Knights Care Limited

Abbey Court Care Home - Leek

Inspection report

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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?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

The inspection took place on 22 and 23 May 2018 and was unannounced. Abbey Court Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. It can accommodate up to 52 people in one adapted building, split into two floors with one unit on each floor. There were 42 people using the service at the time of our inspection.

There was a registered manager in post 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.

At this inspection we identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

People were not always protected from alleged abuse as incidents had not always been reported to the local safeguarding authority.

Quality assurance systems in place had failed to identify some issues and timely action had not always been taken. Some staff felt the system the care plans were recorded on was not always ideal.

The management of medicines was not always safe; however they were being stored appropriately. We have made a recommendation that best practice guidance is considered in the management of medicines.

Risks were not always assessed and planned for, such as for people with behaviour that could challenge. Also, plans did not always have sufficient detail about people's specific health conditions. More robust care plans for people coming towards the end of their life were needed. Consideration had been given to support with protected characteristics but further work was required.

The principles of the Mental Capacity Act 2005 (MCA) were not always being followed as an appropriate level of detail was not always recorded, a person without the legal authority had signed consent and reviews had not always taken place.

We saw one person was not supported appropriately with their drinks which left them at risk. However, we saw many other people who were supported appropriate with their food and drink. People enjoyed the food and had a choice.

Staff felt supported and received training to support people effectively; however, improvements were needed to ensure all potential safeguarding concerns were reported appropriately.

People did not have to wait long for support. Staff had mixed views about staffing but action had been taken by the registered manager and provider to try to improve this.

People felt safe and staff had appropriate checks to ensure they were suitable to work with the people who lived in the home. People also felt the staff were kind and caring and that they were treated with dignity and respect. People were encouraged to be independent and make choices about their own care. People could choose where to spend their time and visitors could come at any time.

Accidents and incidents were monitored by the registered manager to reduce the likelihood of them reoccurring.

People were helped to keep healthy and well as infection control measures were followed. People were supported to access other health professionals when appropriate.

The building was adapted to meet people's needs with a pleasant environment, with further improvements planned. People were also supported to partake in activities.

People, relatives and staff felt the management team were approachable and could go to them if they needed to. They were asked for their opinion, sometimes in a meeting or on a survey, in order to improve care and support and feedback was acted upon. People were able to complain and complains were investigated and responded to.

The registered manager had notified the CQC about events they were required to by law, such as if someone had passed away in the home, and the rating was clearly being displayed as required.

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 were not always protected from alleged abuse.

Risks were not always assessed and planned for.

Lessons had not always been learned.

Medicines were not always managed safely.

People were protected as infection control measures were in place.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staffs had training and were supported in their role, but improvements were required to ensure training was acted upon.

The principles of the Mental Capacity Act 2005 were not always being followed.

Care plans for health conditions sometimes lacked detail and health advice was not always followed.

People enjoyed the food and were offered a choice.

The building was appropriately adapted and maintained with further works planned.

Is the service caring?

Good

The service was caring.

People told us the staff were kind and caring.

Staff knew people well and supported people in a caring manner and in a way to promote independence.

Privacy and dignity was respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

More personalised guidance for people nearing the end of their life was needed.

People and relatives were involved in care plans and reviews but plans did not always contain enough information.

There were activities available for people to partake in.

People could complain and complaints were investigated and responded to.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Quality assurance systems were in place but they did not always identify issue and timely action was not always taken

People and staff felt the management were approachable and the registered manager felt supported by the provider.

Meetings were held with people, relatives and staff and improvements made if suggestions are made.

Notifications were submitted and the CQC rating was clearly being displayed.

Abbey Court Care Home - Leek

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.

The inspection took place on 22 and 23 May 2018 and was unannounced. The inspection was carried out by two inspectors.

