1st Care Limited

Hawthorne Nursing Home

Inspection report

School Walk
Bestwood Village
Nottingham
Nottinghamshire
NG6 8UU

Tel: 01159770331

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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 inspection took place on 1 and 2 November 2016 and was unannounced.

Accommodation for up to 36 people is provided in the service over two floors. The service is designed to meet the needs of older people living with or without dementia. There were 29 people using the service at the time of our inspection.

A registered manager was in post and she was available during the 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.

Staff knew how to keep people safe and understood their responsibilities to protect people from the risk of abuse. However, safeguarding training figures required improvement and appropriate safeguarding records were not kept.

Risks were not always managed so that people were protected from avoidable harm. Medicines management and infection control practices required improvement.

Sufficient staff were on duty to meet people's needs. Staff were recruited through safe recruitment practices.

People's rights were not fully protected under the Mental Capacity Act 2005. The environment could be further improved to better support people living with dementia.

Staff received appropriate induction, training and supervision. People received sufficient to eat and drink. External professionals were involved in people's care as appropriate.

There was limited evidence that people and their relatives were involved in decisions about their care. People did not always receive care that respected their privacy and dignity.

Staff were kind and knew people well. Advocacy information was made available to people.

Not all care records contained sufficient information to support staff to meet people's individual needs.

People generally received personalised care that was responsive to their needs. A complaints process was in place and staff knew how to respond to complaints.

The provider and registered manager were not fully meeting their regulatory responsibilities and systems in place to monitor and improve the quality of the service provided were not fully effective.

People and their relatives were involved or had opportunities to be involved in the development of the service.

Staff told us they would be confident raising any concerns with the registered manager and that appropriate action would be taken.

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 understood their responsibilities to protect people from the risk of abuse. However, safeguarding training figures required improvement and appropriate safeguarding records were not kept.

Risks were not always managed so that people were protected from avoidable harm. Medicines management and infection control practices required improvement.

Sufficient staff were on duty to meet people's needs. Staff were recruited through safe recruitment practices.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's rights were not fully protected under the Mental Capacity Act 2005. The environment could be further improved to better support people living with dementia.

Staff received appropriate induction, training and supervision. People received sufficient to eat and drink.

External professionals were involved in people's care as appropriate.

Is the service caring?

Requires Improvement

The service was not consistently caring.

There was limited evidence that people and their relatives were involved in decisions about their care.

People did not always receive care that respected their privacy and dignity.

Staff were kind and knew people well. Advocacy information was made available to people.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Not all care records contained sufficient information to support staff to meet people's individual needs.

People generally received personalised care that was responsive to their needs.

A complaints process was in place and staff knew how to respond to complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The provider and registered manager were not fully meeting their regulatory responsibilities and systems in place to monitor and improve the quality of the service provided were not fully effective.

People and their relatives were involved or had opportunities to be involved in the development of the service.

Staff told us they would be confident raising any concerns with the registered manager and that appropriate action would be taken.

Hawthorne Nursing 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 1 and 2 November 2016 and was unannounced.

The inspection team consisted of an inspector, a specialist nursing advisor with experience of dementia care 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 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. Before our inspection, we reviewed the PIR and other information we held about the home, which included notifications they had sent to us. A notification is information about important events which the provider is required to send us by law.

We also contacted the commissioners of the service and Healthwatch Nottinghamshire to obtain their views about the care provided in the home.

During the inspection we observed care and spoke with seven people who used the service, five visiting relatives, a kitchen assistant, the kitchen manager, two domestic staff members, a laundry staff member, two activities coordinators, four care staff, a nurse, the registered manager and representatives of the provider. We looked at the relevant parts of the care records of 14 people who used the service, two staff files and other records relating to the management of the home.

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

People told us they felt safe living at the home. One person said, "You can't fault it. It's very safe." A relative said, "We think [our family member] is safe. It's a nice place and we've no worries."

Staff were aware of safeguarding procedures and the signs of abuse. They told us they would report concerns to the registered manager. A safeguarding policy was in place and a majority of staff had attended safeguarding adults training, however nine of 42 staff had not attended the training. This meant that there was a greater risk that staff would not take appropriate action to protect people from abuse.

