Agemco Ltd

Capricorn Cottage

Inspection report

88 Eastgate
Fleet, Holbeach
Spalding
Lincolnshire
PE12 8ND

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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

The inspection took place on 25 November 2015 and was unannounced.

The home is registered to provide care for up to 34 people who are living with autism or learning difficulties. The home is a purpose built care home on a single level. There are kitchen and laundry facilities available for people who can be supported to be independent. There were 26 people living at the home on the day we inspected.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

When we inspected on 14 January 2015 we found that the provider did not ensure the care and treatment people received was appropriate, met their needs and reflected their preferences. There were insufficient staff to care for people and they did not receive appropriate support and training. People were not treated with respect and the provider did not support people's autonomy, independence and involvement in the community. People were not protected from abuse or improper treatment as systems and processes had not been established to identify or investigate abuse. Systems to assess monitor and improve the quality and safety of services provided or to identify, assess and manage risks to the health, welfare and safety of people using the service were ineffective. After the last inspection we asked the provider to take action to make improvements to the concerns we had identified and this action had been taken.

However, despite considerable improvements since our last inspection there were still 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. We found that care was not always planned and delivered in a way which met people's individual needs and risks to people were not always identified.

The Care Quality Commission is required by law to monitor how a provider applies the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way. This is usually to protect themselves. The provider had not followed the requirements in the Mental Capacity Act 2005 (MCA) to ensure people's rights were protected.

The provider had taken action to improve the care provided following our previous inspection. Systems were in place to monitor the quality of the environment and service people received and we saw that the systems were effective and identified areas where improvements were needed. In addition, the provider and registered manager had worked with the local authority to identify what good care looked like, how it could be implement and what skills they and their staff needed to deliver the care.

However, risks to people while receiving care were not fully identified and some risk assessments were generic and did not reflect people's individual abilities. In addition, care was not always planned or delivered to meet some people's needs or to support staff to administer medicines prescribed to be taken as required safely and consistently. Some mealtimes were not a pleasant experience for people.

The staffing numbers and staff training had been reviewed and the registered manager had identified the number of staff needed to meet people's needs. While the appropriate number of staff had been allocated to each shift, staff sickness on the day of our inspection impacted on the care people received. Training had been arranged for staff to update the skills needed to provide safe care and staff received regular supervision to support their skills and development. However, staff did not always provide safe care in line with their training and did not always support people's dignity.

The increase in staffing enabled the provider to offer a range of activities and to support people to access the local community on a daily basis. Information was available to people enable them to make a choice about what they wanted to do on a daily basis. With people occupied in smaller group activities the atmosphere in the home was calm and this allowed staff to spend quality time with people to get to know them and identify how care could be personalised to meet people's individual needs.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Staff knew how to keep people safe and to report any concerns they had to the registered manager or external agencies.

Risks to people were not always fully identified and generic assessments did not identify people's individual needs.

There were usually enough staff to meet people's needs, however, staff sickness at times impacted on the care people received. Appropriate checks were completed to check if staff were safe to work with people living at the home.

Medicines were ordered and stored safely, however, there was no guidance available for support staff to consistently administer medicines prescribed to be taken as required.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff received appropriate training and support. However, they did not always deliver care in line with their training.

The registered manager had not submitted applications for assessment when people were unable to make decisions about where they lived and restrictions placed on them for their own safety.

People were offered a choice at mealtimes and were supported to understand the allergens in their food.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff took time to acknowledge and speak to people. However, they did not always support people to maintain their dignity.

The mealtime experience was institutionalised with people using plastic plates and beakers and cake served on the same plate as

their main course.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People were supported with a range of activities which helped them to access the local community.

Care plans did not accurately identify and record people's needs and care was not always delivered to meet those needs.

The registered manager responded appropriately to formal complaints but did not always identify when people living at the service made a complaint.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The provider's senior management team were supportive and regularly visited the home to drive improvements. There were systems in place to monitor the quality of care people received.

The registered manager reacted positively when concerns were raised, however, they did not always identify on-going concerns with the care provided to people.