We looked at information we held about the service including statutory notifications submitted. Statutory notifications include information about important events which the provider is required to send us by law. We also asked commissioners and Healthwatch if they had any information they wanted to share with us about the service. Healthwatch is an organisation that gathers information from people and relatives who use services and provides feedback to commissioners and regulators (like the CQC) about those services. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with six people who used the service, three relatives, six members of staff that supported people and two professionals that have contact with the people who use the service. We spoke with the provider, registered manager, deputy manager and the clinical lead. We also made observations in communal areas. We reviewed the care plans for seven people who use the service, as well as medicine records and looked at management records such as quality audits. We looked at recruitment files and training records for two members of staff.

Requires Improvement

Is the service safe?

Our findings

People were not always protected from the risk of abuse. One person had made allegations about potential financial abuse which was recorded by staff however this was not reported to the local safeguarding authority and there was no evidence that this had been investigated by the home. When we spoke to the registered manager about this they told us they would expect staff to tell them about concerns or it would be picked up from the care notes, however this had not happened. Another person had made a complaint about a member of staff which was a safeguarding concern; the registered manager took action as a result of this allegation however it had not been reported to the local safeguarding authority and the investigation had not yet been documented. Staff could tell us about the different types of abuse, the signs to be aware of and what action should they take if they felt someone was being abused. There was an appropriate safeguarding policy in place. This meant that despite staff recognising abuse, this had still not enabled concerns to be reported to the local authority and systems had not identified this which could put people at continued risk of alleged abuse.

These issues demonstrated a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks were not always assessed and planned for. Despite this, one relative said, "My relative was off their feet but now they have people around them they've got their confidence back and are walking now." However, other risks, such as behaviour that may challenge the service was not always assessed and planned for. For example, one person could become unsettled and would try to leave the home which would not be safe for them. Staff gave differing accounts of how best to support the person. This left the person at risk as they may not receive support in a way that would address the causes of people's anxiety. Another person had behaviours towards members of staff. One member of staff said, "I found out [about the person's behaviours] when they tried to grab me." This behaviour was not identified in their care plan and this left people at risk of receiving inconsistent support or members of staff at risk.. Another person had behaviour that sometimes challenged, including physical and verbal abuse and aggression and refusal of care. Their care plan acknowledged this but did not include any information to help staff understand the person's behaviour or how they should respond to support them. This meant people were at risk of receiving inconsistent care. Following our feedback, the registered manager put plans in place regarding people's behaviours to support staff.

People could not be assured that their medicines would be managed and administered in a consistently safe way. Medication Administration Records (MARs) are documents which record what medication a person needs and records when the medicine was administered by staff. MAR notes included information about how people could drink, and if they needed altered textures such as thickened fluids. Medicines were prescribed for generic times; morning, breakfast, lunch, tea and bed. Actual times medicines were given were not recorded, except for PRN medicines. A nurse told us that breakfast medicines usually took one and a half hours to complete, finishing between 09.30 and 10.30. Lunch time medicines began at 13.00. This meant there might be a gap of only two and a half hours between two doses of a medicine, when there should be a minimum of four hours. The nurse said they were aware of the need to space doses of some

medicines such as antibiotics and pain relief and would remember when the previous dose was given and give the next dose later, allowing the required amount of time between doses. However, if a different member of staff was to administer the medicines or following a shift change, they would not know when the last dose was administered. We recommend the National Institute for Health and Care Excellence (NICE) best practice guidance for 'Managing Medicines in care homes' is taken into account when recording the administration of medicine.

Prescriptions for topical creams and lotions were on a separate MAR, known as a Topical Medication Administration Record (TMAR) and stored in a separate trolley. We saw examples of TMARs which showed consistent application of topical medicines however some had gaps or the application did not match the guidance. For example, one person's gel should be applied up to three times per day. However, there were multiple days when this was recorded as being applied four times in a day. There were other occasions when it had only been applied once in a day but there was no record that the gel had been offered to the person on the other two occasions. In another example, we saw that someone had been prescribed a cream and a note stated the course had been completed on a particular day. The TMAR recorded that the person had had it applied on a further three occasions after this date. Therefore, we could not be sure that people were always having their topical medicines as prescribed. Improvements were needed to ensure the consistent recording of the administration of topical medicines.

