Midland Healthcare Limited

Nightingale Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced inspection took place on 17 and 23 January 2017. Nightingale Care Home provides residential and nursing care, support and treatment for up to 49 people, some of whom are living with dementia. On the day of our inspection 24 people were using the service.

The service had a registered manager at the time 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.

When we last inspected the service in March 2016 we found there were improvements needed in relation to people's safety. This was because not all incidents had been shared with the local authority for consideration under safeguarding procedures as they should have been. During this inspection we still could not be assured that incidents had been referred to the safeguarding team when they should have been.

People's care records were not always updated or reviewed following incidents which had occurred at the service.

There were not always sufficient staff deployed at the service to provide people with interaction and stimulation.

People were supported to take their medicines however, some improvements were required to ensure these were administered in a timely manner.

Staff had not been provided with all of training required to care for people effectively. Staff told us they received supervision and felt supported.

People told us they were offered choices however, people's rights under the Mental Capacity Act (2005) were not always protected. Relevant applications to deprive people of their liberty had been made.

People had access to sufficient quantities of food and drink and told us they enjoyed the food. Referrals were made to healthcare professionals for support and guidance if people's health needs changed.

Staff supported people in a caring manner and had developed positive relationships with people. People were treated with dignity and offered choices which were respected by staff.

People's care plans contained limited information about their likes, dislikes and backgrounds. Advocacy information was not available with the service.

People were not always offered the opportunity to be involved in planning their own care although attempts had been made to involve people's relatives.

People's care plans were not always regularly reviewed to ensure they contained the correct guidance for staff. Staff were aware of people's care needs and tried to provide activities and stimulation. However, limited activities were provided during our inspection. Information was available to assist people to make complaints and when these were made they had been responded to.

At our inspection in March 2016 we asked the provider to take action to make improvements in respect of the systems used to monitor the quality of the service and to ensure that we were notified of certain events which occurred at the service. During this inspection we found that sufficient improvements had not been made.

The quality assurance systems in place were not sufficiently robust in detecting issues of concern and bringing about improvements. We had not been notified of certain events which had occurred in the service which the provider is required to do by law.

People and their relatives were given opportunities to provide feedback on the service. People, relatives and staff commented positively on the atmosphere of the service

We identified two breaches of 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.

People's care records were not always updated or reviewed following incidents which had occurred at the service and there was a risk that incidents would not be referred to the local authority safeguarding team in a timely manner.

There were not always sufficient staff deployed at the service to provide people with interaction and stimulation.

People were supported to take their medicines however, some improvements were required to ensure these were given when required.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not been provided with all of training required to care for people effectively. Staff told us they received supervision and felt supported.

People told us they were offered choices, however it was not clear whether people's rights under the Mental Capacity Act (2005) were protected.

People had access to sufficient quantities of food and drink and told us they enjoyed the food. Referrals were made to healthcare professionals for support and guidance if people's health needs changed.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff supported people in a caring manner and had developed positive relationships with people. People were treated with dignity and offered choices which were respected by staff.

Limited information was available in people's care plans about people's likes, dislikes and backgrounds.

Advocacy information was not available within the service.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care plans had not been regularly reviewed to ensure they contained the correct guidance for staff.

People were not always offered the opportunity to be involved in planning their own care although attempts had been made to involve people's relatives.

Staff were aware of people's care needs and tried to provide activities and stimulation. However, limited activities were provided during our inspection.

Information was available to assist people to make complaints and when these were made they had been responded to.

Is the service well-led?

Requires Improvement

The service was not always well led.

The quality assurance systems in place were not sufficiently robust in detecting issues of concern and bringing about improvements.

We had not been notified of certain events which had occurred in the service which the provider is required to do by law.

People and their relatives were given opportunities to provide feedback on the service. People, relatives and staff commented positively on the atmosphere of the service

Nightingale Care 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.

This inspection took place on 17 and 23 January 2017 and was unannounced. The inspection team consisted of one inspector, a specialist advisor, who was a nurse, and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we checked the information that we held about the service such as information we had received, previous inspection reports and statutory notifications. A notification is information about important events which the provider is required to send us by law. We contacted commissioners (who fund the care for some people) of the service and asked them for their views.

During the visit we spoke with six people who used the service, five relatives, three members of care staff, a senior care worker, two domestic staff, the maintenance person, the cook, the deputy manager and the registered manager. We looked at the care records of seven people who used the service, the recruitment records of three staff, as well as a range of records relating to the running of the service.

