Lazyday Investments Limited

Sloe Hill Residential Home

Inspection report

Sloe Hill
Mill Lane
St Ippoyts
Hertfordshire
SG4 7NN

Tel: 01462459978
Website: www.sloehill.com

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Ratings

Overall rating for this service	Requires Improvement

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?	**Requires Improvement**

Summary of findings

Overall summary

This inspection was carried out on 27 March 2018 and was unannounced. At their last inspection on 9 May 2017, the provider was found to not be meeting the standards we inspected. At this inspection we found that although they had made some improvements there were some areas that required further improvement and continued to not meet all the standards.

Sloe Hill Residential Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service accommodates up to 28 people in four adapted buildings. At the time of the inspection there were 24 people living there.

The service had a manager who was registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC 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 and associated Regulations about how the service is run.

With effect from April 2015 providers who have been awarded CQC ratings must display them in each and every premises where a regulated activity is delivered, in their main place of business and on their website. Ratings must be displayed legibly and conspicuously so that the public, and the people who use the services, can see them. We found that the rating on the provider's website had been displayed in a way that may be misleading to the public.

There were systems in place to monitor the quality of the home. The management team had embraced monitoring systems and were working on ways to develop them further. However, these systems had not resolved all the issues found on inspection.

People had their individual risks assessed. However, these were not always reflective of changes in people's needs. Staff knew how to recognise and report any risks to people's safety, this included fire safety. People's medicines were managed safely.

People and staff were positive about the running of the home, the registered manager and the provider. There was a complaint's process which people and their relatives knew how to use. People and their relatives were confident that they would receive feedback from the registered manager.
There was sufficient staff to meet people's needs, however, staff had not always been recruited safely.

People were supported by staff who had received updates to their training and who felt supported.

Most people were supported in accordance with the principles of the Mental Capacity Act 2005, however, for one person the process had not been followed robustly.

People were addressed by staff with respect and kindness. People's privacy and dignity was always promoted and confidentiality was promoted.

People received care in a person centred way although activities provided could be further developed to reflect people's individual hobbies and interests. People and their relatives were involved in planning their care but they did not always take part in reviews of their care. People gave us mixed views about the food but we noted the mealtime experience was pleasant. People had regular access to health care professionals.

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.

People had their individual risks assessed. However, these were not always reflective of changes in people's needs.

Staff were not always recruited safely.

Staff knew how to recognise and report any risks to people's safety, this included fire safety.

Medicines were managed safely.

There was sufficient staff to meet people's needs.

Is the service effective?

Good

The service was effective.

People were supported by staff who had received updates to their training.

Most people were supported in accordance with the principles of the Mental Capacity Act 2005, however, for one person the process had not been followed robustly.

People were positive about the food.

People had regular access to health care professionals.

Is the service caring?

Good

The service was caring.

People were addressed by staff with respect and kindness.

People's privacy and dignity was always promoted.

People would benefit from being more involved in the reviewing of their care.

Confidentiality was promoted.

Is the service responsive?

Good

The service was responsive.

People enjoyed the activities provided but these could be further developed to reflect individual hobbies and interests.

People and their relatives were involved in planning their care but they did not always take part in reviews of their care.

People received care in a person centred way.

There was a complaint's process which people and their relatives knew how to use. People and their relatives were confident that they would receive feedback from the registered manager.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The rating on the provider's website had been displayed in a way that may be misleading to the public.

This was the third inspection that the service had been rated Requires Improvement.

There were systems in place to monitor the quality of the home. The management team had embraced monitoring systems and were working on ways to develop them further. However, these systems had not resolved all the issues found on inspection.

People and staff were positive about the running of the home, the registered manager and the provider.

Sloe Hill Residential 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2014 and to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Before the inspection we reviewed information we held about the service including statutory notifications. Statutory notifications include information about important events which the provider is required to send us. We also reviewed the action plan that the registered manager sent to us following the last inspection setting out how they would make the required improvements.

The inspection was unannounced and carried out by one inspector and an expert by experience. An expert by experience is someone who has used this type of service or supported a relative who has used this type of service.

During the inspection we spoke with eight people who used the service, two relatives, four staff members, the team leader and the registered manager. We received information from service commissioners and health and social care professionals. We viewed information relating to three people's care and support. We also reviewed records relating to the management of the service.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us due to their complex health needs.

Requires Improvement

Is the service safe?

Our findings

When we inspected the service on 9 May 2017 we found that they were not meeting the standards in relation to promoting people's safety and welfare. At this inspection we found that there were improvements made in these areas however, some issues remained.