We observed that staff supported people the way they preferred, handing medicine pots to some people, putting tablets in people's hands or for other people or putting individual tablets into people's mouths using spoons. We saw the staff administering the medicines would sign to record that a medicine had been given. If medicine is prescribed to be given 'as and when required' it is called PRN medicine. If someone has PRN medicine there should be a PRN protocol in place which helps staff to identify when the medicine should be given. We saw that PRN protocols were now in place and when the oral medicine was administered it was recorded on the reverse of the MAR. We observed staff offering people their PRN medicine and only prepared it when a person wanted it.

Medicines were stored in locked trollies, a fridge or cupboards in a dedicated, locked room. Some medicines need to be refrigerated or kept at a particular temperature in order to ensure it remains effective. This meant that refrigeration equipment needs to be maintained and kept at an appropriate temperature. The temperature of the room and fridge was checked and recorded daily to ensure storage was maintained within safe temperature ranges.

Controlled drugs (CDs) are prescribed medicines that are often used to treat severe pain and they have additional safety precautions and requirements. There are legal requirements for the storage, administration, records and disposal of CDs. We saw the records had always been signed by two members of staff and they were stored appropriately. This showed us the service managed CDs in a way that met the legal requirements.

People told us, and we saw, that there were enough staff to meet people's needs. One person said, "I ring the bell, they (staff) always come quickly." A relative said, "Yes there is enough staff. They'll come and talk to [relative's name]." We observed there was always at least one nurse or carer in the communal lounges or dining rooms and people were quickly able to attract help. Staff had time to talk to people, sometimes sitting down next to them and talking about various topics people appeared to enjoy. However, staff gave us mixed feedback about staffing. One member of staff said, "Staffing has got better recently." Another told us the staffing was 'OK'. However, comments from other members of staff included, "Upstairs needs more staff. The nurses are counted in the numbers but they are too busy to help." Another staff member commented, "There's not enough staff as they count nurses in the numbers." They went on to explain, which the

registered manager and provider also confirmed with us, that an additional member of staff was introduced on a 'twilight' shift to assist which had improved things. This meant action had been taken to try to improve staffing levels and people did not have to wait long for support.

People and relatives told us they felt the home was safe. One relative said, "It was my relative's decision to stay here, they were too frightened to go home and they felt very safe here." The home had learned from accidents and incidents. For example, when someone had fallen the incident was recorded, analysed and action taken to reduce the likelihood of it reoccurring. We saw that staff were recruited safely. Staff files we viewed included application forms, records of interview and some references. Records showed that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure people were suitable to work with vulnerable adults. Records seen confirmed that staff members were entitled to work in the UK as their identity had been checked. This meant that people were supported by staff who were suitable to work with vulnerable adults.

The service followed infection control measures to help keep people healthy. One person said, "It's nice and clean. They clean every day and move the furniture and clean in the corners [of the room] too." The premises were clean and there were no unpleasant odours. Bathrooms and toilets were equipped with soap dispensers, paper towels and were clean. The sluice room was also locked so people did not have access to it unnecessarily. A nurse discussed the role of staff in preventing and controlling infection, emphasising appropriate hand washing and use of personal protective equipment (PPE). They also talked about how waste was disposed of in colour coded bags with contaminated waste being 'double bagged.' There was also an appropriate 'Infection Control' policy in place and staff received training in this area.

Requires Improvement

Is the service effective?

Our findings

Staff told us they received training and support to care for people effectively. However, there had been an instance of potential safeguarding concerns which staff had recorded but it had not been reported appropriately. Despite this, staff told us they felt appropriately trained and supported. One member of staff said, "I'm definitely supported." We saw staff had received training in areas such as moving and handling, fire and food safety and dementia. One member of staff told us they had their medicine competency checked, they said, "The deputy manager spot checks the staff and does observations on medicines." Staff were also supported to have supervisions in order to discuss their work. One staff member said, "I definitely have supervisions and I am definitely supported." This meant staff were supported in their role to care for people effectively however further improvements were required to ensure staff acted upon their training to ensure all potential safeguarding concerns were reported.

