Bupa Care Homes (CFChomes) Limited

Cold Springs Park Care Home

Inspection report

Cold Springs Park
Penrith
Cumbria
CA11 8EY

Tel: 01768890360

Date of inspection visit:
20 September 2016

Date of publication:
16 January 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This comprehensive inspection took place on 20 September 2016 and was unannounced.

At our last comprehensive inspection of this service in September 2015, we found breaches of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to safe care and treatment and good governance. We asked the provider to send us a report to tell us what action they were going to take. We did not take formal enforcement action at this stage.

We carried out a focused inspection in January 2016 and found continuing breaches of these regulations. We also found breaches in relation to staffing relating to the competencies and skills of staff and notifications of other incidents of the Care Quality Commission. These matters were dealt with outside of the inspection process.

Following that inspection the service was rated as inadequate and placed in special measures. We also issued three Warning Notices. A Warning Notice tells a registered provider or a registered manager that they are not complying with a regulation.

We undertook a further focused inspection in May 2016 to check that the registered provider had complied with the requirements of the Warning Notices. During the inspection we found that the registered provider had met the requirements of the Warning Notices in relation to the previous breaches of the regulations. However, we also found new concerns relating to breaches of other regulations in relation to Regulation 9 – Person Centred Care, Regulation 11- Need for Consent and Regulation 14 – Meeting Nutritional and Hydration needs of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection of 20 September 2016, everyone we spoke to about Cold Springs Park was very positive about the improvements to the service and the current situation at the home, including the management arrangements. However, we found areas where further work was still required.

We have judged that the overall rating for the service is Requires Improvement and in line with our guidance, the service will no longer be in special measures. Although some breaches in the regulations had been addressed some concerns still remained. We need to be confident that the registered provider can demonstrate consistent good practice over time. We will check this again during our next planned comprehensive inspection.

Cold Springs Park Residential Home (Cold Springs Park) is located in the town of Penrith and is owned by BUPA. The home provides residential care for 60 elderly people and is divided into two units, Cold Springs unit and Spring Lakes unit. Spring Lakes unit supports people living with dementia.

There was a registered manager employed at the service. A registered manager is a person who has registered with the Care Quality Commission (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 2008 and associated Regulations about how the service is run.

During our inspection of this service we received positive feedback from visitors and from people who used this service. One person told us; "This is lovely place. The girls (staff) are very nice to me." Another person said; "I am looked after very well thank you."

Visitors to the home also commented on the better standard of care they had experienced and the improvements they had noticed at the service since the appointment of the registered manager.

We found that staff had been provided with training updates since our last visit to the service. Staff had also received support and supervision from their line manager to help ensure they understood and carried out their roles safely. There were times when appropriate staffing levels were not maintained but these had improved recently and new staff were being recruited. We have made a recommendation about the induction and support of agency workers at the service.

The information we held about the service and information we received from health and social care professionals showed that there had been a significant number of accidents and incidents at the home. We looked at a sample of risk assessments and mobility plans for people who used the service. Information designed to keep people safe was not always accurate or sufficiently detailed.

Following our inspection, the registered manager carried out an analysis of the accidents and incidents that had occurred at the home over the last year. The registered manager sent us a copy of the findings together with a plan of what actions would be taken to help reduce the risks of further incidents. We have made a recommendation that the service considers current guidance about supporting people who have been identified as being at risk of falling and takes action to update their practice accordingly.

We looked at the way in which medicines were managed at the home. The sample of medication administration records we checked were accurately completed and we could see that people had been given their medicines correctly. There were minor issues about the way in which "when required" medicines were managed. Not everyone had a clear plan to help staff understand when and why these medicines should be used. We have made a recommendation that the service considers current guidance on the use of "when required" medicines and takes action to update their practice accordingly.

There were some concerns regarding the cleanliness of areas of the home and the protocols for managing infection control and prevention. Housekeepers had been provided with appropriate training and told us that they were provided with suitable cleaning equipment and materials. However, there were discrepancies in the understanding of cleaning procedures within the housekeeping team. We observed some poor infection control practices within the staff team, particularly with regards to the use of protective clothing.

