pots or compliance aids in advance of the time of administration. This is not considered good practice as this process has removed a vital safety-net to check the medicine, strength and dose with the MAR chart and label on the medicine at the same time you check the identity of the person. This was acknowledged by the nurse as not being best practice as it increased the risk of medicines being given to the incorrect person.

Medicines were not stored safely. Staff had not recorded whether they had checked the temperature of medicines refrigerators and store rooms to make sure they were safe for storing medicines.

There were discrepancies in the administration of medicated creams, resulting in people not receiving their medicated creams. For example, on one person's MAR the nursing staff were documenting that the carers were giving a medicated cream three times a day. There was no application record of the administration of the cream or instructions of where and how to apply, since it had been dispensed seven days ago in the person's room. The member of staff caring for the person was unaware that the person had been prescribed cream when they were asked. The cream had been opened but no date of opening had been recorded on the label. It was evident from inspecting the tube that the correct doses had not been applied. This meant that the person did not receive their medicated cream in accordance with their prescription.

Medication such as eye drops have limited efficacy periods once opened and as such should be dated when opened and use by dates also recorded. The drops for five people, that received a total of nine different drop preparations, were inspected and none of the bottles had either dates of opening or disposal recorded on them. There was a risk that people were receiving eye drops that should have been disposed of. One person had eye ointment dispensed on the 24 May 2016 and this product should be disposed of four weeks after opening.

Topical MAR's kept in people's bedrooms did not always contain sufficient information. A topical medication is a medication that is applied to a particular place on or in the body. For example creams, ointment and lotions are applied topically on the skin. One person who was prescribed two creams. One record for staff did not state how often the cream was to be applied and the other record stated; 'apply often to dry skin' but did not define 'often'. The cream was last applied by staff 12 days ago. Neither cream had a date of opening recorded on the containers.

A number of people had not received medicines for several days as the service did not have supplies of them. We also found gaps on the MAR's where people's doses had not been given. Drug omissions were not consistently recorded as drug errors or incidents.

Several of the controlled drugs stored in the controlled drugs cupboard had not been checked since they were last given, in some cases as far back as November 2015. There was not a process in place for regularly checking stocked levels of controlled drugs. Three controlled drug topical administration records were inspected. They showed that though the patches had been applied, there was no record as to where they had been applied. It is important that application sites are rotated and with some of the drugs the same site should not be used within a defined period of time. The missing information on the administration record would make it difficult for staff to check that the topical patch is still in place and to ensure that application sites are rotated. This also put people at unnecessary risk.

An internal audit conducted by the provider in January 2016 identified similar concerns found during our inspection. The audit stated; 'a return visit by the CQC at the present time will almost inevitably result in further adverse inspection results.' An audit conducted by an external pharmacist on April 2016 also raised concerns regarding their management of medicines and these had not been adequately addressed by the service.

This meant there continues to be a breach of Regulation 12(2) (f) & (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service has not complied with this regulation since July 2014.

The service did not prevent avoidable harm or risk of harm to people. People's care plans contained risk assessments in relation to topics such as mobility, nutrition, personal hygiene and skin integrity. Where risks had been identified, the plans contained an inconsistent level of detail on how staff should support people to minimise the risks. In some cases staff were unaware of people's risks and how to effectively manage those risks. A number of people had non-regulating pressure relieving mattresses. Pressure relieving mattresses if set in accordance with the person's weight, can help to prevent the development of pressure ulcers. Care and nursing staff were unaware of what the correct setting should be. There was no reference to the correct setting in the persons' care plans. Moving and handling risk assessments were not all dated and did not in all cases document clear staff instructions regarding individual sling sizes needed or the required type of hoist. One person's bed rail assessment had not been completed accurately. The bed rail did not comply with the Health and Safety Executive guidance, they were not high enough to reduce the risk of the person rolling over the top of them. The person's bed rail assessment had not been reviewed for four months.