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. A person who has Lasting Power Of Attorney (LPOA) has the legal right to make decisions and sign agreement on behalf of someone who has lost their capacity to make their own decisions. We saw an example of a relative signing consent on behalf of a person who no longer had capacity. This consent was about their end of life wishes, consulting professionals, information recorded and photographs being taken; however they did not have the legal right to sign consent on their behalf. We saw other examples that LPOA had been considered and copies were on file as evidence that relatives or representatives had the legal right to make decisions on behalf of people.

Mental capacity assessments were completed to help determine if someone was able to make a specific decision, but these were not always reviewed. For example, one person had been assessed as having capacity to choose where they lived in July 2017. However, all subsequent capacity assessments about other decisions determined they did not have capacity and staff told us they felt the person did not have capacity. The decision-specific assessment about where to live had not been reviewed despite it being possible that the person's ability to decide could have changed. If someone did not have capacity we saw that a best interest decision had been made following mental capacity assessments. However, the people and professionals involved were not named but summarised with the phrase 'multi-disciplinary team'. There was also not always enough detail. For example, when the assessment stated to list all the options considered for the person, the answer was 'all options' but this did not specify what those options were. This meant there was not a clear audit trail of what was considered, who was involved and it was not possible to tell if the appropriate people were involved. This meant people were not consistently protected as the principles of the MCA were not always being followed. We discussed this with the clinical lead who said in future the names of people involved would be documented.

Staff we spoke with had a good understanding of the MCA and how it affected people's decision making abilities and how and when best interest decisions were needed. A nurse said, "Just because people have

been labelled with Alzheimer's, it doesn't mean they can't make choices." They went on to describe how they supported people to make their own decisions about everyday activities. We observed staff checking people gave their consent before being supported, such as being offered their medicines or whether they wanted to wear a protective apron whilst eating or not.

Care plans for supporting people with diabetes were not always specific or personalised but relied on computer generated generic care plans. We saw three care plans for people living with diabetes. They all said, 'BLG is monitored' (blood glucose levels) and 'Identify BLG outside of reportable levels' but contained no information about how frequently blood glucose levels were monitored, or by whom or what the 'reportable levels' were for those people. When we asked staff, they told us the GP managed blood glucose levels for people who had diet controlled diabetes. One person was insulin dependent but their care plan did not mention insulin at all. We saw BGLs had been done and recorded on paper forms. The same person had been hypoglycaemic the previous day but there was no information about this, or how staff should respond within the person's care plan. A nurse was able to tell us the actions they had taken, which was effective in raising the person's blood sugar. Following our feedback, the registered manager took action and ensured a new care plan was written which included more detail in how the person should be supported with their diabetes. A diabetes care plan also included the direction to 'identify any foot problems.' This is best practise because complications of diabetes can include serious foot infections due to loss of sensation and reduced blood flow. However, the care plan did not detail what staff should actually do to prevent foot problems or how and when they should check the person's feet. This meant they were at risk of receiving inconsistent care and not having the symptoms of their health condition effectively monitored.

One person had been assessed by a Speech and Language Therapist (SALT) due to them being at risk of choking. We saw the SALT had assessed them as needing liquids of a particular consistency to try and reduce the risk of the person choking. We saw a member of staff give the person a drink which was not off the correct consistency as it was too thin. We observed the person coughing whilst having the drink. We looked at the person's plan and it had not been updated to reflect the new guidance from SALT and contained old information. This meant the person was at risk of choking as staff had not followed the new guidance and further consideration of how to best support the person had not been considered. Following our feedback, the nurse updated the person's care plan to include the most up to date guidance.

People had access to other health professionals. One relative said, "Every time my relative has been poorly they've got the doctor." One health professional explained they attended a multi-disciplinary meeting at the home in order to discuss people's needs and how to support them. They said, "I have found the manager and deputy as well as clinical lead very helpful and knowledgeable over the residents… I have no concerns with any staff I have had dealings with." The electronic records showed people had been seen by a GP, specialist nurse, or SALT. Further improvements were required to ensure professional advice was consistently followed for all people.