We reviewed the records in relation to the Deprivation of Liberty safeguards (DoLS) and the Mental Capacity Act 2005 (MCA). Protocols had generally been followed and applications had been made appropriately by the registered manager. However, we noted that there were gaps in the knowledge of some of the care staff with regards to mental capacity assessments and best interest agreements. The principles of the MCA had not been followed with any consistency.

Mealtimes at the home had been reviewed and observed to help identify what worked well and where the service could improve the dining experience for people who used this service. People were supported with eating and drinking in a dignified and discreet manner by staff when needed. However, where people had

been identified at risk of malnutrition, we found that their food and fluid intake records had been poorly completed making it difficult to tell whether they had received sufficient food and drink. We have made a recommendation that the service finds out more about training for staff based on current best practice, in relation to supporting people with their nutritional needs, particularly people living with dementia.

Everyone living at Cold Springs Park Care Home had a plan of their care and support needs. We found in the sample we reviewed, that although personal preferences had been recorded, staff did not always respect people's individuality.

We found breaches of regulation in relation to:
Regulation 11 Need for Consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The human and legal rights of people who used this service were not protected because staff did not have a good working knowledge of the principles of the MCA 2005 and DoLS.

Regulation 9(1)(a)(b) Person centred care of the Health and Social Care Act 2008 (Regulated Activities) 2014 in relation to providing care that is appropriate and meets people's needs.

Regulation 17 Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the systems in place had not fully identified and addressed the impact on the wellbeing and continued safety of people who used this service.

You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Staff had been provided with training to help ensure they understood how to recognise and report safeguarding concerns.

People who used the service were not always supported in a safe way with their mobility needs or when they had suffered an accident.

Although medicines were generally managed safely, there was an inconsistent approach to the management of "when required" medicines. This meant that people may not always have received their medicines as their doctor had prescribed.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had received some training to help keep their skills and knowledge up to date. They also met regularly with their line manager to discuss their work and personal development needs.

Staff had gaps in their knowledge and application of the principles of the Mental Capacity Act 2005 and the Deprivation of Liberty safeguards.

There was an inconsistent approach in supporting people, identified at risk, with their nutritional needs.

Is the service caring?

Good

The service was caring.

People who used the service were treated with kindness and respect. Interactions with staff were observed to be warm and friendly.

People were supported with their personal care needs by staff who recognised the importance of privacy and dignity.

People coming to the end of their lives were appropriately supported by staff and external health care professionals.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care records and care plans were mostly up to date and written to reflect people's personal preferences. However, we saw that people did not always have their needs met as they would have preferred.

Group social activities and entertainment were provided but there were limited opportunities for people to pursue their individual hobbies and interests.

People who used the service and their relatives knew how to raise concerns and complaints. However, none of the people we spoke to had ever needed to complain.

Is the service well-led?

Requires Improvement

The service was not always well led.

Staff working at the service and visitors to the service told us that they had noticed improvements to the way in which Cold Springs Park operated since the new manager had been in post.

There were quality assurance systems in place but these were not always consistently applied. These shortfalls compromised the safety and quality of service.

Cold Springs Park Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 20 September 2016 and was unannounced.

The inspection was carried out by a two adult social care inspectors.

Before the inspection we reviewed the information we held about the service. This included the registered provider's service improvement plan, the action plan for previous requirement notices and information shared by the local authority quality manager and commissioners. We also looked at the information we held from notifications sent to us about incidents affecting the service and people living there.

During the inspection we spoke with the regional support manager for BUPA care services, the registered manager, the deputy manager, unit managers, five staff members, three people who lived at the home and four visitors. We looked at records relating to medications for four people, records of accidents and incidents in the home and care records for seven people who used this service. We looked at a sample of the records relating to staff recruitment and supervision. We reviewed the quality audits carried out by the provider and records relating to the maintenance and safety 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 to us.

Requires Improvement

Is the service safe?

Our findings

One of the people who used this service told us; "The girls (staff) are very nice, although I don't know a lot of them. The old ones have left and there are a lot of new girls now."

A regular visitor to the home said; "This is a good place now. The staff are great." Another visitor added; "I am more than happy with the home. The staff are really good and I cannot fault the place."