Information on safeguarding was available to give guidance to people and their relatives if they had concerns about their safety. However, safeguarding records could not be located during our visit which meant we could not view any safeguarding referrals made by staff at the service. This meant that there was a greater risk that staff had not taken all appropriate steps to protect people from abuse.

Risks were not always managed so that people were protected from avoidable harm and were not unnecessarily restricted.

Most people told us that they didn't feel unnecessarily restricted. A person said, "We can go anywhere in here and sit anywhere. Total freedom." Another person said, "We've the option to go where we prefer to go." However a third person said, "We can choose which room we want to sit in. We don't get to go outside though." We observed that the ground floor was split into two parts and people could not walk freely between the two parts. This meant that people did not have a lot of space to walk with purpose. There was also only a small secure outside area and this could not be accessed by people without staff support. This meant that people were restricted from independently accessing an outside space.

A person said, "They're nice and gentle getting me into the wheelchair. I can manage to stand. I'm happy with the equipment I've got." However, we observed that people were not always supported safely when being transferred from a wheelchair to an armchair. This meant that people were placed at risk of avoidable harm.

There were pressure relieving mattresses and cushions in place for people at high risk of developing pressure ulcers and they were functioning correctly. However, people's repositioning charts had not always been fully completed to show that staff had supported people to change their position as frequently as stated in their care plan. We also observed that a person was sat in a chair and their feet were not resting on a surface. They had previously had a stroke and their feet should have been supported if they did not comfortably reach the floor. We also noted that this person's care plan stated they should not be positioned on their left side in bed as this was the side affected by their stroke. However, their repositioning chart documented they had been placed on their left side on one occasion on each of the previous two nights. This meant that people were placed at risk of avoidable harm.

Accident forms were completed, however, actions taken to minimise the risk of re-occurrence were generally

not documented. Falls were not analysed to identify patterns and any actions that could be taken to prevent them happening. We also saw that staff handover records were not fully completed and contained limited information. This meant that there was a greater risk that staff would not learn from accidents and that appropriate actions would not be taken to minimise the risks to people.

Individual risk assessments had been completed to identify people's risk of falls, developing pressure ulcers, nutritional risk and moving and handling risks. When bedrails were in use to prevent people falling out of bed risk assessments had been completed to ensure they could be used safely.

We saw that the premises were well maintained and checks of the equipment and premises were taking place. However, bedroom doors closed too quickly and put people at risk of avoidable harm. The provider agreed to address this issue immediately.

There were plans in place for emergency situations such as an outbreak of fire and personal emergency evacuation plans were in place for all people using the service. This meant that staff would have sufficient guidance on how to support people to evacuate the premises in the event of an emergency. A business continuity plan was in place to ensure that people would continue to receive care in the event of incidents that could affect the running of the service.

We received mixed feedback from people when we asked them if they thought there were enough staff in place to support them safely and meet their needs. One person said, "There seems to be enough staff if I want something." Another person said, "[Staff] manage okay as they are." However, a third person said, "They could do with more staff in the afternoons." Another person said, "They seem on occasion to be short [of staff], like at lunchtime and teatime. We have to wait."

Relative feedback was also mixed. One relative said, "We've not noticed a problem with staffing." Another relative said, "It's the first home where we always see [staff] in and out of the lounge regularly." However a third relative said, "They take a while to get [my family member] to the toilet sometimes and it can become urgent for [them]." Another relative said, "[My family member] is always clean and tidy. But [they] can be wet through when [staff] can't get to [them] as they're busy."

Staff told us that they felt that there were sufficient staff to meet people's needs and keep them safe. A staffing tool was used to calculate staffing levels and the number of staff on duty was in line with the staffing tool calculations.

A person said, "They usually come within five minutes when I've rung [the call bell]." We observed staff respond to people's needs in a timely manner. When people needed assistance going to the toilet or needed support with eating, staff were there to support them. However, we also noted some periods of time where lounge areas were not always supervised by staff. This could place people at risk of avoidable harm.

Safe recruitment and selection processes were followed. We looked at recruitment files for staff employed by the service. The files contained all relevant information and appropriate checks had been carried out before staff members started work.

People's views were mixed on whether staff stayed with them to check that they took their medicines safely. A person said, "Some will leave the tablet pot with me, others will stay. They don't come back and check I've taken them." This person's care plan stated that staff should supervise them taking their medicines. However another person said, "They wait with me to swallow the pills." A relative said, "It [medicines] seems well managed."