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

We were told by the clinical lead that the service did not have an Infection Prevention and Control (IPC) Lead or a similar role to monitor practice. The usual role of an IPC would involve identifying the risks to the service and taking responsibility for implementing and monitoring actions to manage those risks.

Best practice had not been followed in relation to infection control. There was no clear segregation procedures for clean and dirty laundry. Clean linen was being stored in the same areas where dirty laundry entered the room to be separated and washed. The flow of dirty linen was insufficient to prevent cross infection between laundry items. The clinical lead told us that there are proposals to refurbish the laundry room. We observed one member of staff entering the laundry room with the dirty laundry baskets without personal protective equipment (PPE). We also observed staff not wearing the appropriate personal protective clothing when entering the kitchen. Staff were observed not complying with best practice in relation to the wearing of PPE when moving a person onto a commode. Not wearing the appropriate PPE when necessary presented a risk of cross infection.

The provider had not ensured that people were protected from the risk of cross infection. This is a breach of regulation 12 (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Throughout the rest of the service people were cared for in a safe and clean environment. In March 2016 the kitchen had been awarded a five star food hygiene rating by the local authority. Each person's room had a scheduled daily clean and monthly deep clean. Cleaning schedules were completed by the domestic team. Cleaning standards were checked and recorded by senior staff on their daily walkabout of the service. If cleaning issues needed to be addressed they were actioned on the same day. The domestic staff took great pride in their work. One person described the service as being "spotlessly clean."

We reviewed the June 2016 staffing rotas. Staffing levels were predominantly maintained in accordance with the assessed dependency needs of the people who used the service. The staff we spoke with felt in the main the staffing levels were manageable. We were told that the service only used agency staff in exceptional circumstances. One member of staff told us; "The staffing levels are generally manageable. It can be difficult if absences are not covered. We work well as a team. I would be quite happy to have a family member here." People told us they felt safe. One person told us; "I feel safe here. They look after me."

Appropriate arrangements were in place for reporting and reviewing accidents and incidents. This included auditing all incidents to identify any particular trend or lessons to be learned. Accident and incident forms clearly identified the nature of the incident, immediate actions taken and whether any further actions were required, such as reviewing a person's medication and introducing a clinical training matrix.

Records showed a range of checks had been carried out on staff to determine their suitability for the work. For example, references had been obtained and information received from the Disclosure and Barring Service (DBS). The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they were barred from working with vulnerable adults. Other checks had been made in order to confirm an applicant's identity and their employment history.

Staff we spoke with demonstrated a good understanding of how to recognise and report abuse. They understood the term 'whistleblowing'. This is a process for staff to raise concerns about potential malpractice at work.

Is the service effective?

Our findings

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We 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 MCA DoLS require providers to submit applications to a 'supervisory body' for authority to do so. The provider had not met their responsibilities with regard to DoLS. Applications had not been made to the supervisory body where people were being deprived of their liberty. The clinical lead was aware of the need to process the applications.

Care files contained formats for people or their representatives to give consent to photography for medical and identification purposes. These sections were not always signed.

One person was nursed in a recliner chair. There was no evidence to suggest that the person had consented to this level of care or a best interests meeting had been held in relation to its use.

This was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not consistently protected people against the risk of poor or inappropriate care as accurate records were not being maintained. Not all records were completed accurately to manage and ensure that people's on-going needs were met. In some cases care plans did not contain sufficient information to inform or reflect current care given to people. One person whose care plan said they did not need a pressure relieving mattress was on a pressure relieving mattress. The person also had a mattress by the side of their bed. Staff told us this was in case the person fell out of bed. The additional mattress was not referenced in the person's care plan or the reason for its use. One person had a long standing leg wound. On the day of our inspection the wound was observed to be leaking and was visible on the outside of the bandage. The last two entries on the care plan dated the 1 and 4 July 2016 showed that staff recognised the need to take a wound swab as the wound appeared infected. They also recognised the need to take a photo, however in practice neither of these actions occurred. The last photographic documentation had been taken on 9 April 2016. We randomly selected three food and fluid charts at 17.00 on the day of our inspection. One chart had been completed regularly. The other two charts did not have any entries since 09.00. One person was underweight and was at high risk of malnutrition. Their nutritional assessment had not been amended to reflect the change from medium to high risk. Their care plan also stated that the

person was on smoothies and had not mentioned the food supplement they had been prescribed.