Capricorn Cottage

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 was 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 25 November 2015 and was unannounced. The inspection team consisted of an inspector and a specialist advisor. Specialist advisors are senior clinicians and professionals who assist us with inspections.

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 planned to make. We also reviewed other information we held about the provider including information on events they are required to tell us about by law.

As part of the inspection we spoke with the relative of one person living at the home. We also spoke with two people living at the home. We contacted the local authority to get their views on the care provided for people. We also spent time observing the care people received and the relationship between people using the service and the staff.

During the inspection we spoke with two healthcare professionals who visited the service. We spoke four care workers, an activities coordinator, the cook, the administrator, the deputy manager and the registered manager. We looked at seven care plans and the medicine administration records for the home. We also looked at records relating to the management of the home.

Requires Improvement

Is the service safe?

Our findings

When we inspected on 14 January 2015 we found that the provider did not fully identify the risks to people while receiving care and where risks were identified care was not always delivered in accordance with the plans made to keep people safe. Incidents were not always recorded and action had not been taken to reduce the risk of incidents reoccurring in the future.

Prior to the inspection the provider told us that risk assessments were in place and had been reviewed on a regular basis. They also told us that monitoring charts had been implemented where people had been showing behaviours which challenged.

At our inspection on 25 November 2015 we found more risk assessments had been included in people's care plans. Risk assessments were in place to keep people safe from pressure sores and to ensure they received adequate food and drink. However, there were also generic assessments which were identical in each file. For example, we saw there were risk assessments for 'stranger danger' when people were out in the community. There was no reflection that each person may react differently to the danger and so did not reflect people's individual needs.

In addition, one person who was receiving short term care did not have any risk assessments recorded in their care plan despite needing help to move. We discussed this with the registered manager who told us that they did not complete risk assessments for people who were staying with them for respite care. We saw a senior care worker lift the person out of their wheelchair into a chair in the lounge. The care worker held the person under their arms and twisted them into the chair, using their legs and feet to guide them round. They did this without using any manual handling equipment, which put the person at risk of being injured.

This was a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 safe care and treatment.

We found that there was a new process in place for recording incidents and behaviours which might challenge others, which ensured each incident was reviewed and appropriate action taken.

When we inspected on 14 January 2015 we found People were not protected from abuse or improper treatment as systems and processes had not been established to identify abuse or to investigate abuse. This was a breach of Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2014 Safeguarding service users from abuse and improper treatment.

At our inspection on 25 November 2015 we found the provider was meeting the requirements of the regulation. Prior to the inspection the provider had told us they were vigilant with visitors wishing to gain access to the home to keep people safe and when we arrived at the home staff checked our badges to ensure we were who we said. Staff knew what action to take if they had concerns over a person's safety. When concerns were raised the provider and the registered manager took appropriate action and thoroughly investigated the concerns.

When we inspected on 14 January 2015 we found that there were not sufficient numbers of suitably qualified, competent, skilled and experienced staff. This was a breach of Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014 Staffing.
Prior to our inspection the provider told us that staffing levels had been calculated and reviewed to meet the needs of the people living at the home.

At our inspection on 25 November 2015 we found the provider was meeting the requirements of the regulation. For most of the time there was enough staff available to support people. The registered manager had completed a tool which helped them to identify the numbers of staff needed to meet people's needs. During the day activities were offered in three areas of the home and each area was staffed to support people's needs.

However, on the day of our inspection a member of staff had been unable to work due to illness. We saw this impacted on the care people received at tea time, when the overall levels of staff had reduced and a care worker was required to prepare the evening meal. The main dining area was chaotic and there was only one member of staff on the floor supporting people. This was the activities co-ordinator, who was trying to help three people who were all clearly upset at having to wait for her. One person was getting distressed and screaming loudly which unsettled other people in the room.

The deputy manager was now in charge of appointing new members of staff. Records showed that there were structured processes in place for reviewing applications and conducting interviews to ensure staff had the appropriate skills, knowledge and caring nature to support people living at the home. Appropriate checks including two references and a disclosure and barring service check were completed before staff started work at the service. This ensured that staff were safe to work with the people who lived at the service.