Staff told us the registered manager or deputy manager had checked their competency to administer medicines and they had undertaken medicines training within the last few weeks.

We observed the administration of medicines and saw the nurse checked whether people were ready for their medicines before administering them and stayed with people until they had taken their medicines. One person said they wanted to wait until after breakfast and this was respected. We observed the nurse talking with one person about their antibiotics and when they were due to finish. We also observed a person asking about their medicines and what they were for and they were given a brief explanation about each one before they took them.

Medicines Administration Records (MAR) contained a photograph of the person to aid identification, a record of any allergies and their preferences for taking their medicines. MARs were fully completed. When people were prescribed to be given medicines only as required, protocols were in place to provide the additional information required to ensure they could be given safely.

Systems were in place for the ordering and supply of people's medicines. We were told people's regular medicines were received in time to ensure that people did not miss medicines due to a lack of availability.

We saw three people were being given their medicines covertly; there was a record of the involvement of the GP and their authorisation to give the medicines covertly, however, we did not see any evidence of the involvement of a pharmacist. It is important to consult with a pharmacy to ensure that it is safe to give a medicine in a covert manner.

Arrangements were in place for the safe storage of medicines. However, we found the door of the room used for medicines storage was unlocked on one occasion and the medicines fridge was also unlocked. This meant that medicines were not stored securely at all times.

People told us that they thought the home was clean. A person said, "I'm very satisfied with the place being clean." A relative said, "We can't fault [the cleanliness]."

The service was clean and staff generally followed good infection control practices. However, we observed a staff member put a person's denture in the person's mouth without using gloves. This put the person at greater risk of infection.

Requires Improvement

Is the service effective?

Our findings

People told us they were happy with the way staff supported them and staff had the skills needed to support them in the way they wanted. A person said, "They're very able at what they do." Another person said, "I believe they're well trained."

Staff felt supported by management. They told us they had received an induction which prepared them for their role. Staff also told us they had access to training to enable them to keep themselves up to date and they felt they had the knowledge and skills required for their role.

Staff told us they received regular supervision. Training records showed that most staff had attended a wide range of training which included equality and diversity training. Systems were in place to ensure that staff remained up to date with their training and received regular supervision.

People told us they were always given choices by the staff and staff respected their wishes. A person said, "Yes, they do ask me if they need to do something." Another person said, "They ask me very nicely when it's time to move." We saw staff asked permission before assisting people and gave them choices.

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.

The requirements of the MCA were not being fully followed. When people were not able to make some decisions for themselves, mental capacity assessments and best interest decisions were made in most instances. However, we noted that this was not consistent and some people did not have a mental capacity assessment and best interest decision for some important decisions. This included in the areas of personal care and covert medicine. This meant that there was a greater risk that people's rights were not being fully protected.

When people were being restricted, DoLS applications had been made. The registered manager told us that they would be making further DoLS applications.

Two people in the lounge vocalised their concerns and distress very loudly and despite staff interventions to reassure them and distract them which calmed them temporarily, they continued this behaviour for extended periods throughout the afternoon. This had a visible impact on others in the lounge and some

people made comments about the noise. On the second day of our visit, staff moved one of the two people to their bedroom for a period of time until the GP arrived to examine them to identify if there was any cause for their calling out. This meant that the lounge area was much quieter and people appeared more relaxed on the second day of our visit.

When people presented with behaviours that others might find challenging, behavioural care plans were in place. Some of these contained a good level of detail and the behaviours and the actions staff should take were well described, whilst others provided less guidance for staff. This meant that sufficient guidance was not always in place for staff to when supporting people with behaviours that might challenge.

We checked the care records for people who had a decision not to attempt resuscitation order (DNACPR) in place. There were DNACPR forms in place but a number of them had not been fully completed. The registered manager agreed to contact the relevant professionals to review them.

People told us they liked the food and drink provided for them. One person said, "It's very good food. There's a set dish or you can ask for something else. It's home cooking." Another person said, "It's nice food, its lovely. We get plenty too, so I feel full." A relative said, "The cook is excellent. [My family member] looks better and eats well here."