This was in breach Regulation 17 (2) (C) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were not consistently supported through a regular supervision programme, supervision is where staff meet one to one with their line manager. Staff we spoke with told us they had not received supervisions regularly. This position was reflected in the staff records. The lack of supervision meant that staff did not receive effective support on an on-going basis and training needs may not have been acted upon. The provider failed to adhere to its own supervision policy which stated that all staff should have five supervisions in one year. The onus was on the staff members to book supervisions with their manager and this task was not being undertaken. In order to address this issue the manager has introduced a staff supervision and appraisal matrix with the view that staff members will receive regular supervision. The matrix highlighted to staff members the dates their supervisions should be booked.

The provider had an induction process which followed the Care Certificate guidelines. The Care Certificate is an identified set of standards that health and social care workers should adhere to when performing their roles and supporting people. The Care Certificate is a modular induction and training process designed to ensure staff are suitably trained to provide a high standard of care and support. New staff also shadowed more experienced members of staff. To ensure that all staff met people's needs on-going and refresher training was provided on modules such as moving and handling, first aid and basic life support. Staff were sent reminders when their mandatory training was due and this was monitored by the manager. We noted that courses had also been booked where required for practical modules such as pressure ulcer prevention and dementia care.

Although there are concerns regarding the accuracy of some people's nutrition related records people spoke positively about the meals; one person told us "The food is very good here. I've put on weight. I have a cooked breakfast every morning." Another person told us, "I like the food here. I have special utensils." We observed that people had access to drinks all day in the communal areas and drinks were within reach for people in their rooms. The chef prepared food at the correct consistency, in accordance with people's needs. They also demonstrated an understanding of peoples' specific dietary requirements. Where required staff assisted people to eat.

Is the service caring?

Our findings

We observed that people were treated with kindness and understanding by the staff. There was a friendly atmosphere and staff knew people by name and vice versa. People in the main spoke positively about the staff and told us they were caring. People's comments included; "The staff are brilliant. On my birthday I received a card from the staff"; "She's so happy here. I like the way they talk to her. They always talk to her kindly. She is safe and happy here"; "The staff know what they're doing. They're lovely. I would recommend the service to other people. It's very good, there's no doubt about that." There were some notable exceptions regarding feedback on staff; "Some of the agency staff are not so good, especially the night staff" and "One carer never smiles and is not communicative."

We noted a recent compliment had been received by the service; 'I am writing to say how pleased I am regarding the care and attention which my wife [person's name] is receiving. The manager, administrator and care staff go out of their way to make my wife's stay as comfortable as could be. They are always caring, helpful and understanding and give excellent service in a job that can't be easy.'

We observed positive interactions during the day. One person was shouting out for help in their room. They thought they hadn't eaten any breakfast. The carer provided lots of reassurance to the person and advised them they had eaten breakfast earlier. This reassured the person and the carer offered them more food and a drink. This was accepted by the person and they were calm and content. One person had recently moved into the service and told us that they were receiving their medication too late in the evening and their mattress was not at the correct setting. We observed that the member of staff took their comments on board and advised them they would look into the matter. They also took time to explain to the person why the mattress was set in a particular way. The following day we spoke with the person and they told us that they received their medicines much earlier the previous evening; they were provided with a different pillow which aided their sleep and an appointment had been arranged with the GP. They were very pleased with the outcome and described the member of staff who assisted them as a "nice person."