We saw people were given a choice of food and drink and people enjoyed the food. One person said, "It's [the food] very good, there is always a choice I like." Another person said, "The food is gorgeous. At first I was refusing food so they offered my relative a meal too, to encourage me to eat. We get a choice and I can order something not on the menu if I want and there's plenty of food." We overheard other comments about the food such as, "It's lovely." We saw staff asking people prior to lunch what they would like and they were offered a choice. Most people chose one of these but one person asked for a baked potato. Staff asked what they wanted with it and offered a variety of choices. The person made their choice and we later saw they were served this. The person also asked if they could have some more and staff happily obtained it from the kitchen. We observed that when people required altered texture food this was served on sectioned, adapted

plates to help people maintain the independence of eating food for themselves. Carers were on hand to support people who needed them in order to eat and drink. When people were at risk of malnutrition as demonstrated by a risk assessment, they had been referred to a dietician and a GP had been informed. Care included weekly weights and food intake recording. This meant people were supported to eat and drink enough to maintain a balanced diet.

The building was suitable to accommodate people with support needs. Bathrooms were adapted so people could access a bath and equipment was available to help people to move if needed. The building was appropriately maintained. One person said, "If something is not working they notice and get maintenance." Checks were taking place on electrical systems, emergency lights and fire systems to help keep people and staff safe. We were told of further improvements planned to the environment which would give people more options of where to spend their time.

Good

Is the service caring?

Our findings

People told us the staff were kind and caring. One person said, "[Carer's name] is amazing, they're so gentle and do anything for you." The person went on to say, "I'm usually too shy but [carer's name] did my shower and now I'd have another." Another person said, "Care is very good. I love the staff, they are so kind." Other comments included, "Very kind" and "The staff are amazing here" and "Very good staff." A relative said, "The staff are absolutely brilliant, I can't fault anyone." We observed many interactions between care staff and people living in the home. Carers called people by name and knew what was important to them, taking time to talk with them and ask about different things. We observed one person ask a member of staff at lunch time, "Can you tell me what's on my plate?" The member of staff politely explained and offered the person condiments to accompany their meal. Another person was complaining of pain and was repetitive in their behaviour. We saw staff were very kind to the person, offering pain relief and staying with the person to try to make them more comfortable, offering companionship and encouraging them to eat.

People were supported to be as independent and to be involved in their care as much as possible. One person said, "They're good at helping me understand things as I can get muddled" and they went on to say, "They let me do as much as I can for myself." We saw at lunch time people were encouraged to eat independently and where necessary people had access to adapted plates and cutlery and staff who prompted and encouraged them. This helped people have independence, where possible, instead of relying on staff to assist them to eat. A nurse described how they asked people how they wanted their care delivered; ask what clothes they want to wear, showing them alternatives if necessary. They said they encouraged independence even when people are not able to do as much as they used to by giving them a flannel to wash their own face or helping them brush their own hair. Staff gave us another example of a person who could manage their own needs in relation to going to the toilet, but would sometimes need prompting. This meant staff helped the person retain their independence and dignity.

We asked members of staff to tell us about some people living in the home. They knew details of people's lives not captured in documentation and showed they knew them well and cared for their wellbeing. Staff were also able to describe how they would help someone maintain their dignity whilst being supported, such as keeping doors closed and covering people when being assisted with personal care.

The home was spacious and allowed people to spend time on their own if they wished. There were communal lounges on each floor, as well as quiet rooms and people could spend time in their own room. People's bedrooms were personalised and adorned with their choice of items and décor. Relatives could visit at any time. One relative said, "My relative can call me at any time and I can visit at any time." Another relative said, "I can visit at any time. I came with no warning one day and they were very welcoming." This meant people could choose where they spent their time and had personal space.

Requires Improvement

Is the service responsive?