People told us they had enough to drink. A person said, "We get plenty to drink. I've got a glass in my bedroom to use." Another person said, "I asked for a jug of squash for my bedroom and they did that. We can help ourselves to squash in the lounge. The tea trolley comes round three times in the day." A relative said, "[My family member] seems to get plenty to drink, from what I've noticed." We saw that people were offered drinks regularly during our visit.

We observed breakfast being served. People were assisted into the dining room and served breakfast individually. They were offered a choice of breakfast and hot drinks. A care staff member was based in the dining room and the kitchen assistant brought out people's food and checked with others whether they would like anything else. They were attentive to people's needs and happily provided anything which was requested.

We observed lunch being served. Food was appetising and portions were generous. People had been asked what they would like for lunch about one hour before the meal was served. Where people required assistance from staff with their meals, this was provided. However, some people who didn't require full assistance might have benefitted from prompting by staff to eat more of their meals. We also observed that staff did not always explain to people what food they were providing them with to encourage them to eat or remind them of the choices that they had made.

Nutritional assessments had been completed and reviewed monthly and people were weighed at least monthly. The results were reviewed and action recorded if a person lost weight or their food and fluid intake decreased. We saw there were prompt referrals to a dietician when there were concerns about a person's weight or their eating and drinking. Fluid charts were in place to record people's fluid intake where this required monitoring and a fluid target was identified. We saw people were maintaining a good fluid intake in line with their individual target. We saw one person's food intake was not being monitored when their care plan stated it should be. The person was of a very low weight and therefore we would have expected monitoring to be taking place, however, we noted they had gained a small amount of weight over the last few months.

People told us they had access to their GP or healthcare professionals if they needed it. A person said, "The

optician has been once to me and the chiropodist I've seen too." Another person said, "The doctor came for my cough and gave me antibiotics."

We saw evidence within care records that people had access to other professionals as they required. There was evidence of prompt referral to a dietician, the dementia outreach team, a chiropodist, optician, and family doctors. A person who was showing signs of possible depression was referred to and assessed by an external professional.

People told us that other people who used the service came into their bedroom at times. They weren't concerned by this. A person said, "I get people wandering in now and then at night." Another person said, "Occasionally someone comes in my room and goes off again."

Some adaptations had been made to the design of the home to support people living with dementia. Bathrooms, toilets and communal areas were clearly identified. However, not all bedrooms were clearly identified to ensure that people knew where their bedroom was located.

Space in both lounge areas was limited. The front lounge was very noisy at times and did not provide a relaxing environment for people who used the service. The back lounge was very full at times and there was limited space for privacy or for interactions between people as people were sat in chairs around the edges of the room. A number of people were unable to see the television from whether they were sitting.

Requires Improvement

Is the service caring?

Our findings

People told us they felt the staff were kind and caring. One person said, "All of [the staff] are lovely with us." Another person said, "They're lovely. I like [staff] a lot. We laugh along."

Relatives also felt the staff were kind and caring. A relative said, "They're very friendly and caring. They chat to us and greet us like friends." Another relative said, "They're very kind. I'm at ease with them and they make me feel welcome."

Staff were attentive to people's needs and had a good rapport with people. When people were anxious and required reassurance staff provided this in a supportive manner. Staff showed an understanding of the people they cared for and empathy for people. However, we observed a staff member using a tone that was not respectful on two occasions. The staff member told a person to, "Get in there please." On another occasion they told a person to, "Speak English please."

People told us they did not feel involved in their care planning. A person said, "We can ask questions about things but I don't see any files." However, relatives told us they were involved with decisions about the family members' care. A relative said, "[Staff] tell me what's going on." Another relative said, "Our [different relative] does the office side of things. [They] fill things in and are kept informed. [The registered manager] tell us things anyway when we're here." Care records contained limited evidence that people and their relatives had been involved in their care planning.

Advocacy information was available for people if they required support or advice from an independent person. When people had difficulties in communicating verbally, communication care plans were in place. These provided information for staff on how to understand the person's wishes and strategies staff should use to maximise people's understanding and enable them to indicate their wishes.

People told us their privacy was generally respected though staff did not always knock or wait before entering their bedroom. A person said, "They sometimes come in without knocking." Another person said, "They knock and come in, they don't wait." However, a third person said, "They respect us and knock first. I get my privacy too when I want it."