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.

Requires Improvement

Is the service safe?

Our findings

When we last inspected the service in March 2016 we found improvements were needed in relation to people's safety. This was because not all incidents had been shared with the local authority for consideration under safeguarding procedures as they should have been. During this inspection we found that some improvements had been made but that further improvements were required. For example there was not always evidence of timely referral and discussion with the local authority safeguarding team.

People told us they felt safe living at the service. One person told us, "Oh yes I am perfectly safe here", whilst another person when asked if they felt safe replied, "Of course." Most of the relatives we spoke with felt their relations were safe. One person's relative told us, "Yes, we think [relation] is safe". Another relative told us that they did not think that their relative was safe due to recent falls but added, "The staff are brilliant and do everything they can for [relation]. There is nowhere else that [relation] would be any safer." Staff demonstrated to us they were aware of signs indicating a person may have been abused and they knew the process for reporting concerns to a manager.

Records showed that some incidents which had occurred at the service had been reported to the local authority safeguarding team. However, the system for ensuring that incidents were referred when they should be was not robust. During our visit, the registered manager was unable to confirm that two incidents which had occurred at the service were reported to the local authority. This would have enabled the local authority, who are the lead agency for any safeguarding concerns, to determine if any action needed to be taken to ensure the safety of any of the people involved in these incidents. Although these were referred following our feedback, there was a risk that the local authority were not kept informed of these situations or whether further action was needed to ensure people's safety.

People's care records had not always been updated to reflect changes. For example, people had emergency evacuation plans for use in case of an emergency evacuation of the building. We looked at the emergency evacuation plan for a person with a keypad lock on their door and found this information was not recorded. We received assurances following our inspection this had been updated.

Risks to people's health and safety were not always regularly reviewed. The care plans we looked at contained a series of assessments of risk people may face, such as the risk of falling or developing a pressure ulcer. Some of the risk assessments had not been reviewed on a regular basis or updated following incidents which may increase risks to people. For example, one person's falls risk assessment had not been updated since November 2016 despite them previously being noted at very high risk of falls and having experienced falls since this had last been updated. The guidance in the person's mobility care plan was out of date as it was not consistent with the support that staff told us the person now required. Another person had previously been assessed as being at high risk of falls and we found that the risk assessment had not been updated since August 2016. This person had also experienced a fall since their risk assessment had been updated. Staff were able to tell us about the support they gave to people to keep them safe, however there was a risk that staff may not follow a consistent approach or that measures in place were not kept under review.

Care records showed that people had been involved in some decisions about risks they took. For example, a piece of pressure relieving equipment had been replaced with alternative equipment at the request of the person. Another person had a risk assessment for having a keypad lock on their bedroom door and the person and their relative's views showing they were in agreement with this were recorded.

Staff told us that they thought they had enough equipment to meet people's needs safely. We observed people being supported with their mobility by staff who used equipment safely. We found that people who had been assessed as at risk of pressure damage to their skin had pressure relieving equipment in place, and this was being used correctly to ensure effectiveness.

People expressed mixed views on whether there were enough staff to meet their needs. One person when asked if there were enough staff told us, "I think there are enough" whilst another person said the service was "definitely understaffed". People's relatives also expressed mixed views. One person's relative stated, "The staff are wonderful but there just aren't enough of them" whilst another person's relative told us, "There seems to be enough staff."

People told us that staff mostly responded to their needs in a timely way although they sometimes had to wait if staff were busy. One person and their relative told us that they had recently raised concerns about staff not responding to the person's call bell in a timely way and that additional measures had been put into place which documented when staff responded to the call bell. We observed that staff responded to call bells in a timely way during our inspection.

All of the staff we spoke with felt that people would benefit from increased staffing levels. We were told by staff that the number of care staff rostered on duty during the day varied between three and four, in addition to a senior care worker and a nurse. Staff told us that when there were four care staff on duty they had adequate staffing levels but difficulties arose when there were only three care staff on duty. These difficulties were described to us by different members of staff as not being able to monitor people who displayed behaviour which challenged or having time to interact with people and provide activities.