Our findings

There were general plans regarding people's end of life needs including who should be informed and if they had an undertaker in mind. However, these plans were not always personalised and did not always include further details such as religious preferences, or emotional support needs. One member of staff said, "You can't personalise the end of life plans and they don't flow." When we discussed this with the management they explained they were having a local organisation come to visit to support them to improve their end of life planning. We did see clear evidence for one person who had put their own plans and instructions in place which all staff were aware of; 'just in case' medications had been prescribed and obtained for a person in advance being required. This would ensure these medicines were available without delay when they were needed. This meant improvements were required to ensure personalised plans were consistently available for people who wished to discuss their end of life preferences.

People and relatives were involved in the development of their care plans. One relative said, "There was a pre-assessment and we went through it again [when my relative moved in]." Staff told us and we found that care plans did not always have enough detail and information. One member of staff said, "One member of staff said, "The plans are not detailed enough." Another member of staff said, "There's not enough detail [in the care plans]." Information contained in handover records was not always transferred into care plans. For example, when a person was referred to a doctor or dietician. Risk assessments were repeated every month. If risk increased staff told us care plans were reviewed but changes to plans were difficult to see using the electronic system. Some information was in the system but was not easy to find in relation to specific issues. This meant there was a risk that people could receive inconsistent care as staff did not always have sufficient information available to them.

We saw minimal assessment of people's additional support needs other than their personal care needs. For example, people's religious affiliations were recorded but no information about how important it was to them or how the service would support them was evident. The assessment process did not consider people's needs holistically; for example people's sexuality or showing that people had the opportunity to discuss their sexuality, if they chose to. When we discussed this with the registered manager they explained that they ask people if there is anyone they are close to that they would like to be involved and if a person did raise a sensitive issue then staff would ask them how the person would like to be supported. There was an 'Equality and Diversity Policy and Procedure' in place for staff and staff were supported to have training in this area. We saw an action plan was in place which included an action point regarding further supporting people with maintaining things important to them, including their religion and culture which was in progress. This meant the service had started to consider how to support people with a diverse range of needs but further improvements were required to embed this and ensure it was reflected in people's plans of care.

People told us they were supported to partake in activities. One person said, "There's all sorts going on here." Staff we spoke with could describe the activities that some people liked to do. For example, one person liked a game of dominos and looking at photo albums. There were two activities coordinators; one full time and one part time. During our visit the activities coordinators were unavailable. There was also a

minibus available to enable access to the community and trips. An action plan was in place which showed how the home wanted to improve the activities available to people. One action included established an activity board which we saw was now in place.

People and relatives told us they felt able to complain and some felt they had no complaints. One person said, "I've got no complaints whatever." Another person said, "I've got no complaints." We were told of a complaint that had been made, however there was no record of this. When we discussed this with the registered manager they explained it was still being investigated. We saw other examples of complaints which had been recorded, action taken and the complaints had been responded to. There was also an appropriate complaints policy in place. Overall, this meant the home listened to feedback to improve people's experience of care.

Requires Improvement

Is the service well-led?

Our findings

This is the second inspection in which the home has been rated as requires improvement overall. This shows that the service had failed to consistently make and sustain improvements to achieve a good rating overall.

Systems were not effective in identifying all concerns. For example, one potential safeguarding incident had not been identified and action had not been taken. There had been another potential safeguarding incident which the registered manager was aware of but this had not been reported either. We saw another example where an audit had identified some improvements required in relation to the personal history information within a care plan. However, the action taken was insufficient to fully address the action identified as staff had just recorded what the person had done as a job, but had not included any further personal information. Other care plans also lacked detail. For example, information about a specific health condition or details about people's behaviour and how staff should support people was lacking. When we spoke with staff they were able to tell us about what support some people liked, such as the conversations they liked to have and things that worked to keep people calm, however this was not reflected in their care plans. This meant there was a risk that some people may receive inconsistent support as staff did not all have access to current information about some people and this had not been identified through care plan audits.