We observed that there were no areas where people could easily have privacy except their bedrooms. A relative said, "It's a shame there's no quiet area to sit with [my family member]." We saw staff took people to their bedrooms to support them with their personal care and saw staff knocked on people's doors before entering, however, staff did not always wait before entering. We also observed that care records were not stored securely at all times which did not respect people's right to privacy.

We saw some positive examples of staff treating people with dignity and respect. For example, we saw staff discreetly asking people whether they wanted to go to the toilet and using blankets to protect people's dignity when moving them using equipment. However, we also observed a staff member put a person's denture in the person's mouth in front of other people who used the service in the lounge. This did not

respect the person's dignity. We also saw staff left two people in their wheelchairs facing armchairs in the lounge for over ten minutes until staff were available to transfer them into their armchairs. This did not respect their dignity.

People told us their independence was encouraged by staff. We observed that people were supported to eat their meals independently where appropriate. Staff also told us they encouraged people to do as much as possible for themselves to maintain their independence.

Relatives told us they were able to visit family members whenever they wanted to. A relative said, "There are no ties at all to visiting times." Another relative said, "We can come whenever we want." We saw relatives visiting people throughout the inspection. Staff told us people's relatives and friends were able to visit them without any unnecessary restriction. Information on visiting was in the guide for people who used the service.

Requires Improvement

Is the service responsive?

Our findings

People's views were mixed on whether they received care that was responsive to their needs. A person said, "We have to go by what [staff] want for showers." Another person said, "We get what [staff] think for a bath time." However, a third person said, "We can have a bath whenever we want. There's no list as such."

Relative views were also mixed. A relative said, "They know [my family member] likes a laugh so they wind [them] up something rotten sometimes! [They] have been so much better here, more alert and tells us what's been on the news. Brilliant." However, another relative said, "[My family member] just walks up and down – they won't risk taking [them] outside now as [my family member] gets scared being out in the open. I wish they'd do more with [them]." A third relative said, "I wish they'd sit [my family member] so [they] can see the TV and have something to look at. [They] are put beside it mostly." We observed that they asked staff to move their family member so that they could see the television and staff did this. However, when they came back from lunch, the person who used the service was moved by staff to an armchair where they could not see the television.

We saw that people generally received care that was responsive to their needs. Call bells were answered promptly and staff generally responded well to people's requests for assistance.

People told us that although some activities were provided, they felt they generally passed the time by watching TV, talking or sleeping between mealtimes. A person said, "I'd say I'm bored all the time. We just sit, sleep and wait for meals. I've got my friend here and we sit together. I've not been on any outings." Another person said, "We have bingo games. There's nowt else to do apart from TV. I get taken to the church for the monthly lunch they do there." A third person said, "I try and keep occupied. I read my papers and weekly magazine or watch TV and nod off when I want. I join in any games they do but they're not every day. I went on the outing to [a local farm] the other week." A relative said, "[My family member] loves the singsong on a Monday or weekend."

We observed activities taking place during our visit. We observed activities staff speaking with people on a one to one basis and using reminiscence materials to encourage people to talk about memories that were important to them. We observed bingo and a quiz taking place in the afternoon. However, the layout of the lounge made it difficult for some people to take part in the activities.

People told us they weren't asked whether they preferred staff of a particular gender when they received personal care. A person said, "I wasn't asked but it doesn't worry me." Another person said, "They didn't ask me but I don't mind whoever."

An initial physical and social assessment had been completed when people were admitted to the service along with a personal history profile. These documents provided an assessment of people's support needs; however the amount of information about their preferences, their life history, interests and activities they enjoyed was variable. This meant that there was a greater risk that staff did not have sufficient guidance to provide people with personalised care.

Care plans were in place for people's care and support needs. Some of these contained a good level of detail about their preferences in relation to their care and how they liked to be supported whilst others were briefer and contained less personal detail. Most care records had been reviewed monthly, though one set of care records had not been reviewed since August 2016. Reviews gave a brief summary of changes and demonstrated that people's progress and support needs were monitored and reviewed and changes identified.