Safe and effective recruitment practices were not always followed. Robust processes are required to help make sure that all staff were suitable to support people who may be vulnerable. Pre-employment checks were completed prior to staff starting in their role, this included proof of identity and qualifications and criminal record checks. However these were not always sufficient. For example, written references were not always verified to ensure their validity and gaps in employment were not explored.

The recruitment process did not included interview questions. The registered manager told us that they used to use questions but had stopped and adapted the recruitment process due to the fear of losing prospective employees. This meant that there was no evidence to show that the person's skills, knowledge and suitability for the role had been explored. We discussed the need for the registered manager to always satisfy themselves that a person is fit to work with a vulnerable client group.

Therefore this was a breach of Regulation 19 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We observed staff to be working safely. We saw staff carrying out correct manual handling procedures and they ensured people were safely seated and had their walking aids close to them before they left. However, moving and handling assessments were not always accurate, up to date or consistent and this was an area that required improvement to help ensure people received the appropriate and safe support. For example, one person had suffered a fall from a hoist. Following this, there had not been an update to the assessment of their needs or a referral to a health professional who could advise on the most suitable equipment for the person to use. Accidents and incidents were recorded on an internal system. This helped them to identify themes and trends. This system also checked that all remedial actions had been taken. However, the incident with the person falling from the hoist had not been included on the analysis and therefore remedial action had not been identified.

We noted that staff had good knowledge and understanding of fire safety. Staff had recently received training and been part of a drill. Staff knew how to evacuate people in the event of fire and people had individual evacuation plans. There were regular safety checks in place for fire safety equipment. The management team had risk assessed areas within the home, for example, the laundry room and kitchen in relation to fire. However, a robust fire risk assessment in relation to the building and structure by a person qualified to do so had not been completed. The registered manager told us that they were due a fire inspection by Hertfordshire Fire Service. We
told the service that a full risk assessment was required and advised the fire service of this shortfall. This was an area that required improvement.

People told us that they felt safe. One person said, "I could not live on my own, I might fall but here I am looked after and safe enough." Another person said, "I used to have a lot of falls that's why I am here, now I have people to help me." People were supported by staff who knew how to keep people safe and were confident that the registered manager would respond to any concerns of abuse. Staff knew how to recognise and report abuse. There was information about safeguarding people from abuse displayed around the home to help raise awareness and we found that unexplained bruises had been reported and investigated. However, where a person was at risk of repeated bruising due to the fragility of the skin on certain areas, consideration could be given to different clothing or protective pads on their walking aid that the person knocked their legs on. We discussed this with the management team.

Staff were knowledgeable about risks associated with people`s daily living. They were able to tell us names of people who were at risk of falls, at risk of developing pressure ulcers and at risk of malnutrition. We also observed that staff asked for a speech and language therapist assessment for people who were having difficulties swallowing their meals.

People who were at risk of developing pressure ulcers had appropriate risk management plans in place to support staff in understanding how to mitigate these risks. For example, people had appropriate pressure mattresses in place and staff regularly checked if these were set at the right setting.

People told us that there were enough staff to meet their needs. One person said, "There's always someone around here [to help]." Another person said, "I ring this bell and someone comes quite quickly. Look it has an 'express' [emergency] button on it and then they come really fast." Some people had call bell alarms around their necks. One person said, "It's really good it makes me feel safe so when I go to toilet if I am unsteady I can just use this and someone comes and helps me." Relatives told us that they felt there were enough staff. Staff said there were enough staff for them to meet people's needs in a person centred way and enabled them to spend time with people. One staff member said, "We get time to spend with people." We noted that throughout the day the atmosphere was calm and people had their needs met in a timely way.

Medicines were managed in accordance with the prescriber's instructions. We observed staff working safely in the administration of medicines and protocols for medicines on an as needed basis. One person told us, "I have a lot of pain in my legs and they give me pain relief, I can always ask and they will help but they give it to me regularly too." We spoke with a member of staff who was very knowledgeable about a person who was having difficulties with a health condition. The staff member knew exactly what was going on, what the medication was and when it was going to be reviewed and why. We found that quantities of stock agreed with records of medicines received into the home and administered. However, we noted that some of the record keeping in regards to received medicines and medicines carried forward from the previous cycle could cause confusion. A member of the management team agreed that this needed development and they assured us this would be implemented straight away.