Medicines were stored safely and there were systems in place which ensured people's medicines were available to them when needed. We saw that people were supported by a trained member of staff to take their medicine safely who stayed with people them until they had taken their medicine. However, the senior care worker completed the medicine administration record prior to offering people their medicines. So if people refused to take their medicine it had already been recorded as being administered and would need correcting.

Care plans did not contained information to support staff to administer medicines prescribed to be taken as required. For example, medicines to calm people down when they got distressed. In addition, there was no recording of why people had been given medicine prescribed as required to show that staff had tried to support the person through other mechanisms before resorting to medicine.

We saw an external medicines audit had been completed on 15 October 2015 and no concerns had been identified.

Requires Improvement

Is the service effective?

Our findings

We found the provider had not fulfilled their responsibilities in relation to ensuring people's rights were protected when they were unable to make decisions for themselves. 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 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. At our last inspection the registered manager told us they were in the process of completing applications for people to have a DoLS assessment. However, the applications had not been submitted and people were at risk of unlawfully having their liberty deprived.

There was some information in care plans regarding people's ability to make choices and how they should be supported when they were unable to make a choice. When complex decisions needed to be made in relation to a person's health, appropriate best interest meetings were held to ensure the right choice was made for the person. However, people's abilities to make individual decisions were not always assessed before best interest were made in other areas of care. For example, one person's care plan stated, "Long term goals to be done in person's best interest." There were no assessments to see if the person could have made any choices about their long term goals.

This was a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 need for consent.

When we inspected on 14 January 2015 we found that staff did not receive appropriate support and training to enable them to carry out their duties. This was a breach of Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014 Staffing.

Prior to our inspection the provider told us that a training matrix had been devised and staff skills were more effective as individual development needs were addressed. They also said that staff could approach the deputy manager or their supervisor to ask for training in areas they wished to develop.

At our inspection on 25 November 2015 we found the responsibility for training, supervision and appraisal had been assigned to the deputy manager. Records showed that the training was now more structured and there were clear records of what training had been completed and what still needed to be completed. Staff told us they had done lots of training since our last inspection and that plans were in place for them to complete the care certificate.

However, we saw that some of the training was not always effective. For example, we saw one member of staff move a person in an unsafe manner. The deputy manager confirmed this member of staff had received moving and handling training the week prior to our inspection and said they would speak with them about the need to embed training into practice.

Supervision was planned in every three months and there was a record of when staff had last received and were due supervision. In addition, the deputy manager did daily walks around the home and if they saw a member of staff not working in line with the provider's policies they would complete an immediate supervision. However, these were recorded on the daily checks record and not on the staff records. Therefore, it was not easy to see if the same member of staff was making the same errors on multiple occasions.

Prior to the inspection the provider told us the catering staff had received relevant training, including allergen awareness and menu choices were displayed which highlighted any ingredients people may have an allergic reaction to.

We saw people were supported to spend time in small activity groups throughout the day and to eat their midday and evening meals in the small groups. A member of staff told us that people got a choice of meals and that the cook had asked people that morning what they would like for lunch. Pictures of the food choices were available to support people to make a choice. However, people's experience of being able to choose what they wanted to eat was mixed. One person told us, "You sometimes get a choice and you sometimes don't." The menu was a set four week menu. On the day of our inspection the two choices offered for the main meal were beef stew and beef casserole. This did not offer people a wide choice as both were beef and vegetables in gravy and some people did not have the skills to request an alternative meal.

People had been supported to be independent with their eating and drinking at mealtimes and equipment was personalised to meet people's needs. For example, some people had sloping bowls and cutlery which helped them to eat independently and safely.

There had been concerns regarding the diet of one person who was a diabetic. One care worker had taken the lead and they had been working with diabetes nurse and were monitoring the person's dietary intake to try and reduce the person's blood sugars. We saw that this had been successful and that the person had reduced blood sugar on the days this care worker was on duty member of staff worked. The care worker was supporting colleagues to ensure the person received consistent care regardless of who was on duty. The person was also on a gluten free diet and was supported to make food choices with a weekly display of all the allergens the planned meals displayed.