A medicines audit had been carried out however it had not been fully effective at identifying all concerns. For example, one question in the audit was in relation to whether there were any issues with the ordering of stock, which had been ticked as no. However, during the inspection we saw some medicines were out of stock as there had been issues in getting it from the pharmacy. Despite this not being recorded, we did see the home had met with the pharmacy to try to work in partnership and identify solutions to any issues. Another question had asked whether the stock levels of the homely remedies matched records which was ticked as yes. Homely remedies are medicines for minor ailments that could be bought over the counter. However, we found a 14-tablet discrepancy. The timing of the administration of time-critical medicines had also not been recorded and this had not been identified as part of the audit. Another audit on MAR charts had been carried out and this had also not identified a stock issue for one person and it was not clear whether these audits included TMARs or not. When we asked about the MAR audits we were told that new audit tools were being introduced which were more in depth to try and resolve this. This meant medicines audits had not always been effective at identifying and recording issues but some action was being taken to resolve this but it was not yet embedded.

Staff told us and we saw that there was not always enough information available about people and they sometimes found the electronic system frustrating. Staff told us they felt the electronic system being used was not always ideal. One staff member said, "It takes a lot of going around things to find stuff on the system." They went on to say, "Knowing where to find detail is the problem." One staff member said, "The system is OK but it doesn't always work." Another member of staff said, "The system can cut out." We were told of plans to ensure systems were more effective but this had not yet been implemented.

The local authority had identified during a monitoring visit that improvements were required to the

recording of people being repositioned in order to help people maintain their skin integrity. During our inspection we also found that the records suggested some people were not being repositioned as regularly as their care plans required. This had not been identified and timely action to resolve this had not been taken by the service. However, we saw other examples where action had been taken following concerns being highlighted. This meant further improvements were required to ensure action was taken in a timely manner.

The service had failed to take sufficient action to monitor and improve the quality of the service. These issues demonstrated a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager did checks on the accidents and incidents and looked at things such as the type of incident and where and when it occurred to. This was to help identify any trends and reduce the likelihood of incidents occurring again. We saw some months when no accidents had occurred.

A resident and relative survey had been conducted to find out people's opinion of the care they received. Overall the responses had been positive. We saw that action had been taken when feedback was received, such as more activities were required and we were told an additional member of staff was now facilitating activities in the home. The home had sought feedback about what it did well and what it could improve on. One member of staff said, "We have regular team meetings. The provider asks us what improvements are needed. We asked for brighter light bulbs and they were replaced." Another member of staff said, "We have staff meetings with the registered manager, deputy, clinical lead and the owner and they're useful." An action plan was developed to address these improvements prior to the inspection. We saw some actions had been completed, such as implementing an activity board and improvements to food choices. Some actions were still in progress. The provider had also engaged an external consultant to undertake audits in order to help identify improvements. An updated action plan was sent to us following the inspection incorporating our feedback which showed what action had already happened and the evidence for this and the timescales for other actions.

Regular management meetings took place to discuss all aspects of the home, such audits, maintenance, complaints, activities and actions from previous meetings. The provider was at the home regularly and the registered manager felt supported. We saw the home worked in partnership with other organisations and health professionals and had multi-disciplinary meetings to discuss people, their needs and how to support them.

People and relatives knew who the management team were and staff felt supported by them. One relative said, "The deputy is lovely." Another relative confirmed that they knew who the registered manager was. One staff member said, "There is good teamwork and we get to know each other. We have staff meetings." They went on to say, "We can go to the registered manager. We can go to the deputy and clinical lead too. The registered manager helps when needs be." Another member of staff said, "The registered manager is approachable." Another member of staff told us, "The clinical lead is lovely, I can talk to them."

The manager had notified CQC about significant events. Statutory notifications include information about important events which the provider is required to send us by law. For example, they told us if someone passed away whilst living in the home. We used this information to monitor the 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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Potential safeguarding incidents had not always been identified or reported to the local safeguarding authority as required.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance This is the second inspection in which the home has been rated as requires improvement overall. Quality assurance systems had failed to identify and rectify some concerns.