Mission Care

Elmwood

Inspection report

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Ratings

Overall rating for this service	**Good**
Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Good**

Overall summary

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 and to pilot a new inspection process being introduced by the Care Quality Commission (CQC) which looks at the overall quality of the service.

This was an unannounced inspection. There was a registered manager in post. A registered manager is a person who has registered with the CQC to manage the service and shares the legal responsibility for meeting the requirements of the law; as does the provider.

Elmwood provides accommodation and nursing care for up to 67 people who have nursing or dementia care needs. The provider had submitted an application to increase the number of people they could provide regulated activities for, to 70 people. This application was being processed at the time of our inspection. The home was built over three floors. The first and second floors

Summary of findings

were primarily for people who were elderly and frail and or required nursing care. The third floor had been a floor for nursing needs but since March 2014 had changed to support people with dementia.

At our inspection on 7 February 2014 we found that the provider breached regulations relating to people's care and welfare. People's care plans and risk assessments had not always been implemented in the way that had been planned and we had observed some unsafe manual handling techniques. Following this inspection the provider sent us an action plan to tell us the improvements they were going to make. During this inspection we checked to see if these improvements had been made.

We found that the breach in regulations identified at the last inspection had been addressed. We observed safe and respectful manual handling techniques and found that all staff had received refresher manual handling training. People's care plans had all been reviewed and risk assessments updated and we saw that they reflected people's current needs and the care provided.

However people's safety was being compromised in some areas. We found the provider was not meeting the regulations in relation to the management of medicines and in their arrangements for emergencies. You can see the action we have asked the provider to take at the end of the full version of this report.

There were 63 people using the service on the day of the inspection. People told us they were happy and well looked after. We observed good relationships between staff and people at the service and with their relatives. Staff took time to interact with people in a meaningful way.

The provider had systems in place to ensure that people were protected from the risk of potential harm or abuse. We saw the home had policies and procedures in place to guide staff in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, safeguarding and staff recruitment. Staff had received training and understood these policies and procedures. Risk assessments were in place and reflected current risks for people at the service and ways to try and reduce those risks. Equipment at the service was well maintained and monitored and regular checks were undertaken to ensure the safety and suitability of the premises.

Staff knew people's needs and preferences well and interacted positively with people. There were a range of suitable activities in place for individuals and groups. The service had sought views of dementia specialists about the environment and managing aspects of behaviour safely. Staff had received training on dementia and behaviour that may challenge. People and their relatives were supported sensitively in end of life care.

People's nutritional needs were met and they told us they enjoyed the food. Staff had a comprehensive range of training and told us they were well supported to carry out their role. People had access to a range of health and social care professionals when required. There were systems in place to monitor the quality of the service and learning was identified and acted upon.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Aspects of the service were not safe. We found risks associated with the storage and recording of medicines. There were inadequacies with the provider's fire evacuation arrangements.

People told us they felt safe and the service complied with requirements under safeguarding adult procedures, Mental Capacity Act 2005 code of practice and the Deprivation of Liberty Safeguards.

There were adequate staffing levels and safe staff recruitment procedures in place. We observed call bells were responded to promptly. The provider had a system for monitoring the safety of equipment and the safety of the premises.

Is the service effective?

Good

The service was effective. Staff received effective training supervision and support to carry out their roles. Staff were knowledgeable about people's care and support needs.

People told us they enjoyed the food and that there was choice available. We observed that people were supported to eat if required. We saw that people's fluid and food intake was monitored and appropriate action taken if people lost weight.

People's health needs were met. Records showed people were referred to health and social care professionals as required

Is the service caring?

Good

The service was caring. People and their relatives told us staff were kind and caring and we observed this to be the case. Staff knew people's preferences well and interacted with them with interest rather than just on a task focussed basis. People and where appropriate their relatives were involved in decisions about their care and their care plans reflected their current needs.

We saw the provider had systems in place to gather people's views about the service and those of their relatives; people also told us that they felt able to raise any ideas informally with staff or the registered manager.

People were sensitively supported in end of life care. The service was accredited for end of life care by the Gold Standards Framework as commended. People's preferences for their support, care, pain management and end of life wishes if known, were clearly recorded and family members were involved appropriately.

Is the service responsive?

Good

The service was responsive. Regular reviews were held to ensure plans were up to date.

Summary of findings

There were a range of activities available during the day and people's spiritual and cultural needs were addressed.

Staff responded to changes in people's needs and we observed their care plans were up to date and reflected the care and support given.