We checked the information we held about the service. We noted that there had been a reduction in the number of potential safeguarding incidents reported to us. The local authority also reported that they had not received any new complaints and they told us that safeguarding referrals were being made appropriately.

We looked at a sample of staff training records. These showed that staff had been provided with updated training with regards to safeguarding adults and keeping people safe. When we spoke with staff, they confirmed that they had undertaken this type of training recently and were able to give us an overview of the reporting processes.

The information we held about the service also showed that there had been a significant number of incidents where people who used the service had fallen. We were told by the local authority and we saw from the records we reviewed during the inspection that support from health care professionals had been sought. However, some of the falls had been unwitnessed and although people had been checked over by care staff and helped up from the ground, professional medical assistance and checks had not always been obtained. This meant that people who used the service had been placed at risk of receiving unsafe care and treatment.

We looked at a sample risk assessments and mobility plans that had been placed in the care records of people who used this service. Although they had mostly been reviewed and updated, the information recorded was not always sufficiently detailed or accurate. The care plans of one person recorded them as suffering from "dizzy spells" when standing. However, this information had not been included in their falls risk assessment even though they had been identified as being at high risk of falling. Another person had been reviewed by an occupational therapist. The therapist had left clear information as to how this person should be supported with their mobility. When we checked their care plans we found that this information had not been included and that the plan referred to the use of inappropriate equipment. This meant that staff did not have the most up to date information and guidance to help them support people safely.

We reviewed a sample of the accident and incident records that had been maintained at the home. The information sampled corresponded with people's care records and with the information we held about the home, giving an accurate account of events involving people who used the service.

We recommend that the service considers current guidance about supporting people who have been identified as being at risk of falling and takes action to update their practice accordingly.

We found that people who used the service had personal emergency evacuation plans in place and these had recently been reviewed and updated. The fire safety risk assessment for the home had been reviewed and where shortfalls had been identified, an appropriate action plan had been developed with timescales for completion.

On the day of our inspection there were a sufficient number of staff on duty to meet the needs of the people who used the service. We noted that call bells were answered promptly and people did not have to wait long for assistance from staff.

The staff we spoke to during our inspection commented about staffing levels. One person said; "We have been short at times but we usually manage to cover." Another told us; "We have been thin on the ground but there are new staff being recruited." Although staff commented on the staffing levels, no one who used the service, who we spoke to, raised this as an issue.

We reviewed the recruitment processes in place at Cold Springs Park. We found that there were robust systems and checks in place, including consideration of criminal records. This helped to make sure only suitable people were employed to work at the home.

We reviewed the medicines and medicine administration records of some of the people who used the service. We spoke to the registered manager and the senior carer who was responsible for medicines administration on the day of our visit.

We found that medicines had been safely stored. Most medication records were clear, complete and accurate and it was easy to determine that most people had been given their medicines correctly. However, we found minor issues about the way in which "when required" medicines were used. There was an inconsistent approach as to how these medicines should be managed and administered. Not everyone had a clear plan to help ensure staff understood when this type of medication should be offered or administered. This was of particular concern as some of the people who lived at the home were unable to recognise or communicate their needs.

We recommend that the service considers current guidance on the use of "when required" medicines and takes action to update their practice accordingly.

We observed that some areas of the home were not kept in a clean, fresh and hygienic condition. We observed that staff did not consistently demonstrate effective infection control and prevention practices. For example, protective clothing was not always worn by staff when necessary and this raised the risks of cross contamination.

We spoke to the housekeepers on duty at the time of our inspection. They told us that they were provided with appropriate cleaning materials and equipment. They confirmed that they had been provided with training that directly related to housekeeping tasks. However, there were discrepancies in the knowledge and understanding of cleaning procedures within the housekeeping team.

Staff at the home did not consistently follow good infection control and prevention practices. Some staff were not clear about their roles and responsibilities. We spoke to the registered manager about these matters as they compromised the cleanliness of the home and the prevention and control of infection.

We have also considered the impact around the oversight of PRN management and infection control protocols later in this report under the domain of well led.

Requires Improvement

Is the service effective?

Our findings

One of the people who used the service was having breakfast in their room at the time of our inspection visit. They told us that the "food is very nice."