People's dining experience appeared to differ between the ground floor and the first floor. On the ground floor during the lunchtime service people were asked where they would like to sit. They were offered choices of food, drink, sauces and condiments were available on the table. People were chatting with each other and the staff. The atmosphere was friendly and upbeat. One person was having a conversation with a member of staff asking when they were working as they had bought a birthday card for them. People and staff members discussed their families and interests. We were told by one person that a member of staff had recently got engaged and another member of staff had painted their nails. Staff members had formed close relationships with people.

Lunch was observed in the upstairs dining room. In comparison to the ground floor only two people had chosen to eat in the dining room. There was no interaction between them and the staff. The people were not offered a drink until they were prompted by an inspector. The majority of people upstairs had their meal in their room and they were supported attentively by staff sitting alongside them assisting them to eat. Staff enabled people to take their time and enjoy their meal.

From the observed interactions it was evident that staff members demonstrated a clear understanding of people's needs and knew them well. When we spoke with members of staff about the people they cared for they knew people's likes and dislikes and their individual preferences. One member of staff told us about one person they cared for. They described the person as being; "very sociable and likes to talk about her family." They continued to provide an account of how the person liked their personal care to be provided whilst enabling the person's independence, as far as possible.

People's privacy and dignity was respected. Most people had their bedroom doors open. We observed staff announcing themselves and asking if they could enter. People told us that staff made them feel comfortable when receiving personal care. One person told us; "They help me with my personal care. They help me wash my hair. I look after myself and they always check the water." One member of staff told us that one person gets embarrassed when they're helping them with their personal care. The staff member told us; "I knock at their door. I cover them up and help them wash. I respect their routine and how they like things done." The staff we spoke with told us they enjoyed their job and thought there was a good team spirit.

Is the service responsive?

Our findings

We found that the care plans did not reflect people's individualised needs. Care plans were not consistently written in conjunction with people or their representative, and people had not signed their care plans to indicate their agreement. Relatives did feel sufficiently informed of notable events, such as the outcomes of GP visits.

People's care plans were in the main reviewed monthly and up-dated as appropriate. People and relatives we spoke with confirmed that they were not aware of care plan review meetings being held. One relative was unsure if their relative actually had a care plan. This meant that care plans potentially did not reflect people's individualised needs. They were staff-led rather than led by the person or their representative. It was evident that some of the information contained in the care plans was also incorrect and not specific to the person's needs, such as pressure relieving mattress settings and nutritional risks.

'My life, my preferences' documents had been completed in some of the care plans we looked at, but not all. Further development of this work will enhance staff understanding of the ways in which people wanted to receive their care and also inform the activities and stimulation that would benefit individuals.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had access to healthcare professionals where necessary. The records showed that people had received support from tissue viability nurses, diabetes nurses, the speech and language therapy team and GPs.

There was a dedicated activities coordinator who worked five days a week. There was no structured weekend activities programme. Activities included painting, bingo, gardening, music and movement. Regular church services were also held. People were watching TV in the lounge and playing draughts. The activities coordinator provided one-to-one sessions for people who choose to remain in their room. People's comments were largely positive about the activities. One person told us; "The activities are alright. I helped with the gardening. I like to keep busy." The bingo session in the afternoon was well attended and there was lots of laughter from those participating. Apart from access to the garden there were no activities conducted outside of the service. One person told us they had never been offered the opportunity to go out of the service.

The provider had systems in place to receive and monitor any complaints that were made. We reviewed the complaints file. One formal complaint had been received in 2016 and it was handled in accordance with their complaints procedure. The complaint was investigated by the manager and there was a clear audit trail of the outcome and actions taken. People said they knew how to complain. One relative did express concerns about the level of care provided to their relative but had not yet made a formal complaint. They told us that they intended to do so.