During the first day of our inspection visit there were three care workers on shift and we saw staff did not have the time to provide people with any activities or spend time interacting with them. We also observed on the first day of our inspection visit that people would have benefitted from more reassurance and support during a meal time. A number of care staff were off work during our inspection which impacted on the number of staff available to cover shifts resulting in there not always being enough staff to provide four care staff. The registered manager showed us a dependency tool which indicated that three care staff were sufficient to meet the needs of the people living at the service, however this did not match the views of staff or our observations during the inspection visit. The registered manager told us that additional staff had been recruited and were awaiting the completion of employment checks before commencing work.

People could not be assured that recruitment processes were being properly followed to ensure the recruitment of staff was safe. We checked the recruitment records for three members of staff. Records showed that Disclosure and Barring Service (DBS) checks had been carried out prior to staff commencing employment. The DBS supports providers to make safer recruitment decisions. However records did not evidence references had always been obtained. We were told that some references and nursing registration checks were held by head office. We requested this information was sent to us following our inspection but did not receive all of the information we had requested. Therefore we could not be assured that necessary checks were always carried out prior to staff commencing work at the service.

People were supported to take their medicines however improvement was required to ensure people

received these as the prescribed times. We observed staff administering medicines and saw that medicines were checked against records and staff stayed with people until they had taken their medicines. Staff waited until people had received their morning personal care before giving them their medicines and as a result, when people were late getting up, they received their medicines very late in the morning. Staff told us it was an unusual day, but on the first day of the inspection visit morning medicines were still being given at 11.45am. The electronic system used within the service ensured that some medicines given 'as required' (PRN) were not given too close together, but we were concerned that the intervals between some medicines would be reduced.

People's medicines administration records (MARs) contained a photograph of the person to aid identification, a record of any allergies and the person's preferences for taking their medicines. People's MAR charts had been completed consistently and showed people were administered their medicines as intended. However, we found that further guidance was required for staff when medicines were prescribed to be given 'as required' as there was little detail about the circumstances these should be given, which made a risk of inappropriate administration.

People's medicines were stored securely within locked trolleys, refrigerators or cupboards within a locked room. The temperature of the storage areas were recorded daily and were within acceptable limits. We checked one controlled medicine and saw the number remaining corresponded with the number recorded in the controlled medicines record. Although we found that liquid medicines and topical ointments were not labelled with the date of opening we were informed that all unused creams were discarded at the beginning of a new medicines cycle to ensure they remained safe and effective to use.

Processes were in place for the regular ordering and supply of medicines and staff responsible for ordering the medicines told us they received these in a timely manner. A member of staff told us they had had medicines training and their competency had been checked prior to them administering medicines independently. However, a newly recruited nurse who administered medicines had not had their competency assessed since commencing work at the service. This meant that the provider had not assured themselves that the staff member was safe and competent to administer medicines.

Requires Improvement

Is the service effective?

Our findings

People were supported by staff who had received training in areas identified as mandatory such as fire safety, first aid and safeguarding adults. However, records showed that some staff members had not received training in these areas for approximately three years. The registered manager told us that the staff training matrix had not been updated to reflect recent training provided such as safeguarding adults training in December 2016.

People told us that they felt that staff were competent. One person told us that "by and large" staff knew what they were doing. We observed staff following correct procedures when providing care and support, for example when administering medicines and using equipment.

Most of the staff we spoke with told us that they would benefit from training in responding to people who communicated through their behaviour. Staff told us and records confirmed that a number of people who lived at the service communicated through their behaviour and some staff we spoke with were not confident in managing people when they did so.

Staff told us that they felt supported by the registered manager to carry out their roles and responsibilities. They told us that they received regular supervision and had received an induction when they commenced working at the service. However, records did not reflect that staff were being supervised regularly and induction checklists within staff personnel files were not always completed. The registered manager stated that a supervision schedule was in place but told us they had not completed any supervisions in the last three months of 2016.

People told us that they were able to make decisions about how they spent their day and were offered choices. One person told us, "Someone comes around early in the morning and tells us what is for lunch and we can pick what we want." We saw the staff offered people choices and used effective communication methods to improve people's understanding, such as using gestures and speaking clearly.

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.

Staff told us that they had received training in the MCA and were able to describe the basic principles of the legislation. Some of the staff we spoke with told us that improvements were required to the documentation of mental capacity assessments. Records confirmed this to be the case. When people could not make some decisions for themselves, there was some evidence of mental capacity assessments having been completed, but it was unclear as to the specific decision required and there was no information about best interest decisions and how they had been reached. For example, one person had capacity assessments in relation to their mobility and mental health but measures specific to the person such as regular observations and the

use of a sensor mat were not included in the assessment and there was no evidence of a best interest decision having been made. A deputy manager had recently been appointed and they had a good understanding of the requirements of the MCA and told us they recognised there was some work to do to improve in this area.