When we last inspected the service in May 2017 we found that infection control systems were not always effective. At this inspection we found that systems were in place to help ensure effective infection control. During the inspection we saw staff following infection control guidelines. This included handwashing and the use of gloves and aprons. Staff had received training and we noted staff worked in accordance with guidance. However, we did note that one staff member walked down a corridor to the sluice room with an uncovered commode pot. We raised this with management team who told us that they would address this with training.

Lessons learned were shared by the management team meetings, supervision and handovers. Staff told us

that they felt informed about incidents, complaints and updates to practice.

Good

Is the service effective?

Our findings

People and their relatives felt that staff were sufficiently trained for their roles. Staff told us that they felt trained for their jobs and that they had recently completed fire safety and dementia care training. We saw that there was a handwritten training record being completed. However this only included recent training. To know who was due on refresher training, the management team would need to check all previous certificates. We discussed the benefits of having a record of all training of each staff member had attended so that when updates were due they were easy to identify and for the registered manager to have a clear overview of the staff skills and knowledge.

Staff told us they felt supported by the registered manager and seniors on a daily basis to carry out their roles effectively. They told us that one to one supervisions were carried out regularly. One staff member said, "We are well supported, we have supervisions but we can talk to them anytime." Another staff member said, "Support here is good, we get one to ones too."

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).

The management team demonstrated an understanding of when it was necessary to apply for an authority to deprive somebody of their liberty in order to keep them safe. They knew what steps needed to be followed to protect people's best interests and how to ensure that any restrictions placed on a person's liberty was lawful and they had their human rights to freedom protected. However, the appropriate applications and documentation was not consistently in place for all relevant aspects of people's lives.

Some peoples` mental capacity was assessed appropriately. Where people had a diagnosis of dementia, staff assessed if they were able to understand and make decisions about receiving care and support in the home. Where people were assessed as lacking capacity, best interest decisions were documented to ensure the care and support people received was in their best interest. However, this was not consistent across the home and for one person whose plan we viewed, they did not have the appropriate documentation in place. For example, in regards to receiving personal care or the use of a hoist when they needed support to be transferred and did not have the capacity to understand and to contribute to the procedure with staff. We also found a best interest decision had been recorded for a person to stay in their own room but had not been repeated when a decision was made for a person to change rooms to minimise the risk of falls. This was an area that required improvement.

People were supported and encouraged to make their own choices. We heard staff ask, "Can I put the TV on for you?" One staff member told us that a person who had recently moved into the home had asked what

time they had to go to bed. They said, "I asked them, what time would you go to bed at home, then that the time you can go here, nothing changes it's their home." We found that staff were aware of the principles of the MCA and the need of best interest decisions to help ensure the care and people received was in their best interest. We heard staff asking for people`s consent before they delivered any aspect of care and support. A person told us, "They always ask me what I would like to wear when they are helping me dress." Some people signed consent forms in their care plan to agree with their records to be viewed by staff and other health and social care professionals. Staff understood that if a person lacked capacity to make big decisions they could still make decisions about their day to day living. For example, choice of clothes, food and how to spend their day.

People had regular contact with health care professionals and we saw from records that staff involved health care professionals in people`s care when there was a need for it. One person told us, "If I want to see the doctor I just ask and he will see me on his next round." A relative told us, "They take [person] to hospital, they are really good, they arrange a carer to go with [person]." A relative also told us, "They sort out the hearing aids, took [them] to the hospital for tests and new aids and the carers put on [their] elasticated stockings and make sure [their] hearing aids are in every morning, they are very good." Staff told us about involvement from GP, dieticians, chiropodists and opticians. On the day of the inspection we saw people who were being visited by the district nurse.

The home was not purpose built, it was an adapted older building. With this there were challenges for the storage of equipment and continence aids. This meant that some areas of the home were cluttered and at times people's dignity might not be promoted. However, there were extensive grounds that people could access and lounge and dining areas big enough for everyone to use. Most bedrooms were a good size and personalised with people's individual things around them. Bathrooms had sufficient equipment to help people use facilities independently if they were able. The kitchen was at the hub of the house which allowed for the cooking smells to flow through the house and get people ready for their meals.