People told us they did not need to make formal complaints as issues were dealt with promptly by staff. The complaint system was visible; complaints were recorded and responded to promptly.

Is the service well-led?

Good

The service was well led. Staff told us that they were managed and supported well to support and care for people effectively. Staff we spoke with were motivated and caring.

The service sought advice from specialists for dementia and end of life care.

We observed staff and relatives interacted in a relaxed way and people told us that any issues they had were addressed.

There were auditing systems in place to monitor the quality of the service and processes to ensure any necessary action was taken. Accidents and incidents were regularly analysed to make sure the care provided was safe and effective. We saw that issues identified had been addressed, action was taken and any learning was conveyed to staff.

Elmwood

Detailed findings

Background to this inspection

The inspection was carried out by a team of two inspectors, a specialist nursing advisor, a pharmacy inspector 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, the provider completed a Provider Information Return (PIR). 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. Prior to the inspection we reviewed this information along with other information we held about the service. We spoke with two local authority commissioners of services and the local safeguarding team to obtain their views.

During the visit, we spoke with 13 people using the service, nine relatives, two nurses, six care staff, the activities organiser, one domestic staff member, a cook, the registered manager and the clinical director for the service. Not everyone at the service was able to communicate their views to us so we used the Short Observational Framework for Inspection (SOFI) at various points in the day. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We looked at all areas of the building, including some people's bedrooms and the communal areas. We also looked at a sample of 12 records of people who used the service and four staff records and records related to the management of the service.

Is the service safe?

Our findings

We looked at the processes for the handling and administration of medicines. There were some areas of good practice, but the service did not always follow safe practice around storage and recording of medicines.

We saw evidence that people's medicines were reviewed regularly by the GP, with input from specialists where needed, including a psychiatrist and the local hospice. All prescribed medicines were in stock and end-of-life medicines were also kept, where required, to avoid delays in starting treatment. Staff giving medicines received regular medicines training. There was a system in place to deal with the recall of medicines. One person with limited capacity was having essential medicines administered covertly, and the appropriate authorisations were in place for their safety.

Records were kept of medicines received, administered and disposal processes. These were clear, accurate and up to date on one of the three floors. However on the other two floors, we found five boxes of sedating medicines in total which had been prescribed for people previously, but had either been stopped by the prescriber or had been ordered when not needed. These medicines were not listed on people's medicines records or in the receipt log and therefore were not properly accounted for.

When we checked medicines stocks against medicines records for six people, we found discrepancies for all six people. This meant that people's medicines could not be audited accurately. One person was on a sedating medicine for agitation, to be given only when needed. We found that there were no instructions for staff on when to administer this medicine and staff had not recorded the reasons for administering this medicine. There was therefore no guidance for staff to ensure the medicine was given safely and appropriately. Care staff applied prescribed medicinal creams; however, nurses had signed the medicines records without a process in place or evidence to check that these creams had been applied.

Medicines were stored securely, but not at the correct temperatures. The temperature in the medicines rooms was consistently above 25˚C. This was above the recommended temperature to ensure medicines remained fit for use. The temperature of the medicines fridges was not monitored appropriately to ensure that medicines were kept at between 2-8˚C.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see the action we have asked the provider to take at the end of this report.

Staff were trained in first aid and when questioned knew how to respond to an emergency. We were told by a staff member, "We all help each other and staff know how to make the resident safe and call for help." There was a business contingency plan and regular fire drills were held. However, we had concerns that there were no personal emergency evacuation plans to inform staff or emergency services how to support people's safe evacuation from the premises in an emergency. This could place people at risk in such an emergency.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 and you can see the action we have asked the provider to take at the end of this report.

People told us they felt safe and well cared for at the service. One person told us "Staff are really kind here and know what they are doing." Another said "If I need any support people are there."

There were systems in place to ensure the safety and well-being of people using the service. There were up to date safeguarding adults from abuse procedures with relevant contact details for staff to refer to if they needed to raise an alert or seek advice.

Staff we spoke with understood the types of abuse that could occur and how to safeguard people they supported and care for. They were also aware of the home's whistleblowing policy and who they could contact to raise whistleblowing concerns. We saw from staff records that they attended regular refresher training on safeguarding vulnerable adults so that their knowledge was up to date. We were aware there had been two safeguarding alerts raised since the last inspection and that the provider was cooperating in the investigations which were on-going.

There were policies and procedures in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). The Care Quality Commission (CQC) monitors the operation of DoLS that applies to care homes.

Is the service safe?