Some people had Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) forms in place which had been completed appropriately with the involvement of the person themselves in the decision.

People can only be deprived of their liberty to 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.

Records showed that a number of applications had been made to the local authority if people were identified as potentially being deprived of their liberty. Some people's DoLS had been authorised, however we were told that one person was assessed by the local authority a number of weeks ago and the service had not yet received paperwork. We asked a senior member of staff to contact the local authority to check whether the DoLS had been authorised and whether any conditions were attached to the DoL. We received confirmation following our inspection this had been done.

We reviewed the care record of a person who communicated through their behaviour which could challenge staff. The care plans contained limited information about the behaviours and action staff should take. This person's behaviour was unpredictable and they could pose a risk to other people who used the service and staff. Staff told us they did not use restraint and the registered manager confirmed this. However, the person's care record contained guidance that included the use of restraint. Staff had not been trained in restraint and this guidance was not appropriate. Incident records showed that there had been occasions when staff had physically intervened to prevent harm to staff or people living at the service. The lack of clear guidance within people's care plans and a lack of appropriate training meant that people may be at risk of inappropriate restraint.

People were complimentary of the choice and quantity of food available at the service. One person told us, "It is always a full cooked meal or sort of at lunch time and the staff know what I like." We observed that this person was provided with a meal at lunchtime which was in line with their stated preferences.

We observed the lunchtime meals during both days of our inspection visit. On the first day we saw that people sometimes had to wait a long time for meals to be served. The staff who were present in the dining room during the meal time were assisting people to eat and did so patiently and supportively. During the second day of our inspection visit we observed that people did not have to wait long for meals and that people were provided with more support and encouragement during the mealtime.

We spoke to the cook who was aware of people's likes and dislikes, allergies and whether people required specialist diets. We saw that people received support in line with their care plans. For example, one person required observation and support from staff and we saw this was provided. When there was concern about a person losing or gaining weight the frequency at which they were weighed was increased to weekly. We saw that one person was having their food and fluid intake monitored in line with their care plan.

People told us that staff were quick to notice when they were unwell and they would arrange a visit from the GP. One person told us they had several hospital admissions due to their long term health condition and

that staff had called for an ambulance when they needed admission to hospital. They told us they saw the chiropodist regularly.

Staff told us that they felt that the support of external healthcare professionals was sought when required, without delay. Care plans indicated that support from a range of professionals had been sought when this was required. For example, we saw evidence of the involvement of a tissue viability nurse, community psychiatric nurse, speech and language therapist and optician. We spoke to five visiting healthcare professionals. The majority thought that staff were knowledgeable about the people they supported.

Requires Improvement

Is the service caring?

Our findings

People we spoke with were complimentary of the caring attitude of staff. One person told us, "The staff are caring and kind," and another person said, "The staff are really caring and kind. Some you like more than others, but they are all alright." People's relatives also felt that staff were caring. One person's relative told us, "They (staff) are so incredibly supportive and have brought [relation] back from the brink." Another person's relative said, "The staff are brilliant and do everything they can for [relation]."

We observed staff speaking kindly and patiently to people and explaining the support they were providing, for example during the administration of medicines. We also saw a member of staff assisting a person with their meal in a patient and supportive manner. They told the person what food was on each forkful, provided encouragement and ensured the person had enough time to consume each mouthful. We witnessed another person was worried about their relative who also lived at the service and saw that a staff member responded sensitively and compassionately by providing reassurance to the person. On another occasion a person was distressed as their glasses were broken and we saw that the maintenance person took immediate action to repair these.

Some people did not have useful information about their earlier life included in their care plans to help staff know about them, their background and their likes and interests. When we spoke to staff we found them to be knowledgeable about the people they were supporting, but the lack of information in care plans may mean that new staff would not be provided with important information about the person. The electronic care plans being introduced at the service had space for information to be entered about people's preferences, hobbies and daily routine and this had been completed, however, this was not been completed for all of the people living at the service at the time of our inspection visits.

Staff made efforts to communicate with people in a way they would understand, for example by speaking clearly and using gestures. Staff told us about different strategies they would use to help people make choices, for example by using visual cues and showing people the choices available to them. We saw staff asking people for their preferences and giving people time to respond, for example in relation to where they would like to sit and what they would like for lunch.