We saw one person who was meant to be on a weight reducing diet for health reasons had been gaining weight. Staff told us since moving to the new activities systems and having smaller groups at lunch they had identified that the person was eating food that another person did not want and visitors were bringing them sweets. There was no record in the person's care plan to show if they were able to make decisions around healthy eating or the support they required from staff to help them to lose weight .

Records showed that people were appropriately referred to the doctor or community nurse when care workers noticed a change in their needs. The home had a named health liaison nurse who visited to monitor people's health and to provide appropriate health screening. However, we saw in two people's care plans that they had not been to the dentist since 2014 and there was no evidence that they had further visits planned. In addition, there was no evidence in care plans or risk assessments that recommendations by the dentist were being implemented.

Where people displayed reactions which challenged, staff appropriate advice was sought. We spoke with members of a visiting healthcare team who supported the home to manage people's behaviour. They told us that staff understood people's needs and worked in partnership with them to support people to receive appropriate care.

Requires Improvement

Is the service caring?

Our findings

When we inspected on 14 January 2015 we found people were not treated with respect. The provider did not support their autonomy, independence and involvement in the community. This was a breach of Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2014 Dignity and respect.

Prior to our inspection the provider told us they were upholding their social care commitment to dignity and respect and that a person centred approach will be used to improve the experiences of the service delivered for all service users.

At our inspection on 25 November 2015 we found the home was busy but staff took the time to acknowledge and speak to people as they went about their day. We saw lots of good communications from staff towards people living at the home. For example, one person was upset after they fell out of their chair, we saw the activity coordinator comforted them, gave them a hug and took time to sit and talk with them which quickly reassured the person.

However, we found that there was a lack of care planning to support positive communication with people. For example, one person told us that a member of staff had upset them as they had said that the person could not go out any more. We discussed this with the deputy manager who explained that the person wanted to go out on every trip and it had been explained that they needed to take their turn with others in the home. However, the way this had been communicated had increased the person's anxiety. There was nothing in the person's care file to support staff to communicate more effectively with this person.

Care plans recorded brief details on people's likes and dislikes in relation to food and drink. The lunchtime experience was calmer and more relaxed meals being served in the activity groups. When staff supported people to eat they sat next to them and engaged the person with the meal. However, the mealtime experience for people was still institutionalised. Lunch was served at 12 pm, at 2.30pm a drinks trolley came round offering tea or coffee and tea was served at 4pm. Everyone had plastic cups and plates. The tea time experience was particularly poor. People were offered scrambled egg on toast or hot dogs. However, the hot dogs were served with a slice of bread and the eggs were overcooked and grey. In addition, a small cake for pudding was placed on the same plate as the main course.

People were supported to make choices about how they spent their time with activities information on display in the entrance hall and in people's bedrooms. People were able to choose which group activity they wanted to partake in and to move between the groups whenever they wanted. For example, one person was sat at a table doing a jigsaw which was their favourite activity. During the morning some people had gone horse riding, two people we spoke with told us they had been asked if they wanted to go but hadn't felt like it.

We saw at times information in people's care plans reflected how staff wanted them to feel about the care they received rather than how the person actually felt. For example, we saw in one person's care plan it recorded how they liked their person centred board in their bedroom and how looking at the picture of the

football team made them happy. However, at the beginning of the inspection we were shown the person's board in the office waiting to be put on their bedroom wall.

We saw that people were not always supported to maintain their dignity. For example, during the morning we saw one person who had spilt a cup of tea down their front. We raised this with a member of staff who explained that they person often spilt their tea and would be changed before lunch. There was no information in their person's care plan to see if support was needed for them while drinking or if a different drinking beaker would be more appropriate for them. We also saw a person who had spoiled their clothing while eating their lunch was not supported to change. Staff dismissed this on the grounds that they were a messy eater.Their care and support plans had no details around this and how to support the person to retain their dignity.