The registered manager confirmed that no one using the service was subject to DoLS under the Mental Capacity Act 2005. They were aware of the recent court ruling and had contacted the local authority to seek guidance. They knew when to request a standard or urgent authorisation from the local authority. Records showed a DoLS screening checklist to ensure that staff followed their legal obligations. Staff we spoke with were aware of the Mental Capacity Act code of practice and understood what processes should be followed if someone did not appear to have capacity for a decision. Training records confirmed that staff received training on the Mental Capacity Act 2005.

Risks had been identified and effectively monitored. We looked at a sample of twelve risk assessments across the three floors. Possible risks that people might encounter had been identified and risk assessments were completed and reviewed regularly to reduce the likelihood of risk. We saw that these covered a range of possible risks for example, nutritional risk, skin viability risk, falls and behaviour that may challenge. We saw appropriate procedures were in place to monitor these risks such as blood sugar monitoring for people who were diabetic, weight charts, nutritional assessments and skin monitoring tools. We saw evidence of effective wound care with the management of pressure sores for one person, sustained during an acute hospital stay, so that risk of further deterioration was prevented.

We found that prompt action was taken in relation to risks presented and measures put in place to try to reduce reoccurrence. For example where someone had fallen or an injury was found, this had been recorded on a body map, relevant medical help was summoned as appropriate and a new falls risk assessment had been completed. Additional safety measures had been introduced as necessary to help reduce the risk of falling such as a walking frame to aid stability. Daily notes showed that staff monitored people's mobility where there were concerns and other health professionals involved where appropriate. Action was therefore taken to reduce any identified risks.

People we spoke with said staff were available when they needed them. One person told us "There is always a staff member to ask for help from if you need it." Staff told us they thought staffing levels were sufficient to meet people's needs throughout the day and at night. The staff rota confirmed a mix of nurse and care staff on each floor throughout the day and a nurse and care staff on duty at night. This meant there were staff with the appropriate level of skills available at all times. Our observations on all floors confirmed that overall there were enough staff to provide safe care and support. Although we saw that on one occasion staff had difficulty managing someone's personal care needs promptly at a mealtime, we spoke with the registered manager about this who agreed to review staffing levels at mealtimes.

We observed that call bells rang infrequently, but when they did, staff responded quickly. Most people told us that call bells were answered promptly. One person told me "I know to press this button if I need help. The staff always come." Another said "they always try to answer the call bell quickly." We found this to be the case when we tested them on the day. Regular checks were made of people who were in bed or in their bedrooms. Staff told us we "do hourly checks on people nursed in bed to make sure they're clean and safe." We saw that position change charts were fully updated and regularly monitored and kept in a folder for all staff to access.

People were protected by a safe recruitment system. We looked at four staff records and saw the home operated a robust recruitment procedure with the necessary identity and character checks completed.

There were systems in place to monitor the safety of the premises and equipment and reduce the likelihood of risk to people. People at the service and staff told us there was sufficient supply of equipment such as hoists to meet people's needs. We saw that hoists were well maintained and that each resident requiring hoisting when moved, had their own sling. There was a variety of sling types and sizes, which ensured residents' safety and comfort during hoisting. We saw an electronic system available on all floors for staff or anyone using the service or their relative to report any issues with equipment directly to the maintenance team. People we spoke with and staff all said that any repairs were attended to promptly during the week by the provider's maintenance team. There was a system for emergency support if needed at weekends.

Maintenance and service checks were completed and in date for the range of equipment for example, the lift, boiler, hoists, electrical testing and fire-fighting equipment. We saw that any issues that were identified were promptly addressed. Regular checks were completed and recorded on equipment such as pressure mattresses and weighing

Is the service safe?

scales. The registered manager completed and recorded regular health and safety checks of the premises, which we saw were up to date and any issues identified were addressed.

Is the service effective?

Our findings

People we spoke with told us they thought staff understood their roles and knew what they were doing. We spoke with staff who told us they received regular refresher training across a range of important areas such as first aid and dementia care. Following the concerns about manual handling and breach of a regulation at the last inspection in relation to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, all care staff and nurses had received manual handling refresher training. One staff member said "We get loads of training. We have compulsory training and we're told when it's due." Another told us, "We can always ask if there's something that we'd like training on." Another staff member said "I have been working at the home for years. The training is excellent; it's really tailored to people's needs and what we need to know." Staff were therefore provided with regular opportunities to refresh and update their knowledge and skills, to enable them to meet people's needs. Some staff told us they had been supported to undertake additional training such as a management qualification or the Diploma in Health and Social Care.