Relatives were welcomed to the service and could visit people at times that were convenient to them. People maintained contact with their family and were therefore not isolated from those people closest to them. People told us about their family visits. One person held their 80th birthday at the service and all their family attended. One person commented; "This place is ideal. My family come to visit. I please myself and get up and go to bed when I want. They have a nice garden and I go out with my family."

Relatives were mainly very positive about the care provided to their relative. A relative recently wrote to the service; "We are so impressed with the care she has been given and amazed at the improvement in her condition since she joined you. [Person's name] has gone from wanting to be dead by Christmas to looking forward to what her twilight years have to offer and is much more positive about everything."

Is the service well-led?

Our findings

The provider did not have effective systems and processes for identifying and assessing risks to the health, safety and welfare of people who use the service. Since our previous inspection there has been no marked improvement in the level of service provided. We have found an increased number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Medicines were not managed safely. People's rights were not being upheld in line with the Mental Capacity Act (MCA) 2005 which provides a legal framework to protect people who are unable to make certain decisions themselves. Staff were not consistently supported through a regular supervision programme. The provider had not consistently protected people against the risk of poor or inappropriate care as accurate records were not being maintained. Care plans were of an inconsistent quality and this placed people at risk of not receiving care that were specific to their needs. The provider's auditing systems had failed to identify the majority of the shortfalls found at this inspection.

The service had also failed to fully implement their action plan regarding the management of medicines breach found at our previous inspection. Despite having a plan in place no improvements had been made.

This is a breach of Regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People were encouraged to provide feedback on their experience of the service. The service has a 'Quality of Life' programme. People have access to an electronic tablet in the service to provide their views. According to the their website "the system provides a convenient way for our residents, and those close to them, to give on-going feedback and it immediately notifies us with the aim of us fixing it quickly." During the period 8 April – 8 July 2016, 17 people provided feedback. People felt safe and they found staff respectful. The feedback from people identified that development is needed with respect to involving people in developing their care and being more person-centred. To ensure people's views continue to be sought regarding the level of service resident meetings were held. The most recent meeting was held in 8 June 2016. Issues discussed included the night staff, food and activities. From August 2015 to July 2016 14 relatives had provided feedback and the overall feedback was positive regarding the level of service their relative received. The main issue that relatives had highlighted was an odour in the home. On the day of our inspection there were no malodours in the service.

Staff felt well supported by the manager and viewed her as being approachable. One member of staff told us; "I feel sufficiently supported to undertake my role." The manager held regular staff meetings with carers, the clinical team the heads of departments. The meetings covered a number of operational issues such as attendance, arising concerns with people in the service, maintenance, menus and activities. This ensured that each team were aware of any issues that needed to be dealt with.

We were told by the clinical lead that the service has introduced a regular 'resident of the day' system which focused on a particular person on a rotational basis. The family of the person receive an invite to attend the

service to speak in person about their family member. The care plan is audited, their room had a deep clean and the resident had time to speak with key departmental heads such as the manager, the chef, housekeeping and maintenance staff to ensure the service was sufficiently meeting their needs. When fully implemented this should improve their level of person-centred care and the accuracy of the documentation.

To ensure the safety of the service health and safety checks were conducted, such as checks on equipment and standard of electrical, gas and water safety had been completed.

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 9 HSCA RA Regulations 2014 Person-centred care Care plans were not consistently written in conjunction with people or their representative. People had not signed their care plans to indicate their agreement.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's rights were not being upheld in line with the Mental Capacity Act (MCA) 2005.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service did not prevent avoidable harm or risk of harm to people. The provider had not ensured that people were protected from the risk of cross infection.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Diagnostic and screening procedures	Medicines were not managed safely.
Treatment of disease, disorder or injury	

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
	The provider had not consistently protected people against the risk of poor or inappropriate care as accurate records were not being maintained.
	The provider did not have effective systems and processes for identifying and assessing risks to the health, safety and welfare of people who use the service.

The enforcement action we took:

Warning Notice