People gave mixed views about the food. One person said, "The food varies a lot, sometimes it's good and sometimes it really isn't." Another person told us, "They seem to have had a problem with chefs so there have been a lot of changes. Hopefully they will get a decent one to stay." The menu was displayed in the dining area but there were no free standing menus on the tables or picture menus used to help people understand what their choices were. The cook, who on the day of inspection was the deputy manager, went around in the morning asking people what they would like for lunch and supper. One person told us, "If I don't like the food or if I am on an off day then they will make me something else like a jacket potato." At lunchtime this was served to people by staff putting plates in front of people. People would benefit from staff reminding them what they had ordered. Tables were laid with fresh flowers, table cloths and condiments and people were offered extra helpings and plenty to drink. We noted one person being assisted to eat in the dining room. One staff member was assisting a person to eat at the pace of the person and explained what the food was as they went along with a chatty conversation, "It's pineapple upside down pudding – one of my favourites. It's delicious and sticky and would you like to try some?"
The atmosphere at lunchtime was very pleasant. The registered manager was keen to have music on in the background and the people kept the volume down by request. The staff joked with people about singing along and interacted with most people during the meal. However we noted one person who appeared to have dementia and wasn't communicating much spent an hour or more with their lunch – taking up tiny pieces on the edge of their knife. No one came and checked with them for 55 minutes by which time the food was cold. The person struggled with cutting their food but when a staff member whispered to them about help they refused. However, if the person frequently refuses support, staff may consider if it would be enabling to cut up some of the lunch ahead of time and provide the person with a spoon as well to ensure they could eat their food while it was warm.

Two visitors arrived towards the end of lunch and they were taken to the sitting room and offered tea and coffee. The person who they were visiting was reassured they were in no rush and very comfortable.

We saw that at breakfast people had a variety of choices and those that had porridge were also offered a variety of cooked foods. One person had chosen a cooked breakfast but changed their mind and this was replaced with their new choice with no fuss from staff. We heard the staff member telling the cook that they would like a pot of tea as they liked to have two cups with their breakfast.

Drinks were offered regularly and snacks were available, including during the night. For a person who was assessed as not eating or drinking enough, their intake was recorded. However we discussed with the management team the need to have a fluid target so that this could be totalled at the end of the day and staff could identify if the person had not had enough to drink. We did not that the person was recorded to be having a good fluid intake each day and we had no concerns in relation to this person's hydration.

People had their weight monitored regularly and staff used a tool to identify if people were at risk of malnutrition (MUST). People`s care plans included what actions staff had taken when people gained or lost weight. We found that some people were weighed weekly where they were identified as losing weight.

Good

Is the service caring?

Our findings

People received care from staff in a kind, caring and respectful manner. The general culture of the home was peaceful and kind and caring in both actions and words. When a staff member helped someone to sit down we heard them encourage the person saying, "There, you can sit back down now gently." One person told us, "They are so kind, nothing is too much trouble." Another person said, "They know all about my family, when the babies are due (great grandchildren) and who is visiting, the carers know them all." Staff were friendly, courteous and smiling when communicating with people. The staff had time to spend with people, not long periods of time but enough to form good relationships and make people feel cared for.
We observed sensitive and kind interactions between staff and people who used the service. The way people related to staff demonstrated good relationships between them based on respect and trust. The cleaner chatted to everyone as they cleaned their rooms. Everyone liked them and enjoyed the time they spent with them. One person said, "She's lovely, like a breath of fresh air." We heard a conversation between a person and a staff member. The staff member said, "I've got you a lovely soft flannel here, it's extra gentle." The person replied, "Accidental?" The staff member responded, "No EXTRA GENTLE" and they both dissolved into fits of giggles. One staff member said, "We want people to feel like they are at home."

Staff treated people with dignity. They addressed people using their preferred names and we found that staff knew people well. Staff knocked on bedroom doors and greeted people when they went in. Bedroom doors were closed when staff provided personal care to people.

People looked well groomed, their hair looked clean and combed. There was a relaxed and happy atmosphere in the home. The relaxed manner staff approached people with created a sense of calm and a warm homely feel in the home. Staff were familiar with how people communicated and responded appropriately. Relatives told us that staff always treated people with dignity and respect. A staff member told us, "Things are good here, I'd be happy for a relative of mine to live here."

There was a regular church service at the home and people could chose to attend. One person told us, "My daughter takes me to Church every Sunday that's important to me."

We found that friendships and relationships were supported but some areas could be encouraged more. One person told us, "I have a friend upstairs so when she comes to the lounge we have a lovely chat but I can't go and see her because I am afraid of lifts." We discussed this with the management team so that they could consider additional ways to facilitate their relationship. A relative told us, "[Person] likes to speak to [their relative] who hasn't been well and so a carer brings in her own mobile phone which has a speaker on it and each Sunday [they] can speak to [her relative]."