We were shown the training matrix which showed that staff training was up to date. The clinical director told us that if staff failed to attend training after two opportunities they were suspended until it was completed. We saw from staff files that training had been completed.

Newly appointed staff were supported to learn about their roles. They completed an induction programme and training that the provider considered mandatory. The induction included a period of shadowing more experienced staff prior to working alone. We spoke with one member of staff who was newly recruited they said "I have had lots of induction training. It's been very good and informative." Staff supervision and appraisals were recorded. Staff told us they valued the supervision and appraisal process and felt valued and listened to by management.

People we spoke with told us they enjoyed the food. One person said "The food is good I eat everything." Another person told us, "We get plenty of choice and it's lovely." We observed that staff were familiar with people's food and drink preferences. People chose whether to eat in the dining room or in their bedrooms and we saw there was a choice of food. Catering staff showed us the four weekly seasonal menu rotation. We saw this included fresh vegetables and fruit was available each day. We used our structured observation framework for inspectors tool (SOFI) at lunchtime on two floors and made general observations on the other floor. We saw people were offered well-presented hot, well balanced food. Although, we noted from the Residents and Relatives Survey 2014 that the quality of meals was considered good by 27.3% of respondents and average by 40.9% of respondents. This meant that over almost a third of people who responded to the survey thought the quality of meals was below average. This differed from our findings on the day.

Some people were encouraged to eat independently and others were supported by staff. They were supported to eat at their own pace and staff interacted sensitively with them to make it a more pleasurable experience. On two floors the dining experience was calm and relaxed but on another floor the environment was noisy due to the behavioural needs of some people at the service and some relatives told us this was not relaxed for people eating there. We discussed this with the manager who told us they were aware of this and were working to try to improve this.

People's allergies and medical needs were identified and there were instructions in the kitchen for those who required a fortified diet. People's identified nutritional needs were monitored and planned for. We saw people's fluid balance and food intake was monitored, where it was felt to be a concern. Food and fluid balance charts were regularly updated throughout the day. Staff told us and we confirmed in records that when a resident lost weight, their care plan recorded increased weight monitoring and any action taken. This could include referral to a dietician, the introduction of fortified drinks and discussions with family and GP about possible reasons for weight loss.

People's health needs were monitored and responded to effectively. People told us they had no problem accessing external health and medical care when needed. As required staff supported people to access appointments with relevant health professionals such as the dentist, optician, and memory nurse. Pressure care areas of concern were referred first to the medical response team, who then referred to the tissue viability nurses as and when necessary. We were shown a hospital transfer form that was completed when people were admitted to hospital. This provided hospital staff with important information about someone's care. One relative described

Is the service effective?

improvements in their family member's health since they had been at the service. They had been restricted to a wheelchair when they arrived but could now mobilise with the use of a walking aid.

Residents with long term health conditions such as asthma, diabetes, Chronic Obstructive Pulmonary Disease (COPD) and epilepsy had their healthcare needs managed though the GP practice. Staff told us links with the specialist nurse in diabetes were 'excellent' which assisted with the healthcare for those people with diabetes. The GP visited twice a week, reviewed people's medical needs regularly and recorded their advice. We saw the 'doctor's book' where staff wrote their requests for those people who needed or wished to see the GP and that everyone had a medical review on a regular basis.

Is the service caring?

Our findings

People who used the service told us the staff were caring, and they were happy living at the home. One person told us, "I am very happy here especially knowing that my children know I am well looked after…" Another person said, "The staff are good here they are very caring." Someone else commented, "We went to the garden centre and I had a lovely day. I have no complaints." A relative told us, "My mum's well looked after here. It took 10 homes before I found this one and it is the best." Another relative said staff were kind and caring, she said, "They are very good at calling me if there are any problems."

We observed through the day that staff supported people with dignity, respect and in a safe manner. They were familiar with people's preferred names, choice of drinks or activities they enjoyed. We saw staff talked with people informally on occasions during the day as they passed. This was spontaneous and not task orientated. People told us they thought staff understood their preferences well. We carried out a SOFI observation mid- morning on the third floor and found staff interaction with people was positive and inclusive with no negative interaction taking place. We observed staff supported people with behaviours that challenged using distraction techniques successfully when appropriate.

Where appropriate mental capacity assessments had been completed to establish if people had capacity to make particular decisions for themselves. We observed how staff respected people's dignity and privacy by knocking on their doors before entering and by checking with people before they offered care or support. For people who were not able to express their views, staff were able to describe non-verbal signs and behaviour that would help them establish that person's wants and wishes. We observed that people's independence was also encouraged where it was safe to do so, for example with aspects of personal care. People from all floors were supported or encouraged to go out in the garden where they participated in the morning activity.