Care plans generally reflected people's current needs but we found a number of instances when they were inaccurate or lacked required detail. We were told a person required a liquidised diet but their care plan stated they required a soft diet. Another person had a wound dressing in place but this was not recorded within their care plans. A third person was wearing heel protectors and this was not documented in their care plan. Another person's care records were inconsistent regarding their dietary requirements.

A person living with diabetes had a diabetes care plan in place which clearly identified the signs of low and high blood sugar levels and the action for staff to take if this occurred. However another person's care plan did not. A person living with epilepsy did not have guidance in place for staff on how to identify when their health condition was deteriorating.

Care records contained information regarding people's diverse needs and provided support for how staff could meet those needs. We saw that people were supported to attend religious activities in line with their preferences. A person who ate a vegetarian diet received appropriate food to meet those needs.

None of the people we spoke with or their relatives had raised a formal complaint with the registered manager. However, nobody told us they would be uncomfortable making a complaint and a relative said, "We've not had to complain as such. Any concern we mention to [staff] or [the registered manager] is dealt with straight away."

Complaints had been handled appropriately. Guidance on how to make a complaint was in the guide for people who used the service and displayed in the main reception area. There was a clear procedure for staff to follow should a concern be raised. Staff were aware of the complaints process and the action they should take if a person raised a concern or a complaint.

Requires Improvement

Is the service well-led?

Our findings

People and visitors had some opportunities to comment on the running of the service though these could be improved. Activity staff told us that they arranged quarterly meetings for people who used the service, to which relatives were invited. They told us that attendance could be poor on occasions. Some people we spoke with had some awareness of meetings being held but could not recall examples of actions taken following their comments. A person said, "I've never heard of any meeting for us." Another person said, "They do a meeting now and then. Some things are useful that get said." A relative said, "I think they have an odd meeting but we've not been."

We saw that a meeting for people who used the service and visitors had taken place in June 2016 where comments and suggestions on the quality of the service were made. However, there was no documentation to show that actions had been identified and taken in response to any suggestions made.

Most people could not remember being asked for their views on the development of the service through completing surveys. However, a relative said, "I had a survey through from them just the once." We saw surveys had been completed by relatives. However, there was no documentation to show that actions had been identified and taken in response to any suggestions made. There were no surveys sent to people who used the service.

A whistleblowing policy was in place and contained appropriate details and staff told us they would be prepared to raise issues using the processes set out in this policy. The provider's values and philosophy of care were in the guide provided for people who used the service and displayed in the main reception area.

People spoke positively of the atmosphere of the home. A person said, "It's nice in here." A relative said, "It's a happy place. We're really happy [our family member] is here." Staff were positive about their roles and felt that they worked well as a team.

People and relatives spoke positively about the registered manager. A person said, "She's a nice lady and always available." A relative said, "We see her every time we visit and she tells us how our [family member] is doing."

Staff were positive about the registered manager. A staff member said, "[The registered manager] is firm but fair." Staff told us the registered manager was supportive and they could discuss issues openly with her. Staff told us staff meetings were held regularly and they were encouraged to raise issues at the meetings. We saw that staff meetings took place and the registered manager had clearly set out her expectations of staff. Staff told us that they received feedback in a constructive way.

A registered manager was in post and she was available during the inspection. The registered manager felt supported by the provider to ensure the service provided a good quality of care for people.

However, we saw that statutory notifications had not always been made in relation to potential

safeguarding incidents and DoLS authorisations. The PIR had not been fully completed when sent to us prior to our visit.

The provider had a system to regularly assess and monitor the quality of service that people received. However, it was not effective as it had not identified and addressed the issues we found at this inspection.

We saw that audits had been completed by the registered manager and also by representatives of the provider. Audits were carried out in the areas of infection control, medication, care documentation, health and safety, mealtimes and catering. However, clear actions were not always in place when necessary and a care record audit had not taken place since April 2016.

Improvements to the service had not been made and sustained following inspections by us. The CQC inspections in 2012 and 2013 identified breaches in regulations. At our inspection in November 2014, we found that all regulations had been complied with, however, the service was rated 'Requires Improvement'. At our previous inspection in November 2015, also we found that all regulations had been complied with, however, the service was again rated 'Requires Improvement'. At this inspection the service has again been rated as 'Requires Improvement'. This meant that effective processes were not in place to ensure that improvements were made and sustained when required.