People and their relatives told us that they had not seen their care plans, and couldn't recall being involved in care planning. We noted that people were not routinely involved in care plan reviews with most reviews stating 'no changes'. There was some information that indicated that people were involved in planning their care. However one person said, "No, no one talks to me about my care, they just get on with it, never had a meeting that I can remember." Some people signed their care plans to agree for their records to be shared

with other professionals, however there were no records to indicate they reviewed their care plans. We saw that some people`s relatives signed care plans and also had meetings with staff to discuss the content of the care plans, however the outcomes of these meetings were not always recorded and care plans were not updated. This was an area that needed further development.

People were encouraged to maintain relationships with family, friends and partners. Visitors were encouraged and invited to events and staff knew about who was important to people. There were regular events were people could have their family come and spend time with them in the home. For example, a firework party and an upcoming BBQ. Relatives told us that they felt welcome in the home.

People's records were stored securely in order to promote confidentiality for people who used the service.

Good

Is the service responsive?

Our findings

People's care needs were met. One person told us, "I have a shower twice a week and they help me with a strip wash too. I don't like those baths – up and down and across – too scary for me." Another person told us, "I have a shower once a week because that's what I want. They help me." Care was person centred as it was delivered by staff who knew people well.

In most cases, people's care plans were detailed to enable staff to support people appropriately. We also noted that staff knew people very well. However, we noted that the plans did not always include sufficient information for safe and appropriate care to be followed. For example, in regards to size of a sling for mobility and which straps should be used. There were assessments carried out by staff regarding people`s mobility, personal care needs, nutrition and other areas, however one of the care plans we viewed had not been updated and reviewed in regards to a fall. We brought this to the management teams attention.

People told us that they were happy at the home and felt they were receiving good care but would have enjoyed more activities. We noted that people were asked about their interests and hobbies but we could not see how these were incorporated into the scheduling for activities, outings and events. We spoke with an activities organiser who demonstrated a good amount of knowledge about the people they supported. On a noticeboard in the middle of the home but not easily accessible to all were some handwritten notes for a half an hour activity each morning.

Observation during the day indicated that most of the people were very much left to their own devices. We couldn't find any evidence of hobbies and interests being linked to activities within the home. One person enjoyed knitting and knitted little cardigans for the premature babies at the hospital. Most people either brought their own interests with them to fill the time, colouring, crosswords, music, talking books, or they sat in lounges or their rooms dozing and largely unstimulated. One person told us, "I can't go to activities at the moment because I need the toilet and there isn't one close by. I enjoyed the keep fit. They don't really think much about what people would like." Another person told us, "I used to belong to the local Blind Society in Letchworth, they had a bus to take people. I don't know if I could go still. They've never asked me here what I used to do." Following the inspection the provider told us that one person had a keen interest in maps and often remain at the dining table after lunch and sit with staff on their break and look at all the places they had lived and travelled. They told us that they had a collection of maps for the person to look at. However as the person and staff did not tell us about this during the inspection we were unable explore this more during the inspection.

We found that volunteer from the library visited once a month and an additional volunteer visited weekly to play cards with some of the men and spend time chatting with people in their rooms. Also pub lunches were offered for people to enjoy. An exercise class was being enjoyed by a group of people in one lounge. We noted that people in their rooms would have benefited, and maybe a larger group would have joined in, if staff had given them the details of what was on offer and a little more encouragement to participate. A staff member simply said 'Are you coming for activities?' and left it at that when people declined.

The service, at times, supported people at the end of their life. One person had some information documented in their care plan. However, most people did not have any information in place to guide staff on how to support people when they reached the end of their life. We discussed this with the registered manager and a member of the management team who told us that they had only completed this when people were nearing the end of life. We discussed the need to ensure that people had the opportunity to express their wishes while they were able. This was an area that required improvement.

There were complaints documented. We noted that these had been investigated and responded to. One person said, "Well I have complained about the food, sometimes you have to but they haven't done anything, it just varies." Another relative said, "I don't have to make a complaint, if there is a problem we talk to someone and if they can do something then they will." Following our last inspection the registered manager had started a log of all smaller concerns to help them identify any themes emerging so that they could address them prior to a complaint being made.