Relatives appeared relaxed and at ease with members of staff. We saw one group of relatives' picnicked in the garden with their family member. A "café" refreshment area was available for relatives to make tea and coffee and to give people a change of location and interact socially. Relatives told us there was no restriction on visiting. One relative explained that the manager had responded positively when they had requested internet access so that they could maintain contact with their family member while they were abroad; they told us this had since been installed.

The home had a large screen TV in the main reception area which provided information and news about the home and the organisation. These included activities to look out for and weekly news within the home. Information leaflets were located at the main reception which provided further advice to people about the service. There was a Service User guide and a Friends and Relatives Guide, these provided detailed information about the service. People told us they felt they could express their views informally to staff or the manager at any time.

We saw that the service had been accredited and commended for end of life care by the Gold Standards Framework (an organisation that specialises in training for end of life care). They were advised and supported in this by a well-known local hospice which had continued to provide support and input through a practice development cancer nurse specialist. The registered manager told us that the specialist nurse occasionally attended meetings and participated in reflective debriefing with staff when a resident died. They also supported and advised with end of life pain relief.

Care plans we looked at demonstrated that discussions had taken place about individuals' wishes and were either recorded, or recorded as not wishing to be discussed, depending on each individual. They were comprehensive and detailed people's preferences for their support and care, pain management where relevant and end of life wishes. Do not attempt Cardiopulmonary Resuscitation forms (DNAR) had all been completed correctly with individuals involved in the process and or family member's agreement. The registered manager told us that families were welcome to stay with their relatives at the service in the final stages of their loved one's life.

Is the service responsive?

Our findings

At our previous inspection on 7 February 2014 there was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. People's care plans and risk assessments had not always been implemented in the way they were planned. Following this inspection the provider sent us an action plan to tell us the improvements they were going to make.

At this inspection we found that all the care plans had been reviewed and reflected people's current needs. For example we saw that several people on the dementia floor were observed and supported frequently and their care plans and records reflected this. People told us that staff responded to their needs and any changes to the care they required. One person told us "I need a bit more help some days than others and the staff help as needed."

People we spoke with and their relatives told us they were involved in planning and reviewing the care and support received and that their views were listened to. Care plans gave an overview of people's current and immediate needs, any allergies or medical needs were clearly recorded. The plans were detailed and provided information and guidance to staff about how people's individual care and support needs and preferences should be met. For example one care plan referred to someone's previous occupation and how that affected their current behaviour and possible risks.

We saw evidence in care plans of the regular use of body mapping for any wound management and pressure care areas. The healing process was clearly recorded, relatives informed, and the care plan reflected the action taken. People's needs were appropriately responded to. We observed and heard evidence from staff nurses, carers and domestic staff about competent management of an infection control risk through barrier nursing. The process and protective items were all in place and correctly used. This reduced the risk to people of the spread of infection.

Daily records of people's care were completed by staff throughout the day. Records of daily notes were kept within people's care plans and were up to date and recorded the care and support provided and showed that this was in line with the care plan.

We spoke with the registered manager who told us that reviews of people's care plans with individuals and their family members were conducted on a monthly basis to ensure that the care provided was meeting people's needs. We saw that the monthly care plan form was signed by people using the service and or their family members to indicate agreement with any changes made.

There was a weekly activities programme which offered a range of activities to suit a variety of tastes and to provide stimulation and entertainment. Individual activities were provided to people who were unable to leave their room due to illness or poor mobility. There were three full time pastors who work for the provider. We spoke with one of the pastors who informed us that they worked closely with those people, who wished to, and held group activities on a weekly basis such as bible classes. Religious leaders from other faiths were also encouraged to visit the service to meet the spiritual needs of people living there.

Meetings were held quarterly with people who used the service and their relatives. We saw that the service had responded to requests to identify staff faces and names by putting up a photo-board of staff who worked at the service. People had been consulted and kept informed about the changes that had taken place and discussion topics such as the Mental Capacity Act 2005 and the use of CCTV had been included at these meetings.

We saw that the complaints policy was displayed in the reception area and by the lift on each floor. It explained the procedure and who to go to if you were unhappy with the outcome of the complaints investigation. People we spoke with and their relatives told us they had not needed to complain as if there were any issues they would talk with the staff or the registered manager. One person told us "I can just talk to the staff if anything is wrong and it gets sorted."