It was unclear whether anyone living at the service was supported by an advocate. Staff told us about two people who received independent visitors in relation to their finances and a current Deprivation of Liberty authorisation. There was no information on display about advocacy and the registered manager told us that they would make links with a local advocacy service to ensure information about advocacy was available if required.

We observed staff respecting people's privacy and dignity when supporting them. For example, taking action to maintain people's dignity when using moving and handling equipment. We spoke to staff who were able to describe the steps they took to protect people's privacy and maintain their dignity.

Requires Improvement

Is the service responsive?

Our findings

People and their relatives told us that staff were aware of their preferences and individual needs. One person's relative told us, "Individualised care is offered to [relation]." Another person's relative stated, "[Relation] is cared for in a truly personalised way."

People's care records indicated that people's needs had been assessed prior to admission to the service. Care plans were in place to provide information on people's care and support needs. The service was in the process of moving to an electronic care planning system and we checked the paper care plans and electronic care plans where these had been completed. We found that care plans provided basic information about the assistance people required and some personalised information, but in some cases they lacked detail and specifics. For example one person's care plan stated they needed encouragement and assistance to move position but it did not state how frequently this should occur. Another care plan was in place in relation to the person's long term health condition but did not specify the frequency or range of checks required. However, there was evidence of the involvement of a specialist healthcare professional to monitor the person's healthcare condition.

Some people had care plans in relation to behaviour which may challenge; we found that these lacked detailed guidance for staff regarding potential triggers and how to respond to the person. The registered manager accepted more detailed guidance should be contained within care plans. This would ensure staff were using a consistent approach and that clear guidance was provided to new staff.

There was no record of the involvement of people or their relatives in the development and review of care plans. None of the people or relatives we spoke with could recall having any input in care plans or reviews; however some people had only been at the service for a short while. The registered manager told us that they had written to all the families of people who lived at the service to invite them to a review of their relatives care plans but had received only two positive responses. We were provided with a copy of this letter which was sent in February 2016.

We spoke to the registered manager and a senior care worker about the lack of review of some care plans to ensure these reflected people's current level of need. Both the registered manager and senior care worker accepted that care plans had not been reviewed regularly and in some cases were in need of a rewrite. The registered manager told us that people's care plans were being entered onto the electronic system which would result in a rewrite and alert staff when reviews were required in future. We found where care plans had been entered onto the electronic system they had been reviewed. Following our inspection visit the registered manager told us that all care plans had been entered onto the electronic system.

When people needed assistance to move their position regularly to prevent pressure ulcers, records were in place indicating they were mostly re-positioned regularly. Records also confirmed that one person was being observed at fifteen minute intervals in line with their care plan. When we spoke to staff they were knowledgeable about the intervals required for support or observation.

People told us that activities on offer at the service were limited. One person when asked about activities which took place at the service said, "Nothing really, only maybe reading the paper, watching TV and sleeping." Another person also told us that they did not see any activities happening at the service.

We saw no activities taking place on the first day of our inspection visit and very limited individual activities on the second day. Information was available in the service which detailed a weekly plan of activities. The activities designated for the days of our inspection visits did not take place and staff confirmed this was often the case. We saw that some people received very little interaction and stimulation from staff. Staff confirmed that they were too busy to spend time with people and identified that some people would benefit from increased interaction. A staff member told us that the activities co-ordinator was currently required to provide care due to a number of staff members being off work at the time of our inspection. Staff also told us that people used to attend events in the local community and that representatives from a local place of worship used to visit. We were told that both of these activities had not happened for a while and staff did not know whether people would still wish to attend events in the local community or church services. We were told that last summer staff had supported people to go to the seaside for the day.

People told us that they had not raised any complaints about the service and could not describe what they would do if they had any, other than one person saying, "I would tell my son but I have never had to." We spoke to one person's relative who was aware of how to make a complaint.

The staff we spoke with were aware of the action they would need to take to record and manage any complaints. We saw that a copy of the complaints procedure was on display in the service along with comment forms.

We reviewed complaints received by the provider during the last year. There was a record made of two complaints. We found there was a record indicating the complaints had been thoroughly investigated by the registered manager and a response provided. We were made aware of another complaint which was in the process of being addressed; the person's relative confirmed that a meeting had been arranged with the area manager to discuss their concerns.

Requires Improvement

Is the service well-led?