A relative commented; "They try their best to accommodate my relative's wishes, they have even made them special meals as an alternative to what was on the menu." Another visitor to the home told us; "My relative is eating much better now. They have started to put weight on. The food is great."

Health and social care professionals told us that there had been some concerns about how food and fluid intake had been monitored and recorded. However, they also said that they had noted some improvements to this recently.

Since our last visit to the service in May 2016, staff had been provided with training and support in the following topics: Mental Capacity Act, safeguarding, infection control, nutrition and hydration and risk assessment. The staff we spoke to during our visit confirmed that they received training to help keep them up to date and to work safely. They also told us that they received regular support and supervision from their line managers. We reviewed a sample of the staff training and development records. They confirmed what we had been told by staff and the registered manager.

One member of staff told us; "I attend training when I have to. Most recently I have had updates on infection prevention and moving and handling. We are not allowed to use any equipment until we have had specific training on how to use it properly."

We saw that a recently recruited member of staff was in the home on the day of our visit. They told us that they were 'shadowing' an experienced member of staff as part of their induction training.

We also spoke to an agency worker about their induction for working at Cold Springs Park. They told us that they had received some training via the agency they worked for. However, they also said that they had not received any information about working at this home, including information about service user needs or emergency procedures such as fire evacuation procedures.

We recommend that the service seeks advice and guidance from a reputable source and takes action to ensure agency workers are provided with effective induction and support whilst working at the service.

We checked whether the service was working within the principles of the MCA. 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 so that they can 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 registered manager told us about the applications that had been made for some of the people who used the service, in relation to DoLS. We reviewed a sample of the applications and found that they had generally been completed appropriately. We found one omission regarding the covert administration of medicines. We discussed this with the registered manager, who addressed this matter and amended the application. At the time of our inspection, the outcome of the applications had not been determined. The registered manager was aware of the requirement to notify CQC of the outcomes, when known.

Although we had been told that senior staff had received some training in relation to the MCA 2005, when we reviewed care records we found that the principles of the MCA 2005 were not followed with any consistency.

A DoLS application had been made for one person without carrying out a mental capacity assessment. The same person had a record of a decision being made in their best interests. This was regarding the use of bed rails. There was no evidence to support that this person had fallen out of bed or that the use of bed rails was the least restrictive method of keeping them safe.

We observed a senior carer carrying out a MCA 2005 assessment for another person who used this service without the person being there. The senior carer said to us; "I am doing a Mental Capacity Assessment thingy if you can't find it in their records."

We spoke to the manager about these observations at the time of our inspection as they indicated that some staff did not fully understand the principles of the MCA 2005.

This was a breach of Regulation 11 Need for Consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The human and legal rights of people who used this service were not protected because staff did not have a good working knowledge of the principles of the MCA 2005 and DoLS. You can see what action we told the provider to take at the back of the full version of this report.

At our last inspection of the home, we found that the provider had not complied with this regulation. This was because care and treatment had not been provided with the consent of the relevant person.

At our last inspection of Cold Springs Park Care Home, the provider was not meeting people's nutritional needs. Specific management plans were not in place to help manage the risks of continuing weight loss. The records we looked at for recording the food and fluid intake of people had been poorly and inaccurately maintained.

We checked that the provider had made improvements to the way in which people had been supported with eating and drinking. We found that the service had carried out reviews of the dining room experience for people who lived at Cold Springs Park.

The reviews had included observations of mealtimes including people using the service and the support they received from staff. The observations had identified what had worked well and where the service could and had, made improvements to the dining experience.

We observed staff supporting people with eating and drinking during our visit to the home. Staff provided help where needed and in a dignified and discreet manner. We saw that people were offered choices and that they were given time to make their decisions about what they would like to eat and drink.

Although we found that improvements had been made to the ways in which people were directly supported with their nutritional needs, there were still areas where further work was needed, particularly with regards to monitoring people's nutritional and hydration needs accurately.