There were opportunities for people and their relatives to provide feedback through meetings. One relative said, "It seems they have residents meetings and they tell relatives 'if you want to come then you can' but we haven't been." There was also an annual survey which was due to take place shortly. Following the inspection the provider wrote to us and gave examples of where they had listened to people and taken action as a result. They stated, "[Person] stated that the dining room knives are not sharp enough, new knives were ordered and received with 48 hours followed by three compliments on how much easier they were to cut with.[Person] has [visual impairment] and found the dining room lighting a little dim, all nine light bulbs were replaced with 24 hours with two compliments on the change.[Person] received a new electric shaver from [their relative] but was unable to use it as it required a two pin adaptor, this was missing which was understandably frustrating for [person], a new one was purchased within 24 hours. [Person] said that [they] would like some creamy Lancashire cheese and watercress sandwiches, these were purchased and provided within 72 hours." However after this information was provided after the inspection visit we were unable to speak with the people to obtain their views about this.

Requires Improvement

Is the service well-led?

Our findings

When we inspected the service in 2016 we found that following the inspection the provider did not display the rating in the home or on the website. This was a breach of regulation. Following the last inspection on 9 May 2017 we had to prompt the provider to ensure that they correctly the displayed the rating on their website.
Prior to this inspection we reviewed the provider's website to ensure that the rating was displayed clearly showing the service was requiring improvement. We found that the website had been changed since we last reviewed it and it now the information provided for the public was not clear and was misleading.

Therefore this was a breach of Regulation 20a of the Health and Social Act (Regulated Activities) Regulations 2014.

When we inspected the service on 9 May 2017 we found that there were areas of the quality assurance systems that required improvement. At this inspection, we found that the service had made improvements but some areas needed further embedding and development.

There were quality assurance systems in place to help identify and address shortfalls in the home. The management team had embraced monitoring systems and were working on ways to develop them further. However, these systems had not resolved all the issues found at this inspection. This was the third inspection that the service had been rated Requires Improvement.

Quality Assurance systems included internal audits and checks. We found these audits, checks and visits identified where things needed action and the action plans were effective in resolving the issues. By using these audits and sharing the findings and lessons learned with the staff team, the management told us that it had made improvements to the home. For example, a reduction in any discrepancies with medicines.
We also noted that the accident analysis now in place identified themes and trends allowing the management team to implement any actions to mitigate risks. However, we found that this had not identified all issues. For example, a person who had suffered a fall from a hoist had not been recorded on the analysis and therefore no action had been undertaken to investigate the cause or reduce the risk of a reoccurrence. We also found that areas such as involving people in care plans, the recruitment process, end of life care plans and ensuring activity plans were person centred also needed further development. In addition there were other areas, such record keeping in regards to fluid intake, overview of staff training to allow for planning and monitoring and ensuring that the service consistently applied the principles of the MCA 2005, that still needed to be developed further.

We noted that some areas were on the registered manager's internal action plan and progress was being made but not all areas had been fully achieved as yet. This included issues from previous inspections, shortfalls found at the local authority monitoring visit and findings from internal audits and checks. However, the registered manager and the team leader were committed to learning and developing new systems to help ensure that their monitoring was robust and able to identify any shortfalls or areas for development in the home.

People and their relatives were positive about the registered manager and how the home ran. One person said, "Yes it's [registered manager's name] and she's very kind but I can't understand most of what she says." A second person told us, "The manager is [name] and it's hard to understand her but she is very helpful. I needed some skirts and she sorted it all out for me." People were also positive about the providers. One person said, "[Provider] is here a lot, he's always decorating or sorting things out in the home." Another relative told us, "[Provider's names] own the place and [provider] comes and has a chat with everyone every week to see how things are going."

Staff told us they felt that the management team were supportive. One staff member told us, "Any problems you can go to [registered manager]."Another staff member said, "The management here is very good, if something is wrong, they fix it."

We noted that there was leadership in the home, with the team leader and deputy manager supporting the registered manager. Staff told us that they provided support and guidance. We were told that the registered manager walked around the home, checking on people and standards and guiding staff on a regular basis. One staff member said, "Things are fine here, we all know what we are meant to be doing."

The service worked in partnership with other agencies to help ensure people received the appropriate support. We noted that there was contact with the local authority who had a contract with the service to provide a beds for people. There was also contact with a local providers support agency who assisted the service with training. We discussed the benefits of contact with these organisations.

Providers of health and social care are required to inform the Care Quality Commission, (CQC), of certain events that happen in or affect the service. The registered manager had informed the CQC of significant events in a timely way which meant we could check that appropriate action had been taken.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider did not ensure robust recruitment processes were followed.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The rating was not displayed in a way that was clear and not misleading.

The enforcement action we took:

We issued the provider with a fixed penalty notice.