We saw one person was in a specially designed chair which was dirty and covered in marks from where it had hit walls and door frames. This person was sat in the same chair all day and wasn't transferred into any other chair or taken to the toilet. During mealtimes they were not moved and their position was reclined. They were not helped to sit up more upright and were left reclined at an angle which may increase their risk of choking while eating. At teatime they had slipped down much further and their wet incontinence pad was showing.

People's bedrooms were clearly personalised to reflect their interests and hobbies. The bedrooms were finished to a high standard, had good quality furniture. Bedrooms doors had been decorated to look like front doors so that people felt like they had their own homes to go into. People had been able to choose which colour they wanted their doors painted. The garden was well maintained and tidy with seating for when the weather was good.

Requires Improvement

Is the service responsive?

Our findings

When we inspected on 14 January 2015 we found that the provider did not ensure the care and treatment people received was appropriate, met their needs and reflected their preferences. This was a breach of Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2014 Person centred care.

Prior to our inspection the provider told us they were working closely with the local authority in compiling new person centred care plans which incorporated pictorial information which would help people understand the information in their care plan. Activates had been reviewed and people were able to participate in different activities and experiences. Two activity coordinators were now in place and they had received training which enabled them to provide support and activities to meet their needs. Care plans were to be audited on a six monthly basis with family and yearly with other professionals and families. In addition, care plans were to be internally reviewed monthly by senior staff and key workers

At our inspection on 25 November 2015 we found the registered manager had reviewed and updated the care plan format and they now contained pictorial person centred sheets which recorded people's care needs. For example, they recorded how people liked to take their medicine. However, neither the re-written nor the old care plans fully reflected the care people needed. For example, staff told us they were supporting a person to lose weight and encouraging them to walk down the corridor twice a day. However, there was no care plan regarding diet and weight loss to support staff to help this person. Two people were recorded as having epilepsy; the registered manager told us that neither person had fitted in a long while. However, there was still a possibility that people may fit in the future and there were no care plans in place to support staff in the event either person had a seizure.

Most people received care which supported their needs. For example where one person's behaviour had changed staff had raised concerns, increased the number of checks on the person and had referred them for appropriate professional support. Although this care was not recorded in their care plan.

However, other people received care which did not meet their needs or support them to be independent. For example, one person who was anxious was not supported to manage their anxieties and they raised concerns with us about the care and support they received not meeting their needs. Their care plan contained conflicting information, in one part it said the person was independent with personal care, but further on it said they needed help. We spoke with this person and they complained the staff never helped them wash themselves and their hair and this upset them. Furthermore, this person was deemed to be able to keep their own room clean and tidy, but when we checked the room the bed was not made and it was across the toilet door blocking access. We moved the bed and looked in the toilet and found a pile of dirty laundry on the floor, a dirty sink and the toilet was dirty with thick black stains all in the pan. We showed this to the registered manager who said they had been unaware of the issue and would arrange for it to be cleaned.

This was a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 need for consent.

The provider had engaged with health professionals and provided training to the activities co-ordinators and as a consequence the level and type of activities had improved and were more suitable to meet people's needs. The provider had split the home into three areas and provided different activities in each area from 9:30 am until 7:30 pm. People could choose where to spend their time and we saw people moved freely between the activities set during our inspection. The registered manager told us since the introduction of the activities, "[Name] is a different person." They said previously they spent a lot of time in their room now they were always out and about.

A member of staff told us, "It's calmer now they have the [activity groups] going." They told us that with the calmer atmosphere there had been a reduction in the number distressed reactions people displayed. Staff also told us they had been able to learn more about people and their needs and how they displayed their needs. For example, they had spent time talking to a person who wasn't eating well and had learnt more about their likes and dislikes and as a result the person was eating better.

Information on how to make a complaint was available to people in an accessible format and people told us if they had any problems they would talk to the registered manager or deputy manager and they were happy that issues would be resolved. Where concerns had been raised records showed the registered manager had taken action.

The registered manager told us no complaints had been received since our last inspection. However, we saw that they may not have always recognised complaints when they had been raised by people living at the home. We saw an incident record which was clearly a complaint from a person living at the home regarding a member of staff who had allegedly told her she couldn't go out because she went out too often. This had not been treated as a complaint and no action had been taken.