We reviewed the nutritional records of some of the people that used the service. We found that people had received an assessment of their nutritional needs. Where risks had been identified, care and support plans had been developed with input from the dietician or speech and language therapist. The nutritional intake records that we reviewed did not reflect that staff always followed the guidance recorded in care plans. Food and fluid intake diaries had been poorly completed and it was difficult to tell how much someone had eaten or drank. There were inconsistencies in relation to monitoring people's body weights. In the sample of records that we reviewed, we found that one person had not always had their weight checked weekly even though this had been recorded as a need in their care plans and they had been identified as being at risk of poor nutritional intake. However, people told us that they were satisfied with the food and the records we reviewed showed that people were being supported to maintain their body weight.

We recommend that the service finds out more about training for staff based on current best practice, in relation to supporting people with their nutritional needs, particularly people living with dementia.

Good

Is the service caring?

Our findings

During our inspection of the service we received positive feedback from visitors and from people who lived at Cold Springs Park Care Home.

One person told us; "This is lovely place. The girls (staff) are very nice to me." Another person said; I am looked after very well thank you."

Visitors to the home also commented on the standard of care they had experienced.

One person, whose relative was coming to the end of their life said; "My relative has been looked after very well. The home has made sure their pain has been well managed and they have had support from our GP and district nurses. Staff have ensured my relative's skin has been looked after beautifully, they (the relative) have no pressure sores or anything like that."

Another visitor told us; "I cannot fault the care. My relative tells me the staff are good and kind to them. They do try their best to accommodate and I am more than happy with the service."

We spoke to two members of staff who were supporting people with behaviours that could at times become challenging. Prior to these conversations with staff we had reviewed the care records of these people. We found that the staff were very knowledgeable about the specific needs and support requirements of these people.

Staff were able to tell us how they supported people during episodes of distress, whilst protecting their privacy and dignity. We observed a member of staff directly supporting one person. This person had limited verbal communication skills, but the member of staff was very familiar with their communication methods and was able to support this person in a timely and effective manner.

We observed that people were generally treated with respect and dignity, although we did see one or two incidents where people could have been supported better by staff. We brought these matters to the attention of the registered manager at the time. We observed that they were dealt with quickly and appropriately in order to protect and promote people's dignity.

We carried out a SOFI over part of the lunchtime meal. We observed good, meaningful interactions between staff and the people they were supporting. Staff supported people with respect and warmth. People were encouraged to eat and drink independently wherever possible with staff giving verbal prompts when necessary.

People were supported with their personal care needs discreetly and promptly by staff. We heard staff providing explanations to people who used the service, particularly where moving and handling equipment needed to be used or where people became disorientated and confused. We noted that this had a positive effect and helped to reduce people's anxieties.

Requires Improvement

Is the service responsive?

Our findings

One of the visitors we spoke to during the inspection told us; "My relative is much more active and sociable since they came to live here. I have no complaints about the service."

The people we spoke to during our inspection of the service told us that they had never had to make a complaint. They told us that they knew who to speak to if they had "cause for complaint" and people knew that there was a formal process in place should this be needed.

We reviewed the care records of some of the people that used this service. We found that they were generally up to date and written in a person centred way. However, some of the care we observed and information recorded in people's daily notes demonstrated that care was not always delivered in a person centred manner by staff.

We observed one person walking around, looking unwell and dishevelled. They told us that they had "not slept well" because it had been "too noisy." We visited their room and reviewed their care plan. It was obvious from the condition of their room and bathroom, that this person had experienced an issue with their continence. We noted that they had not received any assistance with their personal care needs, even though their care plan recorded that they needed help. We also found that they had been unable to summon assistance because their call bell had been disconnected.

We looked in more detail at their personal care support plans and daily notes. The daily records showed that this person received frequent support with their continence needs. However, the level of support required was not accurately described in their care plans. Personal preferences regarding bathing and washing had been recorded in their care plan, but the daily notes showed that these preferences had been disregarded. This person had not received support that met their individual needs.

Cold Springs Park had introduced a "Resident of the Day" programme. Each day a different person was allocated as resident of the day. This meant that over the course of the month everyone who used this service should have had their care records and needs reviewed and updated in order to reflect their individual needs and choices.

The registered manager told us that care plans were audited prior to being the resident of the day so that any actions, concerns or changes could be discussed with the person or their relative (if they chose to be involved).