We looked at the complaints record and saw that there had been three complaints since the last inspection, two of which had been promptly responded to and resolved. We saw there had been some initial misunderstanding about the third complaint which was in the process of resolution. The registered manager advised that complaints were analysed for learning and were reviewed as part of the provider's quarterly audits, so that any improvements could be identified and acted on.

Is the service well-led?

Our findings

During the inspection we observed there was an open and positive culture at the service. Most staff were observed to be courteous and open to approach from the inspection team. We saw on a number of occasions that relatives and people who used the service approached staff and the registered manager in a relaxed manner either to chat informally or for information. The registered manager told us that she encouraged an open culture as she believed it helped to resolve any problems quickly. One staff member told us, "I feel very supported and comfortable. I could approach senior members of staff or the manager with any issues I have." Another staff member said, "We work well as a team but are not afraid to challenge if we feel something is wrong or people's needs are not being met."

The registered manager and clinical director informed us there had been some initial challenges in setting up the dementia care unit and trying to ensure that people's varied needs for protection and independence and expressed wishes were met as far as possible. They had provided some learning for relatives about dementia and had met separately with families where there had been issues identified to try and resolve these. Staff had received additional training on dementia care and challenging behaviour and nurses with experience of mental health were employed to work alongside carers on that particular floor.

The service sought and used external advice appropriately. They were working with the local authority care home team on learning to use a dementia care tool to help staff understand the needs of people with dementia better. The provider had adapted three rooms on the dementia floor to trial a more dementia friendly environment with the use of specific colours, signage and design that reflected current understanding about some of the needs of people with dementia. The registered manager told us they were waiting for final approval for these to be introduced across the service.

We observed the registered manager, who was a qualified registered nurse was visible during the day interacting with relatives and people who used the service. Staff we spoke with confirmed that this was routine. The registered manager was supported and managed by the clinical director who told us they visited twice a week at present and provided support for the development of the service's dementia care. We also observed the clinical director to be involved in supporting staff and engaged with people who used the service on the dementia floor at times during our inspection.

There was a clear management structure in place and staff we spoke with were clear about their roles and who to approach about particular issues. Staff said that they found the registered manager available and supportive. One staff member said, "I can go for support or advice whenever I need to." Another person told us, "They are a good manager, knowledgeable and capable, they know how to lead." A third member of staff told us they had raised a concern with the manager about care delivery and it was addressed immediately. Staff expressed confidence any concerns would be dealt with and investigated. We saw from records there were regular staff meetings where any learning identified from audits or complaints was discussed and staff contributed to these meetings. Supervision records confirmed that staff were supported in their roles on a regular basis and where necessary any issues identified with their work were discussed and appropriate action taken, for example additional training.

Staff we spoke with told us they were happy in their work and thought that they worked well as a staff team to support and enable people who used the service. One staff member said, "We have to use agency staff sometimes, but we try first to cover the shifts between ourselves. We'll always try and help out first."

Surveys were carried out with residents and relatives biennially through an independent body and the results analysed and recommendations made from the feedback to improve the quality of the service.

While we found some deficiencies with aspects the system for medicines and a lack of personalised evacuation plans for emergencies overall there were clear systems in place to monitor the quality of the service provided through regular audits. The registered manager took immediate action to address the issues we had identified.

There was a monthly analysis of accidents and incidents to make sure the care provided was safe and effective with any learning or action identified. There were infection control audits, equipment checks, detailed monthly weight checks, medication, pressure care and care plan audits that we saw were regularly completed and which identified any learning or actions for a particular floor or staff team. We

Is the service well-led?

saw that any issues identified had usually been addressed by the next audit. The registered manager told us that they carried out checks on night staff but we found no records were made of these checks. They agreed these checks should be recorded to evidence any issues of concern should they arise and record the action taken as a result.

Records we looked at showed the provider's quality assurance team carried out their own audits of the service on a quarterly basis and we were told that it had been decided that the time spent doing these had been extended to a full day in order to improve the quality. We saw that actions were identified from these audits such as a missing fire extinguisher which we found to have been replaced. Monitoring visits were also carried out by the local authority commissioners. We saw from one report sent to us prior to the visit that the commissioner had found no concerns on either their announced or unannounced visits earlier this year.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **People who use services were not protected against the risks associated with the unsafe management of medicines.** (Regulation 13)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The registered person did not have procedures in place for dealing with emergencies to mitigate the risks that can arise from such emergencies for service users.** (Regulation 9 (2)