Requires Improvement

Is the service well-led?

Our findings

When we inspected on 14 January 2015 we found that the provider did not have an effective system to assess monitor and improve the quality and safety of services provided or to identify, assess and manage risks to the health, welfare and safety of people using the service. This was a breach of Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 Good Governance.

Prior to our inspection the provider told us that the senior management team were engaging with the home were conducting monthly audits of the service and were supporting the registered manager with quarterly supervisions. In addition, daily checks on the environment and care were in place along with a set of audits to monitor home. They told us they were working closely with the local authority to improve the care provided for people.

At our inspection on 25 November 2015 we found the provider was committed to improving the quality of care they provided to people. They had increased the amount of time spent at the home by senior people in the organisation to help identify problems with the service and to drive improvements. The registered manager, deputy manager and staff all told us that they felt supported by the senior managers and that they visited the service regularly and interacted with staff and people living at the home.

In addition, the provider had decided to stop providing dementia care for up to four older people and to concentrate on providing a quality service for the 26 people at the home with a learning disability. They had worked with the local authority contracting team and other health and social care professionals to identify what good care looked like and how it could be implemented in the home.

A new deputy manager had been employed to support the registered manager and they had focused on setting up systems to monitor staff training, supervisions and the environment. Records showed there was a now a set of audits which monitored the environment, equipment and infection control. We saw that any problems which were identified had been identified on an action plan and appropriate action taken.

Lines of responsibility had been redefined to include the deputy manager, who was not responsible for the day to day management of staffing and rotas. Staff were clear that they needed to take concerns to their senior who would report to the deputy manager. This allowed the registered manager to step away from the day to day concerns of the home and to focus on how to improve the quality of care people received.

Staff were now supported by robust systems which monitored their training and supervisions. This ensured that they were clear on what training they needed to attend and when. In addition, the deputy manager did two daily walks around the home to monitor the environment and the care provided to people. Where they saw poor care practices, these were raised immediately with the member of staff so they were clear on what was and was not acceptable standard of care. Staff also received information on the home and level of care they were expected to provide at staff meetings. For example, we saw at the last staff meeting they had discussed maintaining people's dignity and respect. Staff told us they felt supported by the registered manager and deputy manager.

Records shows that people living at the home were supported to attend residents meeting and were being encouraged to start to use the meetings as a way to raise any concerns they had about the service. However, this was new to people and they needed support to help them become confident in using the meetings to their full potential. Plans were in place to complete quality audits of the people living at the home, their families and visiting professionals. However, no audits had been completed for us to review and so we could not be assured that people were happy with the service and able to identify to the registered manager any changes they would like to see.

The registered manager was caring and dedicated to supporting the people living at the home and responded positively when we identified concerns. However, we found that they were not always proactive about identifying concerns themselves. For example, following our last inspection they had worked hard to improve the areas of care we had identified as needing improvement in our last report. However, at times they were unable to take a step back and identify that something that they had always done was no longer acceptable. For example, we saw that the tea time experience was not pleasant for people with their cake being served at the same time and on the same plate as their egg on toast or hot dogs. The registered manager who was in the dining room during this meal did not identity the concerns until they were pointed out to them. The registered manager had identified that they needed to improve their management skills to continue to improve the service provided to people and were being supported by the provider to undertake further training.

The provider had worked with the local authority to improve the quality of the care plans. However, we saw that the new care plans they had developed still did not fully describe people's needs, identify risks to care or provide guidance to staff on the care needed to meet people's individual needs. It was confusing to establish any dates within each file. Some documents didn't have dates and some were dated but no there was clarification if this was the date the care plan or risk assessment was created or the date by which it needed to be reviewed. The registered manager who was leading on this work failed to recognise the failings in the care plan and so were unable to identify that further improvements were still needed.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care was not designed to fully meet people's needs and people did not receive care which met their needs or reflected their preferences. Regulation 9(3) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not act in accordance with the Mental Capacity Act 2005. Regulation 11 (3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not assess the risks to people while receiving care or plan care to mitigate those risks. Regulation 12 (2) (a) (b).