Our findings

At our inspection in March 2017 we found that systems in place to assess and monitor the quality of the service were not effective in identifying issues or bringing about improvements to the quality of the service. In addition, the service had failed to notify us of certain events in the service which they had a legal duty to do. The provider submitted an action plan detailing the improvements they planned to make. During this inspection we found that sufficient improvements had not been made.

There weren't robust systems in place to assess the quality of the service provided or to monitor and mitigate risks to people. Although audits had been carried out on staff files, we identified during our inspection that not all of the information to ensure that staff were recruited safely was available. An effective monitoring system would have identified these issues. In addition, there was not always evidence that staff had completed an induction when they commenced working at the service or had received recent supervision.

The registered manager told us that bedroom and domestic audits were carried out on a daily basis and we were shown evidence of people's weight being monitored. However, audits carried out at the service had not identified or addressed all the issues we found during this inspection.

The system to monitor accidents and incidents which occurred within the service was not effective in ensuring that all the required actions had been taken to ensure people's safety. We saw that incident forms contained a section to be completed by the registered manager to document the actions taken to prevent reoccurrence. However, we found these were sometimes poorly completed and did not fully address the risk issue. For example, a person was found on the floor by their bed and the documented action was to ask care staff to check the person at the start of every shift. In addition the system for ensuring that incidents were referred to the local authority safeguarding team when they should be was not robust

The provider had not taken sufficient action in relation to feedback from external agencies such the CQC and the local authority. We identified concerns regarding safeguarding referrals and governance systems during our last inspection in March 2016. Despite the provider submitting an action plan detailing the improvements they would make, we found that further improvements were still required. In addition, not all the information we requested during our inspection visits was available. We requested further information following our visits and did not receive all of the information requested. Minutes from a meeting in April 2016 showed that people's relatives had raised the need for consideration of a range of activities was discussed. We observed during our inspection visits this remained an area for improvement. Therefore we could not always be assured that timely action was taken when areas for improvement were identified.

We saw some records which confirmed that a representative of the provider had visited the service and provided feedback following their visits. However, we saw that some of the actions identified from these visits had not been addressed or sustained. For example, it was noted during that there was no evidence of review of care plans following a fall within the service. We identified this remained an issue during our

inspection. This showed that when issues were identified, timely or consistent action was not always taken in response.

The failure to effectively monitor and assess the quality of the service in order to make necessary improvements constituted an ongoing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider is legally required to notify us without delay of certain events that take place whilst a service is being provided. We found during the inspection there had been some events that took place which should have been reported to us that have not been, for example in relation to safeguarding incidents at the service. This meant we were restricted in how we monitored the service due to a lack of information we should have had.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The registered manager told us the number of incidents which occurred at the service were collated weekly and sent to the provider. Records showed this to be the case, however the records did not evidence an analysis or actions taken in response to incidents. The registered manager told us that one of the advantages of the new electronic system used at the service was its ability to generate reports of incidents and highlight trends and this will be used in future.

We previously identified in our March 2016 inspection that people were provided with limited opportunities to contribute to the development of the service. Records showed that a 'Residents and family meeting' had taken place in October 2016. Although none of the people who lived at the service had chosen to attend, the registered manager confirmed that people had been invited. We did speak to people about their views on the running and development of the service but people did not express an opinion on this.

In spite of the above, people commented positively on the atmosphere of the service. One person's relative told us, "It's lovely here everyone is helpful and nice and will do anything for you." Staff also commented positively on the culture at the service. One staff member told us, "It's very friendly and family orientated. We respect people and work well as a team." During our visit we observed people and visitors felt comfortable speaking with staff and the registered manager.

The service had a registered manager in post. Some of the people and relatives we spoke with were not aware of who the registered manager was, although some of these people had only been in the service a short while. The staff we spoke with felt that the registered manager was approachable and visible. Staff told us that the registered manager monitored the attitude of staff and provided feedback to promote good care. They told us that they felt comfortable approaching the registered manager with any concerns they may have and felt able to contribute to the development of the service. Staff told us that a representative of the provider visited the service on a regular basis and they found them to be supportive.

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 18 Registration Regulations 2009 Notifications of other incidents We had not received notifications of certain events which had taken place at the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not operated effectively to assess, monitor and improve the quality and safety of the service. This included the process for ensuring that risks to service users were mitigated, decisions relating to the care and treatment of service users were recorded and records were kept relating to persons employed at the service.