One of the care records we reviewed belonged to the person who had been "Resident of the Day" the day prior to our inspection. We found that gaps in their care planning had not been identified and the care plan had not been updated to reflect any changes in needs. There was specific guidance in care plans to help staff provide the individualised support this person needed. However, the daily records did not reflect that this support had been provided as the person wished. Additionally the daily records of this person did not accurately reflect an incident that we had brought to the attention of the registered manager during our

inspection. We also noted that this person enjoyed 'music and mixing with other people' but we did not observe that they were assisted to attend the singing and games in the dining room during the morning.

At our last inspection of the service the provider had not been meeting this regulation. Although the provider had made some improvements with regards to identifying and recording people's specific needs this was a continuing breach of Regulation 9(1)(a)(b) Person centred care of the Health and Social Care Act 2008 (Regulated Activities) 2014 in relation to providing care that is appropriate and meets people's needs. You can see what action we told the provider to take at the back of the full version of this report.

In the sample of care records that we reviewed during the inspection, we found that people (or their relatives) had been asked about their hobbies and interests. The details had been recorded in people's admission assessments but this information had not been included as part of their individual care plan development to help ensure their social and leisure needs were supported.

During the inspection we observed staff entertaining some of the people who lived at Cold Springs Park by playing games or singing. Not everyone wanted to participate but were able to watch what was going on if they wished. We noted that there was an activities programme planned. On the day of our inspection visit we observed that there was a church service available in the home if people wished to attend this and in the afternoon musical entertainment had been provided by a local musician. However, we also observed that there was limited support and planning for people's individual interests and hobbies.

We reviewed that complaints and compliments records kept at the service. Where complaints and concerns had been raised, we were able to see that the registered manager had responded and dealt with the issues appropriately. In addition to the complaints, we noted that there were equally as many compliments about the service.

Requires Improvement

Is the service well-led?

Our findings

One of the visitors that we spoke to during our inspection said; "My relative has been here two years. Things have much improved at Cold Springs Park since the new manager took over. The manager is very approachable and the staff are lovely."

Another visitor told us; "The home is really good now. It's better since the new manager came. I can't fault the place."

The staff we spoke to during the visit described the registered manager as "very supportive" and one particular member of staff commented; "The manager has started to turn this place around for the better."

People who used the service and their relatives, were able to comment on the service and provide feedback regarding their views and experiences. Resident and relative meetings were held at the home and people had been asked to complete satisfaction surveys. We looked at a sample of the surveys that had been returned and noted the feedback to be good.

The registered manager showed us some of the work and checks that were being undertaken, with regards to the safety and quality improvement at the home.

The home's fire risk assessment had been reviewed and updated. The general fire safety records were in the process of being reviewed to check that they were accurately completed and up to date. Staff fire drills had been carried out. However, both staff and the registered manager commented that these had not been carried out as successfully as they should have. The person responsible for organising fire drills told us about the plans for further drills to help ensure staff would be competent and confident should an emergency situation arise.

We also asked the registered manager to carry out an analysis of the number of falls, accidents and injuries that had occurred at the home over the last year. The registered manager completed this work after the inspection and sent us a report of the findings. The report included details of the actions that had been taken in order to mitigate risks of further incidents and accidents.

We saw evidence to confirm that staff were supervised in their work. Staff told us that they felt better supported with their role at the home. We observed some gaps in their practices during our inspection of the service. We spoke to the registered manager and showed her examples of where standards had fallen short.

We found evidence to confirm that the standard and quality of the service had, and continued to improve. However, during this inspection we also identified some areas where the registered manager was not fully meeting the requirements of the regulations.

The shortfalls included poor auditing and management of nutrition and hydration. Additionally, although care plans had been written in a person centred way, we observed that staff failed to consistently provide

care and support in line with people's personal preferences and expectations.

There were also minor issues with the management and oversight of 'when required' medicines (PRN) and the consistent application of infection control protocols.

Although some improvements had been made, there was a breach of Regulation 17 Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the systems in place had not fully identified and addressed the impact on the wellbeing and continued safety of people who used this service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not receive care and treatment that was person centred or that reflected their needs and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The human and legal rights of people who used this service were not protected because staff did not have a good working knowledge of the principles of the MCA 2005 and DoLS.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems in place had not fully identified and addressed the impact on the wellbeing and continued safety of people who used this service.